CMS RIF REPORT FOR RECORD: CARR_CLM_REC, STATUS: PROD, VERSION: 21006
PRINTED: 04/26/2021, USER: F43D, DATA SOURCE: CA REPOSITORY ON DB2T

NAME	LENGTH	BEG	END	CONTENTS

*** Carrier Claim Record (NCH)
                    VAR   1 24193   REC

                              STANDARD ALIAS : CARR_CLM_REC
                              SYSTEM   ALIAS : UTLCARRL

1. Carrier Claim Fixed Group
                    1592   1 1592   GRP

2. Claim Record Identification Group
                    8   1   8   GRP

                              Effective with Version 'I' the record
                              length, version code, record identification,
                              code and NCH derived claim type code were moved
                              to this group for internal NCH processing.

                              STANDARD ALIAS : CLM_REC_IDENT_GRP

3. Record Length Count
                    3   1   3   PACK

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

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

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

                              LENGTH   : 5   SIGNED : Y

                              SOURCE   : NCH

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

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

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

LENGTH   : 1

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

SOURCE   : NCH

CODE TABLE   : NCH_NEAR_LINE_REC_VRSN_TB

5. NCH Near Line Record Identification Code
          1   5   5   CHAR

          A code defining the type of claim record being processed.

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

          LENGTH   : 1

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

          SOURCE   : NCH

          CODE TABLE   : NCH_NEAR_LINE_RIC_TB

6. NCH MQA RIC Code
          1   6   6   CHAR

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

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

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

          LENGTH   : 1

SOURCE   : NCH QA PROCESS

                    CODE TABLE   : NCH_MQA_RIC_TB

7. NCH Claim Type Code
                    2   7   8   CHAR

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

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

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

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

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

                    LENGTH   : 2

                    DERIVATIONS :
                    FFS CLAIM TYPE CODES DERIVED FROM:
                    NCH CLM_NEAR_LINE_RIC_CD
                    NCH PMT_EDIT_RIC_CD
                    NCH CLM_TRANS_CD
                    NCH PRVDR_NUM

                    INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                    (Pre-HDC processing -- AVAILABLE IN NCH)
                    CLM_MCO_PD_SW
                    CLM_RLT_COND_CD
                    MCO_CNTRCT_NUM
                    MCO_OPTN_CD
                    MCO_PRD_EFCTV_DT
                    MCO_PRD_TRMNTN_DT

                    DERIVATION RULES:

                    SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
                    FOLLOWING CONDITIONS ARE MET:
                    1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'

2. PMT_EDIT_RIC_CD EQUAL 'F'
3. CLM_TRANS_CD EQUAL '5'

SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (Medicare Advantage IME/GME
CLAIMS - 10/1/05 - FORWARD)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '0'
2. CLM_RLT_COND_CD = '04' & '69'
3. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 63 (HMO NO-PAY CLAIMS)
WHERE THE FOLLOWING CONDITIONS ARE MET:
CLAIMS PROCESSED ON OR AFTER 10/6/08
1. CLM_THRU_DT ON OR AFTER 10/1/06
2. CLM_MCO_PD_SW = '1'
3. CLM_RLT_COND_CD = '04'
4. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'A', 'B' OR 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS
5. ZERO REIMBURSEMENT (CLM_PMT_AMT)

SET CLM_TYPE_CD TO 63 (HMO NO-PAY CLAIMS)
WHERE THE FOLLOWING CONDITIONS ARE MET:
CLAIMS PROCESSED PRIOR to 10/6/08
1. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'A', 'B' OR 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS
2. ZERO REIMBURSEMENT (CLM_PMT_AMT)

SET CLM_TYPE_CD TO 64 (HMO CLAIMS PAID AS FFS)
WHERE THE FOLLOWING CONDITIONS ARE MET:
CLAIMS PROCESSED PRIOR to 10/6/08
1. MCO_CNTRCT_NUM
MCO_OPTN_CD = '1', '2' OR '4'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 64 (HMO CLAIMS PAID AS FFS)
WHERE THE FOLLOWING CONDITIONS ARE MET:
CLAIMS PROCESSED on or after 10/6/08
1. CLM_RLT_COND_CD = '04'
2. MCO_CNTRCT_NUM
MCO_OPTN_CD = '1', '2' OR '4'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT

ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one or
more line item(s) match the HCPCS on the
DMEPOS table).

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

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

SOURCE   : NCH

LIMITATIONS :

 REFER TO :
 NCH_CLM_TYPE_CD_LIM

CODE TABLE   : NCH_CLM_TYPE_TB

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

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

STANDARD ALIAS : CARR_DMERC_CLM_LINK_GRP

9. Claim Locator Number Group
          11   9   19   GRP

This number uniquely identifies the beneficiary in
the NCH Nearline.

COMMON   ALIAS : HIC
STANDARD ALIAS : CLM_LCTR_NUM_GRP
TITLE   ALIAS : HICAN

10. Beneficiary Claim Account Number
              9   9   17   CHAR

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

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

LENGTH   : 9

SOURCE   : SSA,RRB

LIMITATIONS :

 REFER TO :
 CLM_ACNT_NUM_LIM

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
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.

               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 bene-
               ficiary (a.k.a. 'Statement Covers From Date').

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

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

               LENGTH   : 8   SIGNED : N

               SOURCE   : CWF

               EDIT RULES :
                   YYYYMMDD

16. Claim Through Date

8   33   40   NUM

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

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

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

LENGTH   : 8   SIGNED : N

SOURCE   : CWF

EDIT RULES :
    YYYYMMDD

17. NCH Weekly Claim Processing Date
8   41   48   NUM

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

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

LENGTH   : 8   SIGNED : N

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

SOURCE   : NCH

EDIT RULES :
    YYYYMMDD

18. CWF Claim Accretion Date
8   49   56   NUM

The date the claim record is accreted (posted/ processed) to the beneficiary master record at the CWF host site and authorization for

payment is returned to the fiscal interme-
diary or carrier.

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

LENGTH   : 8   SIGNED : N

SOURCE   : CWF

EDIT RULES :
    YYYYMMDD

19. CWF Claim Accretion Number
            2   57   58   PACK

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

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

LENGTH   : 3   SIGNED : Y

SOURCE   : CWF

20. Carrier Claim Control Number
            15   59   73   CHAR

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

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

LENGTH   : 15

COMMENTS :
For the physician/supplier or DMERC claim, this
field allows CMS to associate each line item

with its respective claim.

SOURCE   : CWF

EDIT RULES :
  LEFT JUSTIFY

21. FILLER
        38   74   111   CHAR

        DB2   ALIAS : FILLER
        STANDARD ALIAS : FILLER

        LENGTH   : 38

22. NCH Daily Process Date
        8   112   119   NUM

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

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

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

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

        LENGTH   : 8   SIGNED : N

        SOURCE   : NCH

        LIMITATIONS :

         REFER TO :
         NCH_DAILY_PROC_DT_LIM

        EDIT RULES :
          YYYYMMDD

23. 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

24. Claim Total Segment Count
              2   125   126   NUM

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

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

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

LENGTH   : 2   SIGNED : N

SOURCE   : CWF

25. Claim Segment Number
              2   127   128   NUM

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

NOTE: During the Version I conversion this

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

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

LENGTH   : 2   SIGNED : N

SOURCE   : CWF

26. Claim Total Line Count
          3   129   131   NUM

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

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

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

LENGTH   : 3   SIGNED : N

SOURCE   : CWF

27. Claim Segment Line Count
          2   132   133   NUM

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

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

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

LENGTH   : 2   SIGNED : N

SOURCE   : CWF

28.
       911   134   1044

29. FILLER
       5   134   138   CHAR

DB2   ALIAS : FILLER
STANDARD ALIAS : FILLER

LENGTH   : 5

30. Carrier Claim Entry Code
       1   139   139   CHAR

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

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

LENGTH   : 1

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

SOURCE   : CWF

CODE TABLE   : CARR_CLM_ENTRY_TB

31. FILLER
       1   140   140   CHAR

DB2   ALIAS : FILLER
STANDARD ALIAS : FILLER

LENGTH   : 1

32. Claim Disposition Code
       2   141   142   CHAR

Code indicating the disposition or outcome of the processing

of the claim record.

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

LENGTH   : 2

SOURCE   : CWF

CODE TABLE   : CLM_DISP_TB

33. NCH Edit Disposition Code
          2   143   144   CHAR

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

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

DB2   ALIAS : NCH_EDIT_DISP_CD
SAS   ALIAS : EDITDISP
STANDARD ALIAS : NCH_EDIT_DISP_CD
TITLE   ALIAS : NCH_EDIT_DISP

LENGTH   : 2

SOURCE   : NCH QA Process

CODE TABLE   : NCH_EDIT_DISP_TB

34. NCH Claim BIC Modify H Code
          1   145   145   CHAR

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

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

DB2   ALIAS : NCH_BIC_MDFY_CD
SAS   ALIAS : BIC_MDFY
STANDARD ALIAS : NCH_CLM_BIC_MDFY_CD
TITLE   ALIAS : BIC_MODIFY_CD

LENGTH   : 1

SOURCE   : NCH QA Process

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

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

DB2   ALIAS : BENE_SSA_CNTY_CD
SAS   ALIAS : CNTY_CD
STANDARD ALIAS : BENE_RSDNC_SSA_STD_CNTY_CD
TITLE   ALIAS : BENE_COUNTY_CD

LENGTH   : 3

SOURCE   : SSA/EDB

EDIT RULES :
    OPTIONAL: MAY BE BLANK

36. Carrier Claim Receipt Date
                   8   149   156   NUM

The date the carrier receives the non-
institutional claim.

DB2   ALIAS : CLM_RCPT_DT
SAS   ALIAS : RCPT_DT
STANDARD ALIAS : CARR_CLM_RCPT_DT

LENGTH   : 8   SIGNED : N

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

SOURCE   : CWF

EDIT RULES :
    YYYYMMDD

37. Carrier Claim Scheduled Payment Date
                   8   157   164   NUM

The scheduled date of payment to the physician
or supplier, as appearing on the original non-
institutional claim sent to the CWF host.
**Note: This date is considered to be the
date paid since no additional information as
to the actual payment date is available.

DB2   ALIAS : CARR_SCHLD_PMT_DT
SAS   ALIAS : SCHLD_DT
STANDARD ALIAS : CARR_CLM_SCHLD_PMT_DT

TITLE   ALIAS : SCHLD_PMT_DT

LENGTH   : 8   SIGNED : N

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

SOURCE   : CWF

EDIT RULES :
   YYYYMMDD

38. CWF Forwarded Date
                8   165   172   NUM

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

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

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

LENGTH   : 8   SIGNED : N

SOURCE   : CWF

EDIT RULES :
   YYYYMMDD

39. Carrier Number
                5   173   177   CHAR

The identification number assigned by CMS to a
carrier authorized to process claims from a
physician or supplier.

Effective July 2006, the Medicare Administrative
Contractors (MACs) began replacing the existing
carriers and started processing physician or
supplier claim records for states assigned
to its jurisdiction.

NOTE: The 5-position MAC number will be housed in
the existing CARR_NUM field. During the transi-
tion from a carrier to a MAC the CARR_NUM field
could contain either a Carrier number or a MAC
number. See the CARR_NUM table of codes to
identify the new MAC numbers and their effective

dates.

                    DB2   ALIAS : CARR_NUM
                    SAS   ALIAS : CARR_NUM
                    STANDARD ALIAS : CARR_NUM
                    TITLE   ALIAS : CARRIER

                    LENGTH   : 5

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

                    SOURCE   : CWF

                    CODE TABLE   : CARR_NUM_TB

40. FILLER
                8   178   185   CHAR

                    DB2   ALIAS : FILLER
                    STANDARD ALIAS : FILLER

                    LENGTH   : 8

41. CWF Transmission Batch Number
                4   186   189   CHAR

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

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

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

                    LENGTH   : 4

                    SOURCE   : CWF

42. Beneficiary Mailing Contact ZIP Code
                9   190   198   CHAR

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

                    DB2   ALIAS : BENE_MLG_ZIP_CD
                    SAS   ALIAS : BENE_ZIP

STANDARD ALIAS : BENE_MLG_CNTCT_ZIP_CD
TITLE   ALIAS : BENE_ZIP

LENGTH   : 9

SOURCE   : EDB

43. Beneficiary Sex Identification Code
         1   199   199   CHAR

The sex of a beneficiary.

COMMON   ALIAS : SEX_CD
DB2   ALIAS : BENE_SEX_IDENT_CD
SAS   ALIAS : SEX
STANDARD ALIAS : BENE_SEX_IDENT_CD
TITLE   ALIAS : SEX_CD

LENGTH   : 1

SOURCE   : SSA,RRB,EDB

EDIT RULES :
    REQUIRED FIELD

CODE TABLE   : BENE_SEX_IDENT_TB

44. Beneficiary Race Code
         1   200   200   CHAR

The race of a beneficiary.

DB2   ALIAS : BENE_RACE_CD
SAS   ALIAS : RACE
STANDARD ALIAS : BENE_RACE_CD
TITLE   ALIAS : RACE_CD

LENGTH   : 1

SOURCE   : SSA

CODE TABLE   : BENE_RACE_TB

45. Beneficiary Birth Date
        8   201   208   NUM

The beneficiary's date of birth.

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

LENGTH   : 8   SIGNED : N

SOURCE   : CWF

EDIT RULES :
      YYYYMMDD

46. CWF Beneficiary Medicare Status Code
              2   209   210   CHAR

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

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

          LENGTH   : 2

          DERIVATIONS :
          CWF derives MSC from the following:
          1. Date of Birth
          2. Claim Through Date
          3. Original/Current Reasons for entitlement
          4. ESRD Indicator
          5. Beneficiary Claim Number
          Items 1,3,4,5 come from the CWF Beneficiary
          Master Record; item 2 comes from the FI/Carrier
          claim record. MSC is assigned as follows:

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

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

          SOURCE   : CWF

          CODE TABLE   : BENE_MDCR_STUS_TB

47. Claim Patient 6 Position Surname
              6   211   216   CHAR

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

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

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

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

LENGTH   : 6

SOURCE   : CWF

48. Claim Patient 1st Initial Given Name
               1   217   217   CHAR

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

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

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

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

LENGTH   : 1

SOURCE   : CWF

49. Claim Patient First Initial Middle Name

```
1   218   218   CHAR
```

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

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

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

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

LENGTH   : 1

SOURCE   : CWF

50. Beneficiary CWF Location Code
```
     1   219   219   CHAR
```

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

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

LENGTH   : 1

SOURCE   : CWF

CODE TABLE   : BENE_CWF_LOC_TB

51. Claim Principal Diagnosis Group
```
     8   220   227   GRP
```

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

STANDARD ALIAS : CLM_PRNCPAL_DGNS_GRP

52. Claim Principal Diagnosis Version Code
                    1   220   220   CHAR

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

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

                    DB2   ALIAS : UNDEFINED
                    SAS   ALIAS : PDVRSNCD
                    STANDARD ALIAS : CLM_PRNCPAL_DGNS_VRSN_CD

                    LENGTH   : 1

                    CODE TABLE   : CLM_DGNS_VRSN_TB

53. Claim Principal Diagnosis Code
                    7   221   227   CHAR

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

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

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

                    DB2   ALIAS : PRNCPAL_DGNS_CD
                    SAS   ALIAS : PDGNS_CD
                    STANDARD ALIAS : CLM_PRNCPAL_DGNS_CD

                    LENGTH   : 7

                    SOURCE   : CWF

                    EDIT RULES :
                        ICD-9-CM

54. FILLER
                    1   228   228   CHAR

                    DB2   ALIAS : FILLER
                    STANDARD ALIAS : FILLER

LENGTH   : 1

55. Carrier Claim Payment Denial Code
            2   229   230   CHAR

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

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

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

DB2   ALIAS : CARR_PMT_DNL_CD
SAS   ALIAS : PMTDNLCD
STANDARD ALIAS : CARR_CLM_PMT_DNL_CD

LENGTH   : 2

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

CODE TABLE   : CARR_CLM_PMT_DNL_TB

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

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

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

LENGTH   : 1

57. Claim Payment Amount
                    6   232   237   PACK

Amount of payment made from the Medicare trust fund for the
services covered by the claim record. Generally, the amount
is calculated by the FI or carrier; and represents what was
paid to the institutional provider, physician, or supplier,
with the exceptions noted below. ***NOTE: In some
situations, a negative claim payment amount may be pre-
sent; 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.
After 7/5/2011, the payment amount could also include
a payment adjustment given to hospitals to account for
the higher costs per discharge for "low-income hospitals".
After 10/1/2012, the payment amount could also include
adjustments for value based purchasing, readmissions,
and Model 1, Bundled Payments for Care Improvement. After
10/1/2014, the payment amount could also include the
uncompensated care payment (UCP).

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
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 noninstitutmonal (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 :

```
 REFER TO :
  PMT_AMT_EXCEDG_CHRG_AMT_LIM
```

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

58. Carrier Claim Primary Payer Paid Amount
                 6   238   243   PACK

Effective with Version H, the amount of a payment made on behalf of a Medicare bene-ficiary by a primary payer other than Medicare,

that the provider is applying to covered
Medicare charges on a non-institutional claim.

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

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

LENGTH   : 9.2   SIGNED : Y

SOURCE   : CWF

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

59. FILLER
                1   244   244   CHAR

                DB2   ALIAS : FILLER
                STANDARD ALIAS : FILLER

                LENGTH   : 1

60. Carrier Claim Referring UPIN Number
                6   245   250   CHAR

                The unique physician identification number
                (UPIN) of the physician who referred the
                beneficiary to the physician who performed
                the Part B services.

                COMMON   ALIAS : REFERRING_PHYSICIAN_UPIN
                DB2   ALIAS : RFRG_UPIN_NUM
                SAS   ALIAS : RFR_UPIN
                STANDARD ALIAS : CARR_CLM_RFRG_UPIN_NUM
                TITLE   ALIAS : REFERRING_PHYSICIAN_UPIN

                LENGTH   : 6

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

                SOURCE   : CWF

61. Carrier Claim Referring Physician NPI Number
                10   251   260   CHAR

                The national provider identifier (NPI) number

of the physician who referred the beneficiary
to the physician who performed the Part B
services.

NOTE: Effective May 2007, the NPI will 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 on 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 re-
ceive any currently issued UPINs. Effective May
2007, no new UPINs (legacy number) will be generated
for new physicians (Part B and Outpatient claims)
so there will only be NPIs sent in to the NCH
for those physicians.

DB2   ALIAS : RFRG_PHYSN_NPI_NUM
SAS   ALIAS : RFR_NPI
STANDARD ALIAS : CARR_CLM_RFRG_PHYSN_NPI_NUM

LENGTH   : 10

SOURCE   : CWF

62. Carrier Claim Provider Assignment Indicator Switch
                1   261   261   CHAR

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

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

LENGTH   : 1

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

SOURCE   : CWF

CODE TABLE   : CARR_CLM_PRVDR_ASGNMT_IND_TB

63. NCH Claim Provider Payment Amount
                6   262   267   PACK

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

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

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

                        LENGTH   : 9.2   SIGNED : Y

                        SOURCE   : NCH QA Process

64. NCH Claim Beneficiary Payment Amount
                6   268   273   PACK

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

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

                        DB2   ALIAS : NCH_BENE_PMT_AMT
                        SAS   ALIAS : BENE_PMT
                        STANDARD ALIAS : NCH_CLM_BENE_PMT_AMT
                        TITLE   ALIAS : BENE_PMT

                        LENGTH   : 9.2   SIGNED : Y

                        SOURCE   : NCH QA Process

65. Carrier Claim Beneficiary Paid Amount
                6   274   279   PACK

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

                        NOTE: Beginning with NCH weekly process date
                        10/3/97 this field was populated with data.

Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2   ALIAS : CARR_BENE_PD_AMT
SAS   ALIAS : BENEPAID
STANDARD ALIAS : CARR_CLM_BENE_PD_AMT
TITLE   ALIAS : BENE_PD_AMT

LENGTH   : 9.2   SIGNED : Y

SOURCE   : CWF

66. NCH Carrier Claim Submitted Charge Amount
          6   280   285   PACK

Effective with Version H, the total submitted charges on the claim (the sum of line item submitted charges).

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

DB2   ALIAS : CARR_SBMT_CHRG_AMT
SAS   ALIAS : SBMTCHRG
STANDARD ALIAS : NCH_CARR_SBMT_CHRG_AMT
TITLE   ALIAS : SBMT_CHRG

LENGTH   : 9.2   SIGNED : Y

SOURCE   : NCH QA Process

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

67. NCH Carrier Claim Allowed Charge Amount
          6   286   291   PACK

Effective with Version H, the total allowed charges on the claim (the sum of line item allowed charges).

NOTE1: The amount includes beneficiary-paid amounts (i.e., deductible and coinsurance).

NOTE2: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2   ALIAS : CARR_ALOW_CHRG_AMT
SAS   ALIAS : ALOWCHRG
STANDARD ALIAS : NCH_CARR_ALOW_CHRG_AMT
TITLE   ALIAS : ALOW_CHRG

LENGTH   : 9.2   SIGNED : Y

SOURCE   : NCH QA Process

EDIT RULES :
    $$$$$$$CC

68. Carrier Claim Cash Deductible Applied Amount
        6   292   297   PACK

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

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

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

LENGTH   : 9.2   SIGNED : Y

SOURCE   : CWF

69. Carrier Claim HCPCS Year Code
        1   298   298   NUM

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

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

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

LENGTH   : 1   SIGNED : N

SOURCE   : CWF

70. Carrier Claim MCO Override Indicator Code
        1   299   299   CHAR

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

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

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

LENGTH   : 1

SOURCE   : CWF

CODE TABLE   : CARR_CLM_MCO_OVRRD_IND_TB

71. Carrier Claim Hospice Override Indicator Code
          1   300   300   CHAR

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

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

DB2   ALIAS : HOSPC_OVRRD_IND_CD
SAS   ALIAS : HOSPOVRD
STANDARD ALIAS : CARR_CLM_HOSPC_OVRRD_IND_CD
TITLE   ALIAS : HOSPC_OVERRIDE

LENGTH   : 1

SOURCE   : CWF

CODE TABLE   : CARR_CLM_HOSPC_OVRRD_IND_TB

72. Claim Business Segment Identifier Code
          4   301   304   CHAR

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

loads that may be redistributed with the implemen-
tation of contracting reform as required by MMA.

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

LENGTH      : 4

SOURCE      : CWF
```

73. Claim Clinical Trial Number
            8   305   312   CHAR

Effective September 1, 2008 with the implementation
of CR#3, the number used to identify all items
and services provided to a beneficiary during their
participation in a clinical trial.

NOTE:
CMS is requesting the clinical trial number be
voluntarily reported. The number is assigned by
the National Library of Medicine (NLM) Clinical
Trials Data Bank when a new study is registered.

```
DB2     ALIAS : CLM_CLNCL_TRIL_NUM
SAS     ALIAS : CTRILNUM
STANDARD ALIAS : CLM_CLNCL_TRIL_NUM

LENGTH      : 8
```

74. Recovery Audit Contractor (RAC) Adjustment Indicator Code
            1   313   313   CHAR

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

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

LENGTH      : 1

CODE TABLE    : CLM_RAC_ADJSTMT_TB
```

75. Claim Paperwork (PWK) Code
            2   314   315   CHAR

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

DB2   ALIAS : CLM_PWK_CD
STANDARD ALIAS : CLM_PWK_CD

LENGTH   : 2

CODE TABLE   : CLM_PWK_TB

76. Claim Care Improvement Model 1 Code
              2   316   317   CHAR

Effective with CR#7, the code used to identify that
the care improvement model 1 is being used for
bundling payments. The valid value for care
improvement model 1 is '61'.

DB2   ALIAS : CARE_MODEL_1_CD
SAS   ALIAS : CMODEL1
STANDARD ALIAS : CLM_CARE_IMPRVMT_MODEL_1_CD

LENGTH   : 2

CODE TABLE   : CLM_CARE_IMPRVMT_MODEL_TB

77. Claim Care Improvement Model 2 Code
              2   318   319   CHAR

Effective with CR#7, the code used to identify that
the care improvement model 2 is being used for
bundling payments. The valid value for care
improvement model 2 is '62'.

DB2   ALIAS : CARE_MODEL_2_CD
SAS   ALIAS : CMODEL2
STANDARD ALIAS : CLM_CARE_IMPRVMT_MODEL_2_CD

LENGTH   : 2

CODE TABLE   : CLM_CARE_IMPRVMT_MODEL_TB

78. Claim Care Improvement Model 3 Code
              2   320   321   CHAR

Effective with CR#7, the code used to identify that
the care improvement model 3 is being used for
bundling payments. The valid value for care
improvement model 3 is '63'.

DB2   ALIAS : CARE_MODEL_3_CD
SAS   ALIAS : CMODEL3
STANDARD ALIAS : CLM_CARE_IMPRVMT_MODEL_3_CD

LENGTH   : 2

CODE TABLE : CLM_CARE_IMPRVMT_MODEL_TB

79. Claim Care Improvement Model 4 Code
        2   322   323   CHAR

        Effective with CR#7, the code used to identify that
        the care improvement model 4 is being used for
        bundling payments. The valid value for care
        improvement model 4 is '64'.

        DB2   ALIAS : CARE_MODEL_4_CD
        SAS   ALIAS : CMODEL4
        STANDARD ALIAS : CLM_CARE_IMPRVMT_MODEL_4_CD

        LENGTH   : 2

        CODE TABLE   : CLM_CARE_IMPRVMT_MODEL_TB

80. Claim Fraud Prevention System (FPS) Model Number
        2   324   325   CHAR

        Effective with Version 'K', this field identifies an
        FPS analytic model that identifies claims that may
        be high risk for fraud based on specific information.

        DB2   ALIAS : CLM_FPS_MODEL_NUM
        SAS   ALIAS : FPSMODEL
        STANDARD ALIAS : CLM-FPS-MODEL-NUM

        LENGTH   : 2

        COMMENTS :
        Valid Values: 0 - 9, A -Z

81. Claim FPS Reason Code
        3   326   328   CHAR

        Effective with Version 'K', this field identifies the
        reason codes used to explain why a claim was not
        paid or how the claim was paid. These codes also
        show the reason for any claim financial adjustment
        such as denial, reductions or increases in payment.

        DB2   ALIAS : CLM_FPS_RSN_CD
        SAS   ALIAS : FPSRSN
        STANDARD ALIAS : CLM_FPS_RSN_CD

        LENGTH   : 3

        CODE TABLE   : CLM_ADJ_RSN_TB

82. Claim FPS Remarks Code
        5   329   333   CHAR

Effective with Version 'K', the codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.

DB2   ALIAS : CLM_FPS_RMRK_CD
SAS   ALIAS : FPSRMRK
STANDARD ALIAS : CLM_FPS_RMRK_CD

LENGTH   : 5

CODE TABLE   : CLM_RMTNC_ADVC_TB

83. Claim FPS MSN 1 Code
                5   334   338   CHAR

Effective with Version 'K', the field used to identify the Medicare Secondary Notice Code.

DB2   ALIAS : CLM_FPS_MSN_1_CD
SAS   ALIAS : FPSMSN1
STANDARD ALIAS : CLM-FPS-MSN-1-CD

LENGTH   : 5

CODE TABLE   : CLM_FPS_MSN_CD_TB

84. Claim FPS MSN 2 Code
                5   339   343   CHAR

Effective with Version 'K', the field used to identify the Medicare Secondary Notice Code.

DB2   ALIAS : CLM_FPS_MSN_2_CD
SAS   ALIAS : FPSMSN2
STANDARD ALIAS : CLM-FPS-MSN-2-CD

LENGTH   : 5

CODE TABLE   : CLM_FPS_MSN_CD_TB

85. Claim Mass Adjustment Indicator Code
                1   344   344   CHAR

Effective with Version 'K', the field used to identify if the adjustment claim is part of a mass adjustment project.

DB2   ALIAS : MASS_ADJSTMT_CD
SAS   ALIAS : MADJSTMT
STANDARD ALIAS : CLM_MASS_ADJSTMT_IND_CD

LENGTH   : 1

CODE TABLE   : CLM_MASS_ADJSTMT_IND_CD_TB

86. Claim Paper Provider Code
               2   345   346   CHAR

Effective with CR#8, the code used to identify the
provider type that submitted the paper claim.

NOTE: This data element will not be implemented in
CWF until the January 2014 release, which means you
will not begin to see data in this field in the NCH
until the January implementation. We are adding
this field with the NCH CR#8 October release because
we will not be doing a January 2014 release.

DB2   ALIAS : CLM_PAPER_PRVDR_CD
SAS   ALIAS : PPRVDR
STANDARD ALIAS : CLM_PAPER_PRVDR_CD

LENGTH   : 2

CODE TABLE   : CLM_PAPER_PRVDR_TB

87. Claim Residual Payment Indicator Code
               1   347   347   CHAR

Effective with CR#11, this field is used by CWF claims processing
for the purpose of bypassing its normal MSP editing that would
otherwise apply for ongoing responsibility for medicals (ORM) or
worker's compensation Medicare Set-Aside Arrangements (WCMSA).
Normally, CWF does not allow a secondary payment on MSP involving
ORM or WCMSA, so the residual payment indicator will be used to
allow CWF to make an exception to its normal routine.

DB2   ALIAS : CLM_RSDL_PMT_CD
SAS   ALIAS : RSDLPMT
STANDARD ALIAS : CLM_RSDL_PMT_IND_CD

LENGTH   : 1

SOURCE   : CWF

CODE TABLE   : RSDL_PMT_IND_TB

88. Claim Accountable Care Organization (ACO) Identification Number
               10   348   357   CHAR

Effective with CR#12, this field identifies the unique identifi-
cation number assigned to the Accountable Care Organization (ACO).

DB2   ALIAS : CLM_ACO_ID_NUM
SAS   ALIAS : ACOIDNUM
STANDARD ALIAS : CLM_ACO_ID_NUM

LENGTH   : 10

COMMENTS :
(CMS CR9468) - CWF July 2016 Release

89. Medicare Beneficiary Identification (MBI) Number
                11   358   368   CHAR

Effective with CR#12, this field represents the Medicare beneficiary
identification number. This field is being added due to the removal
of the Social Security Number from the Medicare card (SSNRI project).
The MBI will replace the HICN on the Medicare card. CMS will
continue to use the HICN within internal systems.

NOTE: We will not see MBI's on the claims until October 2017
(start of the transition period).

DB2   ALIAS : MBI_ID
SAS   ALIAS : MBIID
STANDARD ALIAS : MBI_ID

LENGTH   : 11

COMMENTS :
SSNRI Project
CWF October 2017 Release

90. Claim Beneficiary Identifier Type Code
                1   369   369   CHAR

Effective with CR#12, this field identifies whether the claim was
submitted by the provider, during the transition period, with a
HICN or MBI.

NOTE: This field will not be populated with data until the start
of the transition period (October 2017).

DB2   ALIAS : BENE_ID_TYPE_CD
SAS   ALIAS : BENEIDCD
STANDARD ALIAS : CLM_BENE_ID_TYPE_CD

LENGTH   : 1

COMMENTS :
(SSNRI Project)
CWF October 2017 Release

CODE TABLE   : CLM_BENE_ID_TYPE_TB

91. Claim Provider Validation Code
                2   370   371   CHAR

Effective with CR#14 (April 2019 release), this field is used to

inform the Common Working File (CWF) to perform an edit check to ensure that the provider that was submitted on the Prior Authorization (PA) request is the same provider on the claim.

DB2   ALIAS : UNDEFINED
SAS   ALIAS : CVLDTNCD

LENGTH   : 2

CODE TABLE   : CLM_PRVDR_VLDTN_TB

92.
            673   372   1044   CHAR

            DB2   ALIAS : H_FILLER_7

            LENGTH   : 673

93. Carrier Specific Group
            534   1045   1578   GRP

94. Carrier Claim Referring PIN Number
            14   1045   1058   CHAR

            Carrier-assigned identification (profiling)
            number of the physician who referred the
            beneficiary to the physician that performed
            the Part B services.

            COMMON   ALIAS : REFERRING_PHYSICIAN_PIN
            DB2   ALIAS : RFRG_PIN_NUM
            SAS   ALIAS : RFR_PRFL
            STANDARD ALIAS : CARR_CLM_RFRG_PIN_NUM
            TITLE   ALIAS : RFRG_PIN

            LENGTH   : 14

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

            SOURCE   : CWF

95. Care Plan Oversight (CPO) Provider Number
            6   1059   1064   CHAR

            Effective with NCH weekly process date 3/7/97,
            the Medicare provider number of the HHA or Hospice
            rendering Medicare covered services during
            period the physician is providing care plan
            oversight. The purpose of this field is to
            ensure compliance with the CPO requirement that
            the beneficiary must be receiving covered HHA or

Hospice services during the billing period. There
can be only one CPO provider number per claim, and
no other services but CPO physician services are
to be reported on the claim. This field is only
present on the non-DMERC processed carrier claim.

NOTE: On the Version G format, this field is stored
as a redefinition of the NEAR_LINE_ORGNL_BENE_CAN_NUM
(the first 3 positions contain 'CPO', followed by
the 6-position provider number). During the
Version H conversion the data was moved to this
dedicated field.

DB2   ALIAS : CPO_PRVDR_NUM
SAS   ALIAS : CPO_PROV
STANDARD ALIAS : CPO_PRVDR_NUM

LENGTH   : 6

SOURCE   : CWF

96. CPO Organization NPI Number
                10   1065   1074   CHAR

The National Provider Identifier (NPI) number
of the HHA or Hospice rendering Medicare ser-
vices during the period the physician is pro-
viding care plan oversight. The purpose of
this field is to ensure compliance with the
CPO requirement that the beneficiary must be
receiving covered HHA or Hospice services
during the billing period. There can be only
one CPO provider number per claim, and no
other services but CPO physician services are
to be reported on the claim. This field is only
present on the non-DMERC processed carrier claim.

NOTE: Effective May 2008, the NPI will become the
national standard identifier for covered health
care providers. NPIs will replace the current
legacy provider numbers (UPINs, PINs, OSCAR
provider numbers, etc.) on the standard HIPPA
claim transactions. (During the NPI transition
phase the capability was there for the NCH to receive
NPIs along with an existing legacy number (UPIN, NPIs,
OSCAR provider numbers, etc.)).

NOTE1: CMS has determined that dual provider iden-
tifiers (legacy numbers and NPIs) must be avail-
able on the NCH. After the 5/08 NPI implementation,
the standard system maintainers will add the legacy
number to the claim when it is adjudicated. Effect-
tive May 2008, no NEW UPINs (legacy number) will be
generated for NEW physicians (Part B and Outpatient

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

    DB2   ALIAS : CPO_ORG_NPI_NUM
    SAS   ALIAS : CPO_NPI
    STANDARD ALIAS : CPO_ORG_NPI_NUM

    LENGTH   : 10

    SOURCE   : CWF

97. Claim Blood Pints Furnished Quantity
        2 1075 1076   PACK

    Number of whole pints of blood furnished to the beneficiary, as reported on the carrier claim (non-DMERC).

    DB2   ALIAS : BLOOD_PT_FRNSH_QTY
    SAS   ALIAS : BLDFRNSH
    STANDARD ALIAS : CLM_BLOOD_PT_FRNSH_QTY
    TITLE   ALIAS : BLOOD_PINTS_FURNISHED

    LENGTH   : 3   SIGNED : Y

    COMMENTS :
    Prior to Version H this field was stored in a blood trailer. Version H eliminated the blood trailer.

    SOURCE   : CWF

    EDIT RULES :
       NUMERIC

98. Claim Blood Deductible Pints Quantity
        2 1077 1078   PACK

    The quantity of blood pints applied (blood deductible) as reported on the carrier claim (non-DMERC).

    DB2   ALIAS : BLOOD_DDCTBL_PT
    SAS   ALIAS : BLD_DED
    STANDARD ALIAS : CLM_BLOOD_DDCTBL_PT_QTY
    TITLE   ALIAS : BLOOD_PINTS_DEDUCTIBLE

    LENGTH   : 3   SIGNED : Y

    COMMENTS :
    Prior to Version H this field was stored in a blood trailer. Version H eliminated the blood trailer.

SOURCE   : CWF

EDIT RULES :
    NUMERIC

99. Carrier Claim Billing NPI Number
    10   1079   1088   CHAR

Effective with CR#8, this field identifies the National
Provider Identifier (NPI) number assigned to the
billing provider.

DB2   ALIAS : CARR_BLG_NPI_NUM
SAS   ALIAS : BLGNPI
STANDARD ALIAS : CARR_CLM_BLG_NPI_NUM

LENGTH   : 10

100. Carrier Claim Site of Service NPI
    10   1089   1098   CHAR

Effective with CR#13 (January 2018 release), this field
identifies the Site of Service National Provider Identifier
(NPI).

DB2   ALIAS : CARR_SOS_NPI_NUM
SAS   ALIAS : CARRSOS
STANDARD ALIAS : CARR_CLM_SOS_NPI_NUM

LENGTH   : 10

COMMENTS :
CMS CR6001/5767 (CWF implemented in 2009)

NOTE: CMS CR did not require the NCH to add
this field to our copybooks. The field is now being
added because a user recently asked us to add the
field.

SOURCE   : CWF

101. FILLER
    480   1099   1578   CHAR

DB2   ALIAS : H_FILLER_8

LENGTH   : 480

102. Carrier NCH Edit Code Count
    2   1579   1580   NUM

The count of the number of edit codes
annotated to the carrier claim during

HCFA's CWFMQA process. The purpose of
this count is to indicate how many claim
edit trailers are present.

DB2   ALIAS : EDIT_TRLR_CNT
SAS   ALIAS : CEDCNT
STANDARD ALIAS : CARR_NCH_EDIT_CD_CNT

LENGTH   : 2   SIGNED : N

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

SOURCE   : NCH

103. Carrier NCH Patch Code Count
        2   1581   1582   NUM

Effective with Version H, the count of the
number of HCFA patch codes annotated to the
carrier claim during the Nearline maintenance
process.   The purpose of this count is to
indicate how many NCH patch trailers are
present.
NOTE: During the Version H conversion this
field was populated with data throughout
history (back to service year 1991).

DB2   ALIAS : PATCH_TRLR_CNT
SAS   ALIAS : CPATCNT
STANDARD ALIAS : CARR_NCH_PATCH_CD_I_CNT

LENGTH   : 2   SIGNED : N

SOURCE   : NCH

104. Carrier MCO Period Count
        1   1583   1583   NUM

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

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

DB2   ALIAS : CARR_MCO_PRD_CNT
SAS   ALIAS : CMCOCNT
STANDARD ALIAS : CARR_MCO_PRD_CNT

```
LENGTH      : 1   SIGNED : N

SOURCE      : NCH

EDIT RULES :
    RANGE: 0 TO 2
```

105. Carrier Claim Demonstration ID Count
                1   1584   1584   NUM

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

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

```
DB2     ALIAS : DEMO_TRLR_CNT
SAS     ALIAS : CDEMCNT
STANDARD ALIAS : CARR_CLM_DEMO_ID_CNT

LENGTH      : 1   SIGNED : N

SOURCE      : NCH

EDIT RULES :
    RANGE: 0 TO 5
```

106. Carrier Claim Diagnosis Code J Count
                2   1585   1586   NUM

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

NOTE: Effective with Version 'J', the count of diagnosis
code trailers was expanded from 8 to 12.

```
DB2     ALIAS : DGNS_TRLR_CNT
SAS     ALIAS : CDGNCNT
STANDARD ALIAS : CARR_CLM_DGNS_CD_J_CNT

LENGTH      : 2   SIGNED : N

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

SOURCE      : NCH
```

EDIT RULES :
     RANGE: 0 TO 12

107. Carrier Claim Line Count
                2   1587   1588   NUM

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

                DB2   ALIAS : LINE_ITM_TRLR_CNT
                SAS   ALIAS : CLINECNT
                STANDARD ALIAS : CARR_CLM_LINE_CNT

                LENGTH   : 2   SIGNED : N

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

                SOURCE   : CWFB CLAIMS

                EDIT RULES :
                     RANGE: 1 TO 13

108. FILLER
                4   1589   1592   CHAR

                DB2   ALIAS : FILLER
                STANDARD ALIAS : FILLER

                LENGTH   : 4

109. Carrier Claim Variable Group
                VAR   1593   24193   GRP

110. NCH Edit Group
                65   1593   1657   GRP

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

                STANDARD ALIAS : NCH_EDIT_GRP

                OCCURS MIN: 0 OCCURS MAX: 13

                  DEPENDING ON : CARR_NCH_EDIT_CD_CNT

111. NCH Edit Trailer Indicator Code
                1   1593   1593   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

112. NCH Edit Code
      4   1594   1597   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

113. NCH Patch Group
      330   1658   1987   GRP

STANDARD ALIAS : NCH_PATCH_GRP

OCCURS MIN: 0 OCCURS MAX: 30

  DEPENDING ON : CARR_NCH_PATCH_CD_I_CNT

114. NCH Patch Trailer Indicator Code
      1   1658   1658   CHAR

Effective with Version H, the code indicating
the presence of an NCH patch trailer.

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

DB2   ALIAS : PATCH_TRLR_IND_CD
SAS   ALIAS : PATCHIND
STANDARD ALIAS : NCH_PATCH_TRLR_IND_CD

LENGTH   : 1

SOURCE   : NCH

CODE TABLE   : NCH_PATCH_TRLR_IND_TB

115. NCH Patch Code
                 2   1659   1660   CHAR

Effective with Version H, the code annotated
to the claim indicating a patch was applied
to the record during an NCH Nearline record
conversion and/or during current processing.

NOTE: Prior to Version H this field was located
in the third and fourth occurrence of the
CLM_EDIT_CD.

DB2   ALIAS : NCH_PATCH_CD
SAS   ALIAS : PATCHCD
STANDARD ALIAS : NCH_PATCH_CD
TITLE   ALIAS : NCH_PATCH

LENGTH   : 2

SOURCE   : NCH

CODE TABLE   : NCH_PATCH_TB

116. NCH Patch Applied Date
                 8   1661   1668   NUM

Effective with Version H, the date the NCH patch
was applied to the claim.

DB2   ALIAS : NCH_PATCH_APPLY_DT
SAS   ALIAS : PATCHDT
STANDARD ALIAS : NCH_PATCH_APPLY_DT
TITLE   ALIAS : NCH_PATCH_DT

LENGTH   : 8   SIGNED : N

```
                         SOURCE        : NCH

                         EDIT RULES :
                            YYYYMMDD
```

117. MCO Period Group
```
              74  1988  2061   GRP
```

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

                         STANDARD ALIAS : MCO_PRD_GRP

                         OCCURS MIN: 0 OCCURS MAX: 2

                          DEPENDING ON : CARR_MCO_PRD_CNT
```

118. NCH MCO Trailer Indicator Code
```
              1  1988  1988   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.

                         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
```

119. MCO Contract Number
```
              5  1989  1993   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

120. MCO Option Code
                1   1994   1994   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

121. MCO Period Effective Date
                8   1995   2002   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

122. MCO Period Termination Date
             8   2003   2010   NUM


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

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

                    DB2     ALIAS : MCO_PRD_TRMNTN_DT
                    SAS     ALIAS : MCOTRMDT
                    STANDARD ALIAS : MCO_PRD_TRMNTN_DT
                    TITLE   ALIAS : MCO_PERIOD_TERM_DT

                    LENGTH       : 8   SIGNED : N

                    SOURCE        : CWF

                    EDIT RULES :
                       YYYYMMDD


123. MCO Health PLANID Number
             14   2011   2024   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


124. Claim Demonstration Identification Group
             90   2062   2151   GRP
```

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

STANDARD ALIAS : CLM_DEMO_ID_GRP

OCCURS MIN: 0 OCCURS MAX: 5

DEPENDING ON : CARR_CLM_DEMO_ID_CNT

125. NCH Demonstration Trailer Indicator Code
        1 2062 2062   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).

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

126. Claim Demonstration Identification Number
        2 2063 2064   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 appro-
private 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 parti-
cipating 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 follow-
ing 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 Partner-
ships 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 imple-
mented 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 effective-
ness of LVRS and maximum medical therapy (in-
cluding pulmonary rehab) for Medicare bene-
ficiaries 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 SEN-
SITIVE 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 diag-
nosed, advanced-stage congestive heart failure,
diabetes, or coronary heart disease. Three demon-
stration 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 trans-
mitting the claims to Trailblazers for processing.

NOTE: Effective October, 2000 for carrier claims.

40 = Payment of Physician and Nonphysician Services
in certain Indian Providers -- the purpose of
this demo is to extend payment for services of
physician and nonphysician practitioners
furnished in hospitals and ambulatory care clinics.
Prior to the legislation change in BIPA, reim-
bursement for Medicare services provided in IHS
facilities was limited to services provided in
hospitals and skilled nursing facilities. This
change will allow payment for IHS, Tribe and
Tribal Organization providers under the Medicare
physician fee schedule.

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

45 = Chiropractic

48 = Medical Adult Day-Care Services -- the purpose
of this demonstration is to provide, as part of the
episode of care for home health services, medical

adult day care services to Medicare beneficiaries as
a substitute for a portion of home health services
that would otherwise be provided in the beneficiaries
home. This demo would last approx. 3 years in not
more than 5 sites. Payment for each home health ser-
vice episode of care will be set at 95% of the amount
that would otherwise be paid for home health services
provided entirely in the home.

NOTE: Effective July 5, 2005 for HHA claims.

49 = Hemodialysis

53 = Extended Stay

54 = ACE Demo

56 = ACA 3113 Lab Demo

58 = used to identify the Multi-payer Advanced Primary
Care Practice (MAPCP) demonstration.
(eff. 7/2/12 - CR7693/7283)

59 = ACO Pioneer Demonstration
(CMS CR8140) - eff. 1/2014

60 = Power Motorized Device (PMD)

61 = CLM-CARE-IMPRVMT-MODEL-1

62 = CLM-CARE-IMPRVMT-MODEL-2

63 = CLM-CARE-IMPRVMT-MODEL-3

64 = CLM-CARE-IMPRVMT-MODEL-4

65 = rebilled claims due to auditor denials -- code being
implemented for a demonstration to determine the efficiency
of allowing providers to rebill for all outpatient services,
minus a penalty, when an inpatient claim is denied in full
because of medical review because the beneficiary did not
require inpatient services. (eff. 7/2/12 -- CR7738)

66 = rebilled claims due to provider self-audit after
claim submission/payment -- code being implemented for
a demonstration to determine the efficiency of allowing
providers to rebill for all outpatient services, minus a
penalty, when an inpatient claim is denied in full be-
cause of medical review because the beneficiary did not
require inpatient services. (eff. 7/2/12 -- CR7738)

67 = rebilled claims due to provider self-audit after
the patient has been discharged,but prior to payment --
code being implemented for a demonstration to determine

the efficiency of allowing providers to rebill for all
outpatient services, minus a penalty, when an inpatient
claim is denied in full because of medical review because
the beneficiary did not require inpatient services.
(eff. 7/2/12 -- CR7738)

68 = CWF will not apply the 3-day hospital stay requirement
when processing a SNF claim.
(CMS CR8215) - eff. 1/2014

70 = used for Electrical Workers Insurance Fund claims.
(eff. 7/2/12)
71 = Intravenous Immune Globin (IVIG)
75 = Comprehensive Care for Joint Replacement (CCJR)
(eff. 4/2016)
77 = Shared Savings Program (eff. 10/2016)
78 = Comprehensive Primary Care Plus (CPC+) (eff. 4/2017)
79 = Acute Myocardial Infarction (AMI) Episode Payment
Model (EPM) ((eff. 1/2018)
80 = Coronary Artery Bypass Graft (CABG) Episode Payment
Model (EPM) (eff. 1/2018)
81 = Surgical Hip and Femur Fracture Treatment (SHFFT)
Episode Payment Model (EMP) (eff. 1/2018)
82 = Medicare Diabetes Prevention Program (MDPPs)
(eff. 4/2018)
83 = Maryland Primary Care Program (MDPCP)
(eff. 1/2018)
86 = Bundled Payments for Care Improvement Advanced Model
87 = Prospective Bundled Payments for Radiation Oncology (RO)
Model (eff. 1/2020)
89 = Vermont All-Payer- (VT ACO Model) (eff. 1/2019)
91 = Emergency Triage, Treat, and Transport (ET3) Model - is a
voluntary, 5-year payment model that will provide
greater flexibility to ambulance care teams to address
emergency health care needs of Medicare FFS beneficiaries
following a 911 call. (eff. 1/2020)
92 = Direct Contracting (DC) Model - Professional and Global
Options: Total Care Capitation (TCC), Primary Care Capitation
(PCC), Advanced Payment Option (APO), Telehealth Expansion,
3-day SNF Rule Waiver, Post-Discharge and Care-Management
Home Visits - The Direct Contracting (DC) Model creates a
new opportunity for CMS to test an array of financial risk-
sharing arrangements, leveraging lessons learned from other
Medicare ACO initiatives. As an ACO-like Model, DC allows
participating organizations to take on the financial risk for
Medicare Part A and B expenditures for a defined popula-
tion of fee-for-service Medicare beneficiaries over a
defined period of time (5 years, separated into 1-year
increments called Performance Years (PYs)). eff. 4/2021
94 = ESRD Treatment Choices (ETC) - eff. 1/2020 - Outpatient
and Carrier Only (eff. 1/2020)
95 = Oncology Care Model Plus (OCM+) - eff. 1/2020
96 = New Primary Care First (PCF) model - has two separate
but related components: (1) the PCF component and (2)

the Seriously Ill Population (SIP) component. Both components will test alternative payments and the provision of technical support to primary care practices. These PCF and/or SIP participants will receive a combination of claims and non-claims-based payments based on their attributed Medicare fee-for-service (FFS) beneficiaries. Every participating practice will be given a unique practice ID by the CMS implementation support contractor. Providers in a practice will be uniquely defined by the combination of each provider's tax ID number (TIN) and national provider identifier (NPI). Eff. 1/2021

97 = Kidney Care Choices (KCC) Kidney Care First (KCF) - For the CMS Kidney Care First (KCF) Option, nephrologists and and nephrology practices will receive adjusted capitated payments for managing beneficiaries with Chronic Kidney Disease (CKD) stages 4 and stages 5 and ESRD (End State Renal Disease), and will be eligible for upward or downward payment adjustments based on the quality of their performance and improvements in their performance over time. This model is designed to emulate the basic design of the Primary Care First (PCF) Model. eff. 4/2021.

98 = Pennsylvania Rural Health Model (PARHM) - The provides provides rural acute care hospitals and Critical Access Hospitals (CAH) the opportunity to participate in hospital global budget payments for all inpatient and outpatient hospital services and CAH swing bed services. CMS reimburses participant rural hospitals according to an annual global budget, which is provided by the Commonwealth of Pennsylvania. Participant rural hospitals also submit claims to CMS, but zero claims payments are made. Eff. 1/2018

99 = Opiod Use Disorder (OUD) Treatment Model - is a 4-year The purpose of Value in OUD Treatment is to "increase access of applicable beneficiaries to opioid use disorder treatment services, improve physical and mental health outcomes for such beneficiaries, and to the extent possible, reduce Medicare program expenditures." Eff. 4/2021

DB2   ALIAS : CLM_DEMO_ID_NUM
SAS   ALIAS : DEMONUM
STANDARD ALIAS : CLM_DEMO_ID_NUM
TITLE   ALIAS : DEMO_ID

LENGTH   : 2

SOURCE   : CWF

127. Claim Demonstration Information Text
            15   2065   2079   CHAR

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

five positions of this text field.

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

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

LENGTH   : 15

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

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

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

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

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

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

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

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

SOURCE   : CWF

LIMITATIONS :

 REFER TO :
 CHOICES_DEMO_LIM

128. Carrier Claim Diagnosis Group
            108 2152 2259   GRP

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

STANDARD ALIAS : CARR_CLM_DGNS_GRP

OCCURS MIN: 0 OCCURS MAX: 12

  DEPENDING ON : CARR_CLM_DGNS_CD_J_CNT

129. NCH Diagnosis Trailer Indicator Code
            1 2152 2152   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

130. Claim Diagnosis Version Code
            1 2153 2153   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 10/2014.

DB2   ALIAS : CLM_DGNS_VRSN_CD
SAS   ALIAS : DVRSNCD
STANDARD ALIAS : CLM_DGNS_VRSN_CD

LENGTH   : 1

CODE TABLE   : CLM_DGNS_VRSN_TB

131. Claim Diagnosis Code
              7   2154   2160   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
STANDARD ALIAS : CLM_DGNS_CD

LENGTH   : 7

EDIT RULES :
   ICD-9-CM

132. Carrier Line Item Group
              21931   2260   24190   GRP

OCCURS MIN: 1 OCCURS MAX: 13
OCCURS MIN: 1OCCURS MAX: 13

   DEPENDING ON : CARR_CLM_LINE_CNT

133. NCH Line Item Trailer Indicator Code
                1   2260   2260   CHAR

                Effective with Version H, the code indicating
                the presence of a line item trailer on the non-
                institutional claim.

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

                DB2   ALIAS : LINE_TRLR_IND_CD
                SAS   ALIAS : LINEIND
                STANDARD ALIAS : NCH_LINE_TRLR_IND_CD

                LENGTH   : 1

                SOURCE   : NCH

                CODE TABLE   : NCH_LINE_TRLR_IND_TB

134. Carrier Line Performing PIN Number
              10   2261   2270   CHAR

                The profiling identification number (PIN) of the
                physician\supplier (assigned by the carrier) who
                performed the service for this line item on the
                carrier claim (non-DMERC).

                COMMON   ALIAS : PHYSICIAN/SUPPLIER_PROVIDER_NUM
                DB2   ALIAS : LINE_PRFRMG_PIN
                SAS   ALIAS : PRF_PRFL
                STANDARD ALIAS : CARR_LINE_PRFRMG_PIN_NUM
                TITLE   ALIAS : PRFRMG_PIN

                LENGTH   : 10

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

                SOURCE   : CWF

135. Carrier Line Performing UPIN Number
              6   2271   2276   CHAR

                The unique physician identification number
                (UPIN) of the physician who performed the
                service for this line item on the carrier
                claim (non-DMERC).

                DB2   ALIAS : LINE_PRFRMG_UPIN
                SAS   ALIAS : PRF_UPIN

STANDARD ALIAS : CARR_LINE_PRFRMG_UPIN_NUM
TITLE   ALIAS : PRFRMG_UPIN

LENGTH   : 6

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

SOURCE   : CWF

LIMITATIONS :

 REFER TO :
  CARR_LINE_PRFRMG_UPIN_LIM

136. Carrier Line Performing NPI Number
          10   2277   2286   CHAR

A placeholder field (effective with Version H)
for storing the NPI assigned to the performing
provider.

DB2   ALIAS : LINE_PRFRMG_NPI
SAS   ALIAS : PRFNPI
STANDARD ALIAS : CARR_LINE_PRFRMG_NPI_NUM

LENGTH   : 10

SOURCE   : CWF

137. Carrier Line Performing Group NPI Number
          10   2287   2296   CHAR

The National Provider Identifier (NPI) of the
group practice, where the performing physician
is part of that group.

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

CMS has determined that dual provider identifiers
(old legacy numbers and new NPI) must be available
in the NCH. After the 5/07 NPI implementation, the
standard system maintainers will add the legacy
number to the claim when it is adjudicated. We
will continue to receive the OSCAR provider
number and any currently issued UPINs. Effective

May 2007, no NEW UPINs (legacy number) will be
generated for NEW physicians (Part B and Outpatient
claims), so there will only be NPIs sent in to the
NCH for those physicians.

```
DB2     ALIAS : PRFRMG_GRP_NPI
SAS     ALIAS : PRGRPNPI
STANDARD ALIAS : CARR_LINE_PRFRMG_GRP_NPI_NUM

LENGTH      : 10

SOURCE      : CWF
```

138. Carrier Line Provider Type Code
                1   2297   2297   CHAR

Code identifying the type of provider
furnishing the service for this line item
on the carrier claim (non-DMERC).

```
DB2     ALIAS : LINE_PRVDR_TYPE_CD
SAS     ALIAS : PRV_TYPE
STANDARD ALIAS : CARR_LINE_PRVDR_TYPE_CD
TITLE   ALIAS : PRVDR_TYPE

LENGTH      : 1

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

SOURCE      : CWF

CODE TABLE     : CARR_LINE_PRVDR_TYPE_TB
```

139. Line Provider Tax Number
                10   2298   2307   CHAR

Social security number or employee
identification number of physician/supplier
used to identify to whom payment is made for
the line item service on the noninstitutional
claim.
Note: The first 9 positions contain the Social
Security/Tax Number and the 10th position contains
the provider type code.

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

LENGTH      : 10
```

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

SOURCE   : NCH

140. Line NCH Provider State Code
             2   2308   2309   CHAR

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

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

DB2   ALIAS : LINE_PRVDR_STATE
SAS   ALIAS : PRVSTATE
STANDARD ALIAS : LINE_NCH_PRVDR_STATE_CD
TITLE   ALIAS : PRVDR_STATE

LENGTH   : 2

DERIVATIONS :
DERIVED FROM:
CARR_LINE_PRFRMG_PRVDR_ZIP_CD

DERIVATION RULES:

Use the first three positions of the provider
zip code to derive the LINE_NCH_PRVDR_STATE_CD
from a crosswalk file.   Where a match is not
achieved this field will be blank.

SOURCE   : NCH

CODE TABLE   : GEO_SSA_STATE_TB

141. Carrier Line Performing Provider ZIP Code
             9   2310   2318   CHAR

The ZIP code of the physician/supplier who
performed the Part B service for this line
item on the carrier claim (non-DMERC).

DB2   ALIAS : LINE_PRVDR_ZIP_CD
SAS   ALIAS : PROVZIP
STANDARD ALIAS : CARR_LINE_PRFRMG_PRVDR_ZIP_CD
TITLE   ALIAS : PRVDR_ZIP_CD

LENGTH   : 9

COMMENTS :

Prior to Version H this field was named:
CWFB_PRFRMG_PRVDR_ZIP_CD and the field size
was S9(9).

SOURCE   : CWF

142. Line HCFA Provider Specialty Code
              2 2319 2320   CHAR

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

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

LENGTH   : 2

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

SOURCE   : CWF

CODE TABLE   : CMS_PRVDR_SPCLTY_TB

143. Carrier Line Provider Specialty Code
              2 2321 2322   CHAR

The carrier's specialty code for the provider
(usually different from HCFA's) used for
pricing the service for this line item on
the carrier claim (non-DMERC).

NOTE: The LINE_HCFA_PRVDR_SPCLTY_CD is the code to use,
This code is an hold over field from the days before the
Physician Fee Schedule was implemented. CMS allowed
carriers to have their own set of codes for developing
local pricing profiles, i.e. prevailing charge, customary
charge, or reasonable charge systems. Physician services
are no longer priced using this method. Some carriers
still maintain these local specialties but they are NOT
recognized by CMS.

It has been determined that this field is useless for
national pricing or statistics. CWF systems still allows
this field and passes the data (if submitted) on to the
NCH.

DB2   ALIAS : PRVDR_SPCLTY_CD
SAS   ALIAS : CARRSPCL
STANDARD ALIAS : CARR_LINE_PRVDR_SPCLTY_CD

TITLE   ALIAS : CARR_PRVDR_SPCLTY

LENGTH   : 2

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

SOURCE   : CWF

EDIT RULES :
      CARRIER INFORMATION FILE

144. Line Provider Participating Indicator Code
                1   2323   2323   CHAR

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

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

            LENGTH   : 1

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

            SOURCE   : CWF

            CODE TABLE   : LINE_PRVDR_PRTCPTG_IND_TB

145. Carrier Line Reduced Payment Physician Assistant Code
                1   2324   2324   CHAR

            Effective 1/92, the code on the carrier (non-DMERC)
            line item that identifies claims that have been
            paid a reduced fee schedule amount (65%, 75% or 85%)
            because a physician's assistant performed the
            services.

            COMMON   ALIAS : PA_65/75/85%_FEE
            DB2   ALIAS : PHYSN_ASTNT_CD
            SAS   ALIAS : ASTNT_CD
            STANDARD ALIAS : CARR_LINE_RDCD_PHYSN_ASTNT_CD
            TITLE   ALIAS : PHYSN_ASTNT_CD

            LENGTH   : 1

            COMMENTS :
            Prior to Version H this field was named:

CWFB_RDCD_PMT_PHYSN_ASTNT_CD.

SOURCE   : CWF

CODE TABLE   : CARR_LINE_RDCD_PHYSN_ASTNT_TB

146. Line Service Count
                6 2325 2330   PACK

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

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

LENGTH   : 7.3   SIGNED : Y

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

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

SOURCE   : CWF

147. Line HCFA Type Service Code
                1 2331 2331   CHAR

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

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

LENGTH   : 1

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

SOURCE   : CWF

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

CODE TABLE   : CMS_TYPE_SRVC_TB

148. Carrier Line Type Service Code

        2 2332 2333   CHAR

                      Carrier's type of service code (usually
different from HCFA's) used for pricing the
service reported on the line item on the
carrier claim (non-DMERC).

                      DB2   ALIAS : LINE_TYPE_SRVC_CD
SAS   ALIAS : PTYPESRV
STANDARD ALIAS : CARR_LINE_TYPE_SRVC_CD
TITLE   ALIAS : CARR_TYPE_SRVC

LENGTH   : 2

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

SOURCE   : CWF

149. Line Place of Service Code

        2 2334 2335   CHAR

                      The code indicating the place of service, as
defined in the Medicare Carrier Manual, for
this line item on the noninstitutional claim.

                      COMMON ALIAS : POS
DB2   ALIAS : LINE_PLC_SRVC_CD
SAS   ALIAS : PLCSRVC
STANDARD ALIAS : LINE_PLC_SRVC_CD
TITLE   ALIAS : PLC_SRVC

LENGTH   : 2

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

SOURCE   : CWF

CODE TABLE   : LINE_PLC_SRVC_TB

150. Carrier Line Pricing Locality Code

        2 2336 2337   CHAR

                      Code denoting the carrier-specific locality
used for pricing the service for this line
item on the carrier claim (non-DMERC).

                      DB2   ALIAS : PRCNG_LCLTY_CD
SAS   ALIAS : LCLTY_CD

STANDARD ALIAS : CARR_LINE_PRCNG_LCLTY_CD
TITLE   ALIAS : PRICING_LOCALITY

LENGTH   : 2

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

SOURCE   : CWF

EDIT RULES :
    CARRIER INFORMATION FILE

151. Line First Expense Date
         8   2338   2345   NUM

          Beginning date (1st expense) for this line item
          service on the noninstitutional
          claim.

          DB2   ALIAS : LINE_1ST_EXPNS_DT
          SAS   ALIAS : EXPNSDT1
          STANDARD ALIAS : LINE_1ST_EXPNS_DT
          TITLE   ALIAS : 1ST_EXPNS_DT

          LENGTH   : 8   SIGNED : N

          COMMENTS :
          Prior to Version H this field was named:
          CWFB_1ST_EXPNS_DT.

          SOURCE   : CWF

          EDIT RULES :
             YYYYMMDD

152. Line Last Expense Date
         8   2346   2353   NUM

          The ending date (last expense) for the line
          item service on the noninstitutional claim.

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

          LENGTH   : 8   SIGNED : N

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

```
SOURCE        : CWF

EDIT RULES :
    YYYYMMDD
```

153. Line HCPCS Code
```
              5   2354   2358   CHAR
```

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


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

LENGTH       : 5
```

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

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

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

Level II
Includes codes and descriptors copyrighted by
the American Dental Association's Current Dental
Terminology, Fifth Edition (CDT-5). These are
5 position alpha-numeric codes comprising
the D series. All other level II codes and
descriptors are approved and maintained jointly
by the alpha-numeric editorial panel (consisting
of CMS, the Health Insurance Association of

America, and the Blue Cross and Blue Shield
Association). These are 5 position alpha-
numeric codes representing primarily items and
nonphysician services that are not
represented in the level I codes.

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

154. Line HCPCS Initial Modifier Code
```
2   2359   2360   CHAR
```

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

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

LENGTH       : 2
```

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

```
SOURCE       : CWF
```

EDIT RULES :
    CARRIER INFORMATION FILE

155. Line HCPCS Second Modifier Code
```
2   2361   2362   CHAR
```

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

```
DB2     ALIAS : UNDEFINED
SAS     ALIAS : MDFR_CD2
STANDARD ALIAS : LINE_HCPCS_2ND_MDFR_CD
```

TITLE   ALIAS : SECOND_MODIFIER

LENGTH   : 2

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

SOURCE   : CWF

EDIT RULES :
    CARRIER INFORMATION FILE

156. Line HCPCS Third Modifier Code
        2   2363   2364   CHAR

        Prior to Version H this field was named:
        HCPCS_3RD_MDFR_CD.

        DB2   ALIAS : HCPCS_3RD_MDFR_CD
        SAS   ALIAS : MDFR_CD3
        STANDARD ALIAS : LINE_HCPCS_3RD_MDFR_CD

        LENGTH   : 2

        SOURCE   : CWF

157. Line HCPCS Fourth Modifier Code
        2   2365   2366   CHAR

        Prior to Version H this field was named:
        HCPCS_4TH_MDFR_CD.

        DB2   ALIAS : HCPCS_4TH_MDFR_CD
        SAS   ALIAS : MDFR_CD4
        STANDARD ALIAS : LINE_HCPCS_4TH_MDFR_CD

        LENGTH   : 2

        SOURCE   : CWF

158. Line NCH BETOS Code
        3   2367   2369   CHAR

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

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

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

LENGTH   : 3

DERIVATIONS :
DERIVED FROM:
LINE_HCPCS_CD
LINE_HCPCS_INITL_MDFR_CD
LINE_HCPCS_2ND_MDFR_CD
HCPCS MASTER FILE

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

SOURCE   : NCH

CODE TABLE   : BETOS_TB

159. Line IDE Number
                7 2370 2376   CHAR

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

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

DB2   ALIAS : LINE_IDE_NUM
SAS   ALIAS : LINE_IDE
STANDARD ALIAS : LINE_IDE_NUM

TITLE   ALIAS : IDE_NUMBER

LENGTH   : 7

SOURCE   : CWF

160. Line National Drug Code
               11 2377 2387 CHAR

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

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

LENGTH   : 11

SOURCE   : CWF

161. Line NCH Payment Amount
               6 2388 2393 PACK

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

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

LENGTH   : 9.2   SIGNED : Y

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

SOURCE   : NCH

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

162. Line Beneficiary Payment Amount
               6 2394 2399 PACK

Effective with Version H, the payment (reim-bursement) made to the beneficiary related

to the line item service on the noninstitu-
tional claim.

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

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

LENGTH   : 9.2 SIGNED : Y

SOURCE   : CWF

163. Line Provider Payment Amount
          6 2400 2405 PACK

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

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

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

LENGTH   : 9.2 SIGNED : Y

SOURCE   : CWF

164. Line Beneficiary Part B Deductible Amount
          6 2406 2411 PACK

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

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

LENGTH   : 9.2 SIGNED : Y

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

SOURCE   : CWF

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

165. Line Beneficiary Primary Payer Code
                1   2412   2412   CHAR

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

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

        LENGTH   : 1

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

        SOURCE   : CWF,VA,DOL,SSA

        CODE TABLE   : BENE_PRMRY_PYR_TB

166. Line Beneficiary Primary Payer Paid Amount
                6   2413   2418   PACK

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

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

        LENGTH   : 9.2   SIGNED : Y

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

SOURCE   : CWF

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

167. Line Coinsurance Amount

      6 2419 2424   PACK

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

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

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

LENGTH   : 9.2   SIGNED : Y

SOURCE   : CWF

168. Carrier Line Psychiatric, Occupational Therapy, Physical Therapy Limit Amount

      6 2425 2430   PACK

For type of service psychiatric, occupational
therapy or physical therapy, the amount of
allowed charges applied toward the limit cap
for this line item service on the noninstitutional
claim.

DB2   ALIAS : PSYCH_OT_PT_LMT
SAS   ALIAS : LLMTAMT
STANDARD ALIAS : CARR_LINE_PSYCH_OT_PT_LMT_AMT
TITLE   ALIAS : PSYCH_OT_PT_LIMIT

LENGTH   : 9.2   SIGNED : Y

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

SOURCE   : CWF

169. Line Interest Amount

      6 2431 2436   PACK

Amount of interest to be paid for this line

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

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

LENGTH   : 9.2   SIGNED : Y

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

SOURCE   : CWF

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

170. Line Primary Payer Allowed Charge Amount
            6   2437   2442   PACK

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

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

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

LENGTH   : 9.2   SIGNED : Y

SOURCE   : CWF

171. Line 10% Penalty Reduction Amount
            6   2443   2448   PACK

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

DB2   ALIAS : TENPCT_PNLTY_AMT
SAS   ALIAS : PNLTYAMT
STANDARD ALIAS : LINE_10PCT_PNLTY_RDCTN_AMT
TITLE   ALIAS : TENPCT_PNLTY

LENGTH   : 9.2   SIGNED : Y

SOURCE   : CWF

172. Carrier Line Blood Deductible Pints Quantity
        2 2449 2450 PACK

The blood pints quantity (deductible) for the
line item on the carrier claim (non-DMERC).

DB2   ALIAS : LINE_BLOOD_DDCTBL
SAS   ALIAS : LBLD_DED
STANDARD ALIAS : CARR_LINE_BLOOD_DDCTBL_QTY
TITLE   ALIAS : BLOOD_DDCTBL

LENGTH   : 3   SIGNED : Y

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

SOURCE   : CWF

EDIT RULES :
   NUMERIC

173. Line Submitted Charge Amount
        6 2451 2456 PACK

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

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

LENGTH   : 9.2   SIGNED : Y

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

SOURCE   : CWF

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

174. Line Allowed Charge Amount
        6 2457 2462 PACK

The amount of allowed charges for the line item

service on the noninstitutional claim. This
charge is used to compute pay to providers or
reimbursement to beneficiaries. **NOTE: The

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

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

DB2   ALIAS : LINE_ALOW_CHRG_AMT
SAS   ALIAS : LALOWCHG
STANDARD ALIAS : LINE_ALOW_CHRG_AMT
TITLE   ALIAS : ALOW_CHRG

LENGTH   : 9.2   SIGNED : Y

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

SOURCE   : CWF

EDIT RULES :
   $$$$$$$CC

175. Carrier Line Clinical Lab Number
            10 2463 2472   CHAR

The identification number assigned to the
clinical laboratory providing services for
the line item on the carrier claim (non-DMERC).

DB2   ALIAS : CLNCL_LAB_NUM
SAS   ALIAS : LAB_NUM
STANDARD ALIAS : CARR_LINE_CLNCL_LAB_NUM
TITLE   ALIAS : LAB_NUM

LENGTH   : 10

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

SOURCE   : CWF

176. Carrier Line Clinical Lab Charge Amount
            6 2473 2478   PACK

Fee schedule charge amount applied for the line
item clinical laboratory service on the carrier
claim (non-DMERC).

DB2   ALIAS : CLNCL_LAB_CHRG_AMT
SAS   ALIAS : LAB_AMT
STANDARD ALIAS : CARR_LINE_CLNCL_LAB_CHRG_AMT
TITLE   ALIAS : LAB_CHRG

LENGTH   : 9.2   SIGNED : Y

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

SOURCE   : CWF

EDIT RULES :
   $$$$$$$$C

177. Line Processing Indicator Code
            2 2479 2480   CHAR

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

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

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

DB2   ALIAS : LINE_PRCSG_IND_CD
SAS   ALIAS : PRCNGIND
STANDARD ALIAS : LINE_PRCSG_IND_CD

LENGTH   : 2

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

SOURCE   : CWF

CODE TABLE   : LINE_PRCSG_IND_TB

178. Line Payment 80%/100% Code

1   2481   2481   CHAR

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

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

LENGTH   : 1

COMMENTS :
Prior to Version H this field was named:
CWFB_PMT_80_100_CD.

SOURCE   : CWF

CODE TABLE   : LINE_PMT_80_100_TB

179. Line Service Deductible Indicator Switch
1   2482   2482   CHAR

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

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

LENGTH   : 1

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

SOURCE   : CWF

CODE TABLE   : LINE_SRVC_DDCTBL_IND_TB

180. Line Payment Indicator Code
1   2483   2483   CHAR

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

DB2   ALIAS : LINE_PMT_IND_CD

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

LENGTH   : 1

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

SOURCE   : CWF

181. Carrier Line Miles/Time/Units/Services Count
           6 2484 2489 PACK

The count of the total units associated with
services needing unit reporting such as
transportation, miles, anesthesia time units,
number of services, volume of oxygen or blood
units. This is a line item field on the carrier
claim (non-DMERC) and is used for both allowed
and denied services.

NOTE: For anesthesia (MTUS Indicator = 2) this
field should be reported in time unit intervals,
i.e. 15 minute interals or fraction thereof. It
appears that some carriers are reporting minutes
instead of time units.

DB2   ALIAS : LINE_MTUS_CNT
SAS   ALIAS : MTUS_CNT
STANDARD ALIAS : CARR_LINE_MTUS_CNT
TITLE   ALIAS : MTUS_CNT

LENGTH   : 7.3   SIGNED : Y

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

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

SOURCE   : CWF

LIMITATIONS :

 REFER TO :
 CARR_LINE_MTUS_CNT_LIM

EDIT RULES :
    For CARR_LINE_MTUS_IND_CD equal to 2 (anesthesia
    time units) there is one implied decimal point.

182. Carrier Line Miles/Time/Units/Services Indicator Code
              1 2490 2490   CHAR

                         Code indicating the units associated with
                         services needing unit reporting on the line
                         item for the carrier claim (non-DMERC).

                         DB2   ALIAS : LINE_MTUS_IND_CD
                         SAS   ALIAS : MTUS_IND
                         STANDARD ALIAS : CARR_LINE_MTUS_IND_CD
                         TITLE   ALIAS : MTUS_IND

                         LENGTH   : 1

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

                         SOURCE   : CWF

                         CODE TABLE   : CARR_LINE_MTUS_IND_TB

183. Claim Principal Diagnosis Group
              8 2491 2498   GRP

                         Effective with Version 'J', the group used to
                         identify the diagnosis codes at the time level.
                         This group contains the diagnosis code and the
                         diagnosis version code.

                         STANDARD ALIAS : LINE_DGNS_GRP

184. Line Diagnosis Version Code
              1 2491 2491   CHAR

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

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

                         DB2   ALIAS : UNDEFINED
                         SAS   ALIAS : LDVRSNCD
                         STANDARD ALIAS : LINE_DGNS_VRSN_CD

                         LENGTH   : 1

                         CODE TABLE   : LINE_DGNS_VRSN_TB

185. Line Diagnosis Code
              7 2492 2498   CHAR

The code indicating the diagnosis
supporting this line item procedure/service
on the noninstitutional claim.

DB2   ALIAS : LINE_DGNS_CD
SAS   ALIAS : LINEDGNS
STANDARD ALIAS : LINE_DGNS_CD
TITLE   ALIAS : DGNS_CD

LENGTH   : 7

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

SOURCE   : CWF

186. Carrier Line Anesthesia Base Unit Count
          6 2499 2504   PACK

The base number of units assigned to the line
item anesthesia procedure on the carrier claim
(non-DMERC).

DB2   ALIAS : ANSTHSA_UNIT_CNT
SAS   ALIAS : ANSTHUNT
STANDARD ALIAS : CARR_LINE_ANSTHSA_UNIT_CNT
TITLE   ALIAS : ANSTHSA_UNITS

LENGTH   : 7.3   SIGNED : Y

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

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

SOURCE   : CWF

187. Carrier Line CLIA Alert Indicator Code
          1 2505 2505   CHAR

Effective with Version G, the alert code (resulting
from CLIA editing) added by CWF as a line item
on the carrier claim (non-DMERC).

DB2   ALIAS : CLIA_ALERT_IND_CD
SAS   ALIAS : CLIAALRT
STANDARD ALIAS : CARR_LINE_CLIA_ALERT_IND_CD
TITLE   ALIAS : CLIA_ALERT

LENGTH   : 1

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

SOURCE   : CWF

CODE TABLE   : CARR_LINE_CLIA_ALERT_IND_TB

188. Line Additional Claim Documentation Indicator Code
         1   2506   2506   CHAR

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

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

LENGTH   : 1

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

SOURCE   : CWF

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

CODE TABLE   : LINE_ADDTNL_CLM_DCMTN_IND_TB

189. Carrier Line DME Coverage Period Start Date
         8   2507   2514   NUM

Effective 5/92 through 6/94, as line item on the
carrier claim (non-DMERC), the date durable medical
equipment (DME) coverage period started per certi-
ficate of medical necessity, prescription, other
documentation or carrier determination. This field
is applicable to line items involving DME,
prosthetic, orthotic and supply items, immuno-
suppressive drugs, pen, ESRD and oxygen items
referred to as DMEPOS).

DB2   ALIAS : DME_CVRG_STRT_DT
SAS   ALIAS : DMEST_DT
STANDARD ALIAS : CARR_LINE_DME_CVRG_PRD_STRT_DT
TITLE   ALIAS : DME_CVRG_START_DT

LENGTH   : 8   SIGNED : N

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

SOURCE   : CWF

LIMITATIONS :

 REFER TO :
 CARR_LINE_DME_CVRG_STRT_LIM

EDIT RULES :
   YYYYMMDD

190. Line DME Purchase Price Amount
              6   2515   2520   PACK

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

              DB2   ALIAS : DME_PURC_PRICE_AMT
              SAS   ALIAS : DME_PURC
              STANDARD ALIAS : LINE_DME_PURC_PRICE_AMT
              TITLE   ALIAS : DME_PURC_PRICE

              LENGTH   : 9.2   SIGNED : Y

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

              SOURCE   : CWF

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

191. Carrier Line DME Medical Necessity Month Count
              2   2521   2522   PACK

              Effective 5/92 through 6/94, as line item on the
              carrier claim (non-DMERC), the count determined by
              the carrier showing the length of need (medical
              necessity for DME in months from the start date
              through the determined period of need.

This field is applicable to line items involving
DME, prosthetic, orthotic and supply items, immuno-
suppressive drugs, pen, ESRD and oxygen items
referred to as DMEPOS).

Exception: If the DME is determined to be
medically necessary for the life
of the beneficiary, 99 is placed
in this field, rather than a month
count.

DB2   ALIAS : DME_NCSTY_MO_CNT
SAS   ALIAS : NCSTY_MO
STANDARD ALIAS : CARR_LINE_DME_NCSTY_MO_CNT
TITLE   ALIAS : DME_NCSTY_MONTHS

LENGTH   : 3   SIGNED : Y

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

SOURCE   : CWF

LIMITATIONS :

 REFER TO :
  CARR_LINE_DME_NCSTY_LIM

192. Line Consolidated Billing Indicator Code
                1 2523 2523   CHAR

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

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

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

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

LENGTH   : 1

CODE TABLE   : LINE_CNSLDTD_BLG_TB

193. Line Duplicate Claim Check Indicator Code
                1 2524 2524   CHAR

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

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

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

LENGTH   : 1

SOURCE   : CWF

CODE TABLE   : LINE_DUP_CLM_CHK_IND_TB

194. Carrier Line Point of Pickup Zip Code
                9 2525 2533   CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD
CR#1, the code identifying the point of pickup
zip code on carrier claims. The point of pickup
zip code is used for pricing ambulance services.

NOTE: Prior to 10/2005 (implementation of NCH/NMUD
CR#2), this data was stored in positions 247-251 on
the carrier line item trailer.

NOTE: Effective with CR#7, the Point of Pickup Zip Code
field was renamed to Point of Pickup/Place of Service
(POS) zip code field so the field could house both zip
codes. Effective with Version 'K', the field is being
renamed back to the Point of Pickup Zip code. The Place
of Service Zip code field is a new field effective with
Version 'K'. During the Version 'K' conversion, any
Place of Service Zip code in the Point of Pickup/Place of
Service Zip Code field was moved to the Place of Service
Zip Code field.

DB2   ALIAS : PNT_PCKP_ZIP_CD
SAS   ALIAS : PNT_PCKP
STANDARD ALIAS : CARR_LINE_PNT_PCKP_ZIP_CD

LENGTH   : 9

SOURCE   : CWF

195. Carrier Line Drop Off Zip Code
          9   2534   2542   CHAR

Effective with Version 'J', the code used to identify the drop off zip code on carrier claims. The drop off zip code is used for pricing ambulance services.

DB2   ALIAS : DROP_OFF_ZIP_CD
SAS   ALIAS : DROP_OFF
STANDARD ALIAS : CARR_LINE_DROP_OFF_ZIP_CD

LENGTH   : 9

196. Carrier Line HPSA/Scarcity Indicator Code
          1   2543   2543   CHAR

Effective 10/3/2005 with the implementation of NCH/ NMUD CR#2, the code used to track health professional shortage area (HPSA) and physician scarcity bonus payments on carrier claims.

NOTE: Prior to 10/3/2005, claims contained a modifier code to indicate the bonus payment. A 'QU' represented a HPSA bonus payment and an 'AR' represented a scarcity bonus payment. As of 1/1/2005, the modifiers were no longer being reported by the provider. NCH & NMUD were not ready to accept the new field until 10/3/2005.

DB2   ALIAS : HPSA_SCRCTY_IND_CD
SAS   ALIAS : HSCRCTY
STANDARD ALIAS : CARR_LINE_HPSA_SCRCTY_IND_CD

LENGTH   : 1

SOURCE   : CWF

CODE TABLE   : CARR_LINE_HPSA_SCRCTY_IND_TB

197. Carrier Line RX Number
          30   2544   2573   CHAR

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

NOTE1: MMA required the implementation of a competative acquisition program (CAP) for Part B drugs and biologicals not paid on a

cost or PPS basis. Physicians will be given
a choice between buying and billing these
drugs under the average sales price (ASP) or
obtaining these drugs from an approved CAP
vendor. The prescription number is needed
to identify which claims were submitted for
CAP drugs and their administration.

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

DB2   ALIAS : CARR_LINE_RX_NUM
SAS   ALIAS : RX_NUM
STANDARD ALIAS : CARR_LINE_RX_NUM

LENGTH   : 30

COMMENTS :
The prescription order number consist of:
--Vendor ID Number (positions 1 - 4)
--HCPCS Code (positions 5 - 9)
--Vendor Controlled Prescription Number
   (positions 10 - 30)

SOURCE   : CWF

LIMITATIONS :

 REFER TO :
 CARR_LINE_RX_NUM_LIM

198. Line Hematocrit/Hemoglobin Test Type Code
          2 2574 2575   CHAR

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

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

          LENGTH   : 2

          CODE TABLE   : LINE_HCT_HGB_TYPE_TB

199. Line Hematocrit/Hemoglobin Result Number
          3 2576 2578   CHAR

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

claim.

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

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

LENGTH   : 3

200. Line Hematocrit/Hemoglobin Result Number -- Redefined
              3   2579   2581   NUM

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

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

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

LENGTH   : 2.1   SIGNED : N

REDEFINE   : LINE_HCT_HGB_RSLT_NUM

201. Worker's Compensation Indicator Code
              1   2582   2582   CHAR

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

DB2   ALIAS : LINE_WC_IND_CD
SAS   ALIAS : WCINDCD
STANDARD ALIAS : LINE_WC_IND_CD

LENGTH   : 1

CODE TABLE   : LINE_WC_IND_TB

202. Line Paperwork (PWK) Code
                    2 2583 2584   CHAR

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

            DB2   ALIAS : LINE_PWK_CD
            STANDARD ALIAS : LINE_PWK_CD

            LENGTH   : 2

            CODE TABLE   : LINE_PWK_TB

203. Line Unique Tracking Number
                    14 2585 2598   CHAR

            Effective with CR#7, the number assigned to each Power
            Mobility Device (PMD) prior authorization request.
            Prior to the NCH April release (CR#7), the PMD
            tracking number was stored in the demonstration trailer.
            The tracking number was reflected in the claim by
            demo # '60'.

            Effective with the CWF January release, demo '60' was
            implemented with CR7495 (Implementation of Prior
            Authorization for Power Mobility Devices (PMD) to
            facilitate a three year mandatory prior authori-
            zation process in 7 states. This initiative was
            designed as a tool to protect the Medicare trust
            fund by deterring fraudulent and abusive billing
            practices, and make the physician or treating
            practitioner more accountable for the items he or
            she orders to prevent improper payments. Under
            this demonstration for a PMD, a physician/treating
            practitioner must submit a request for prior authori-
            zation to support Medicare coverage requirements of
            the PMD item.

            Prior to CR#9, this field was named:
            LINE_PMD_TRKNG_NUM.

            DB2   ALIAS : LINE_UNIQ_TRKNG_NU
            SAS   ALIAS : UNIQNUM
            STANDARD ALIAS : LINE_UNIQ_TRKNG_NUM

            LENGTH   : 14

            COMMENTS :
            (CMS CR7495)

204. Line Place of Service (POS) Physician Last Name or Organization Name
          60   2599   2658   CHAR

                    Effective with Version 'K', the field used to
                    identify the last name of the physician or the
                    organization who rendered the services.

                    DB2   ALIAS : POS_PHYSN_ORG_NAME
                    SAS   ALIAS : LPONAME
                    STANDARD ALIAS : LINE_POS_PHYSN_ORG_NAME

                    LENGTH   : 60

205. Line Place of Service (POS) Physician First Name
          35   2659   2693   CHAR

                    Effective with Version 'K', the field used to
                    identify the first name of the physician who
                    rendered the services.

                    DB2   ALIAS : POS_PHYSN_1ST_NAME
                    SAS   ALIAS : LP1NAME
                    STANDARD ALIAS : LINE_POS_PHYSN_1ST_NAME

                    LENGTH   : 35

206. Line Place of Service (POS) Physician Middle Name
          25   2694   2718   CHAR

                    Effective with Version 'K', the field used to
                    identify the middle name of the physician who
                    rendered the services.

                    DB2   ALIAS : POS_PHYSN_MDL_NAME
                    SAS   ALIAS : LPMNAME
                    STANDARD ALIAS : LINE_POS_PHYSN_MDL_NAME

                    LENGTH   : 25

207. Line Place of Service (POS) Physician Address Line 1 Name
          55   2719   2773   CHAR

                    Effective with Version 'K', the field used to
                    identify the address of the physician who rendered
                    the services.

                    DB2   ALIAS : POS_PHYSN_1_ADR
                    SAS   ALIAS : LPADR1
                    STANDARD ALIAS : LINE_POS_PHYSN_ADR_1_NAME

                    LENGTH   : 55

208. Line Place of Service (POS) Physician Address Line 2 Name
          55   2774   2828   CHAR

Effective with Version 'K', the field used to
identify the address of the physician who
rendered the services.

DB2   ALIAS : POS_PHYSN_2_ADR
SAS   ALIAS : LPADR2
STANDARD ALIAS : LINE_POS_PHYSN_ADR_2_NAME

LENGTH   : 55

209. Line Place of Service (POS) Physician City Name
            30   2829   2858   CHAR

Effective with Version 'K', the field used to
identify the city where the services were
rendered.

DB2   ALIAS : POS_PHYSN_CITY_NAM
SAS   ALIAS : LPCITY
STANDARD ALIAS : LINE_POS_PHYSN_CITY_NAME

LENGTH   : 30

210. Line Place of Service (POS) Physician State Code
            2   2859   2860   CHAR

Effective with Version 'K', the field used to
identify the state where the services were
rendered.

DB2   ALIAS : POS_PHYSN_STATE_CD
SAS   ALIAS : LPSTATE
STANDARD ALIAS : LINE_POS_PHYSN_STATE_CD

LENGTH   : 2

CODE TABLE   : GEO_STATE_TB

211. Line Place of Service (POS) Physician Zip Code
            15   2861   2875   CHAR

Effective with Version 'K', the field used to
identify the zip code where the services were
rendered.

DB2   ALIAS : POS_PHYSN_ZIP_CD
SAS   ALIAS : LPZIPCD
STANDARD ALIAS : LINE_POS_PHYSN_ZIP_CD

LENGTH   : 15

212. Line Other Applied Indicator 1 Code
            2   2876   2877   CHAR

Effective with Version 'K', the code used to
identify the reason the claim payment amount
was adjusted during claims processing.

Effective with Version L (January 2021 release), this
field was expanded from 1 byte to 2 bytes.

DB2   ALIAS : UNDEFINED
SAS   ALIAS : APLDIND1

LENGTH   : 2

213. Line Other Applied Indicator 2 Code
            2   2878   2879   CHAR

Effective with Version 'K', the code used to
identify the reason the claim payment amount
was adjusted during claims processing.

Effective with Version L (January 2021 release), this
field was expanded from 1 byte to 2 bytes.

DB2   ALIAS : UNDEFINED
SAS   ALIAS : APLDIND2

LENGTH   : 2

SOURCE   : CWF

214. Line Other Applied Indicator 3 Code
            2   2880   2881   CHAR

Effective with Version 'K', the code used to
identify the reason the claim payment amount
was adjusted during claims processing.

Effective with Version L (January 2021 release), this
field was expanded from 1 byte to 2 bytes.

DB2   ALIAS : UNDEFINED
SAS   ALIAS : APLDIND3

LENGTH   : 2

SOURCE   : CWF

215. Line Other Applied Indicator 4 Code
            2   2882   2883   CHAR

Effective with Version 'K', the code used to
identify the reason the claim payment amount
was adjusted during claims processing.

Effective with Version L (January 2021 release), this field was expanded from 1 byte to 2 bytes.

DB2   ALIAS : UNDEFINED
SAS   ALIAS : APLDIND4

LENGTH   : 2

SOURCE   : CWF

216. Line Other Applied Indicator 5 Code
      2 2884 2885 CHAR

Effective with Version 'K', the code used to identify the reason the claim payment amount was adjusted during claims processing.

Effective with Version L (January 2021 release), this field was expanded from 1 byte to 2 bytes.

DB2   ALIAS : UNDEFINED
SAS   ALIAS : APLDIND5

LENGTH   : 2

SOURCE   : CWF

217. Line Other Applied Indicator 6 Code
      2 2886 2887 CHAR

Effective with Version 'K', the code used to identify the reason the claim payment amount was adjusted during claims processing.

Effective with Version L (January 2021 release), this field was expanded from 1 byte to 2 bytes.

DB2   ALIAS : UNDEFINED
SAS   ALIAS : APLDIND6

LENGTH   : 2

SOURCE   : CWF

218. Line Other Applied Indicator 7 Code
      2 2888 2889 CHAR

Effective with Version 'K', the code used to identify the reason the claim payment amount was adjusted during claims processing.

Effective with Version L (January 2021 release), this field was expanded from 1 byte to 2 bytes.

DB2   ALIAS : UNDEFINED
            SAS   ALIAS : APLDIND7

            LENGTH   : 2

            SOURCE   : CWF

219. Line Other Applied 1 Amount
            6   2890   2895   PACK

            Effective with Version 'K', the field used to
            identify amounts that were used to adjust the
            amount payable when processing the line item.

            DB2   ALIAS : OTHR_APLD_1_AMT
            SAS   ALIAS : APLDAMT1
            STANDARD ALIAS : LINE_OTHR_APLD_1_AMT

            LENGTH   : 9.2   SIGNED : Y

220. Line Other Applied 2 Amount
            6   2896   2901   PACK

            Effective with Version 'K', the field used to
            identify amounts that were used to adjust the
            amount payable when processing the line item.

            DB2   ALIAS : OTHR_APLD_2_AMT
            SAS   ALIAS : APLDAMT2
            STANDARD ALIAS : LINE_OTHR_APLD_2_AMT

            LENGTH   : 9.2   SIGNED : Y

221. Line Other Applied 3 Amount
            6   2902   2907   PACK

            Effective with Version 'K', the field used to
            identify amounts that were used to adjust the
            amount payable when processing the line item.

            DB2   ALIAS : OTHR_APLD_3_AMT
            SAS   ALIAS : APLDAMT3
            STANDARD ALIAS : LINE_OTHR_APLD_3_AMT

            LENGTH   : 9.2   SIGNED : Y

222. Line Other Applied 4 Amount
            6   2908   2913   PACK

            Effective with Version 'K', the field used to
            identify amounts that were used to adjust the
            amount payable when processing the line item.

            DB2   ALIAS : OTHR_APLD_4_AMT

SAS   ALIAS : APLDAMT4
                         STANDARD ALIAS : LINE_OTHR_APLD_4_AMT

                         LENGTH   : 9.2   SIGNED : Y

223. Line Other Applied 5 Amount
                   6 2914 2919   PACK

                         Effective with Version 'K', the field used to
                         identify amounts that were used to adjust the
                         amount payable when processing the line item.

                         DB2   ALIAS : OTHR_APLD_5_AMT
                         SAS   ALIAS : APLDAMT5
                         STANDARD ALIAS : LINE_OTHR_APLD_5_AMT

                         LENGTH   : 9.2   SIGNED : Y

224. Line Other Applied 6 Amount
                   6 2920 2925   PACK

                         Effective with Version 'K', the field used to
                         identify amounts that were used to adjust the
                         amount payable when processing the line item.

                         DB2   ALIAS : OTHR_APLD_6_AMT
                         SAS   ALIAS : APLDAMT6
                         STANDARD ALIAS : LINE_OTHR_APLD_6_AMT

                         LENGTH   : 9.2   SIGNED : Y

225. Line Other Applied 7 Amount
                   6 2926 2931   PACK

                         Effective with Version 'K', the field used to
                         identify amounts that were used to adjust the
                         amount payable when processing the line item.

                         DB2   ALIAS : OTHR_APLD_7_AMT
                         SAS   ALIAS : APLDAMT7
                         STANDARD ALIAS : LINE_OTHR_APLD_7_AMT

                         LENGTH   : 9.2   SIGNED : Y

226. Line Therapy CAP Indicator 1 Code
                   1 2932 2932   CHAR

                         Effective with Version 'K', the field used to
                         identify whether the claim line is subject to a therapy cap.

                         DB2   ALIAS : LINE_THRPY_1_CD
                         SAS   ALIAS : LTHRPY1
                         STANDARD ALIAS : LINE_THRPY_CAP_IND_1_CD

LENGTH   : 1

CODE TABLE   : LINE_THRPY_CAP_IND_CD_TB

227. Line Therapy CAP Indicator 2 Code
         1   2933   2933   CHAR

                    Effective with Version 'K', the field used to
                    identify whether the claim line is subject to a therapy cap.

                    DB2   ALIAS : LINE_THRPY_2_CD
                    SAS   ALIAS : LTHRPY2
                    STANDARD ALIAS : LINE_THRPY_CAP_IND_2_CD

                    LENGTH   : 1

                    CODE TABLE   : LINE_THRPY_CAP_IND_CD_TB

228. Line Therapy CAP Indicator 3 Code
         1   2934   2934   CHAR

                    Effective with Version 'K', the field used to
                    identify whether the claim line is subject to a therapy cap.

                    DB2   ALIAS : LINE_THRPY_3_CD
                    SAS   ALIAS : LTHRPY3
                    STANDARD ALIAS : LINE_THRPY_CAP_IND_3_CD

                    LENGTH   : 1

                    CODE TABLE   : LINE_THRPY_CAP_IND_CD_TB

229. Line Therapy CAP Indicator 4 Code
         1   2935   2935   CHAR

                    Effective with Version 'K', the field used to
                    identify whether the claim line is subject to a therapy cap.

                    DB2   ALIAS : LINE_THRPY_4_CD
                    SAS   ALIAS : LTHRPY4
                    STANDARD ALIAS : LINE_THRPY_CAP_IND_4_CD

                    LENGTH   : 1

                    CODE TABLE   : LINE_THRPY_CAP_IND_CD_TB

230. Line Therapy CAP Indicator 5 Code
         1   2936   2936   CHAR

                    Effective with Version 'K', the field used to
                    identify whether the claim line is subject to a therapy cap.

                    DB2   ALIAS : LINE_THRPY_5_CD
                    SAS   ALIAS : LTHRPY5

STANDARD ALIAS : LINE_THRPY_CAP_IND_5_CD

LENGTH　　　　: 1

CODE TABLE　　: LINE_THRPY_CAP_IND_CD_TB

231. Line FPS Model Number
　　　　　　　2　2937　2938　CHAR

Effective with Version 'K', this field identifies an
FPS analytic model that identifies claims that may
be high risk for fraud based on specific information.

DB2　　ALIAS : LINE_FPS_MODEL_NUM
SAS　　ALIAS : LMODEL
STANDARD ALIAS : LINE-FPS-MODEL-NUM

LENGTH　　　　: 2

232. Line FPS Reason Code
　　　　　　　3　2939　2941　CHAR

Effective with Version 'K', this field identifies the
reason codes used to explain why a claim was not
paid or how the claim was paid. These codes also
show the reason for any claim financial adjustment
such as denial, reductions or increases in payment.

DB2　　ALIAS : LINE_FPS_RSN_CD
SAS　　ALIAS : LFPSRSN
STANDARD ALIAS : LINE-FPS-RSN-CD

LENGTH　　　　: 3

CODE TABLE　　: CLM_ADJ_RSN_TB

233. Line FPS Remark Code
　　　　　　　5　2942　2946　CHAR

Effective with Version 'K', the codes used to
convey information about remittance processing or
to provide a supplemental explanation for an
adjustment already described by a Claim
Adjustment Reason Code.

DB2　　ALIAS : LINE_FPS_RMRK_CD
SAS　　ALIAS : LFPSRMRK
STANDARD ALIAS : LINE-FPS-RMRK-CD

LENGTH　　　　: 5

CODE TABLE　　: CLM_RMTNC_ADVC_TB

234. Line FPS MSN 1 Code

```
        5   2947   2951   CHAR
```

Effective with Version 'K', the field used
to identify the Medicare Secondary Notice Code.

```
DB2     ALIAS : LINE_FPS_MSN_1_CD
SAS     ALIAS : LFPSMSN1
STANDARD ALIAS : LINE-FPS-MSN-1-CD

LENGTH      : 5

CODE TABLE    : CLM_FPS_MSN_CD_TB
```

235. Line FPS MSN 2 Code
```
        5   2952   2956   CHAR
```

Effective with Version 'K', the field used to
identify the Medicare Secondary Notice Code.

```
DB2     ALIAS : LINE_FPS_MSN_2_CD
SAS     ALIAS : LFPSMSN2
STANDARD ALIAS : LINE-FPS-MSN-2-CD

LENGTH      : 5

CODE TABLE    : CLM_FPS_MSN_CD_TB
```

236. Line Rendering Billing NPI Association Code
```
        1   2957   2957   CHAR
```

Effective with CR#8, the field used to identify the render-
ing provider NPI is a member of a group practice billing
National Provider Identifier (NPI). This field is only
found on Carrier claims.

```
DB2     ALIAS : BLG_NPI_ASCTN_CD
SAS     ALIAS : NPIASCTN
STANDARD ALIAS : RNDRNG_BLG_NPI_ASCTN_CD

LENGTH      : 1

CODE TABLE    : LINE_RNDRNG_BLG_NPI_ASCTN_TB
```

237. Line Prior Authorization Indicator Code
```
        4   2958   2961   CHAR
```

Effective with CR#9 (October 2014 release), the indicator assigned
by CMS for each prior authorization program to define the applicable
line of business (i.e. Part A, Part B, DME, Home Health and Hospice).

```
DB2     ALIAS : LINE_AUTHRZTN_CD
SAS     ALIAS : LPRIOR
STANDARD ALIAS : LINE_PRIOR_AUTHRZTN_IND_CD
```

LENGTH   : 4

CODE TABLE   : LINE_PRIOR_AUTHRZTN_TB

238. Line Next Generation (NG) Affordable Care Organization (ACO) Indicator 1 Code
         1   2962   2962   CHAR

Effective with CR#11, this field represents the benefit enhancement
indicator that identifies claims that qualify for a specific
claims processing edit.

NOTE: There are 5 occurrences of this field on a claim, but each
value can only be represented once.

NOTE2: The 5 occurrences of this field are found at the claim level
on all institutional claim types and at the line level on Carrier
claims.

DB2   ALIAS : LINE_NG_ACO_1_CD
SAS   ALIAS : LNGACO1
STANDARD ALIAS : LINE_NG_ACO_IND_1_CD

LENGTH   : 1

SOURCE   : CWF

CODE TABLE   : NG_ACO_IND_TB

239. Line Next Generation (NG) Affordable Care Organization (ACO) Indicator 2 Code
         1   2963   2963   CHAR

Effective with CR#11, this field represents the benefit enhancement
indicator that identifies claims that qualify for a specific
claims processing edit.

NOTE: There are 5 occurrences of this field on a claim, but each
value can only be represented once.

NOTE2: The 5 occurrences of this field are found at the claim level
on all institutional claim types and at the line level on Carrier
claims.

DB2   ALIAS : LINE_NG_ACO_2_CD
SAS   ALIAS : LNGACO2
STANDARD ALIAS : LINE_NG_ACO_IND_2_CD

LENGTH   : 1

SOURCE   : CWF

CODE TABLE   : NG_ACO_IND_TB

240. Line Next Generation (NG) Affordable Care Organization (ACO) Indicator 3 Code
         1   2964   2964   CHAR

Effective with CR#11, this field represents the benefit enhancement
indicator that identifies claims that qualify for a specific
claims processing edit.

NOTE: There are 5 occurrences of this field on a claim, but each
value can only be represented once.

NOTE2: The 5 occurrences of this field are found at the claim level
on all institutional claim types and at the line level on Carrier
claims.

```
DB2    ALIAS : LINE_NG_ACO_3_CD
SAS    ALIAS : LNGACO3
STANDARD ALIAS : LINE_NG_ACO_IND_3_CD

LENGTH      : 1

SOURCE      : CWF

CODE TABLE    : NG_ACO_IND_TB
```

241. Line Next Generation (NG) Affordable Care Organization (ACO) Indicator 4 Code
              1   2965   2965   CHAR

Effective with CR#11, this field represents the benefit enhancement
indicator that identifies claims that qualify for a specific
claims processing edit.

NOTE: There are 5 occurrences of this field on a claim, but each
value can only be represented once.

NOTE2: The 5 occurrences of this field are found at the claim level
on all institutional claim types and at the line level on Carrier
claims.

```
DB2    ALIAS : LINE_NG_ACO_4_CD
SAS    ALIAS : LNGACO4
STANDARD ALIAS : LINE_NG_ACO_IND_4_CD

LENGTH      : 1

SOURCE      : CWF

CODE TABLE    : NG_ACO_IND_TB
```

242. Line Next Generation (NG) Affordable Care Organization (ACO) Indicator 5 Code
              1   2966   2966   CHAR

Effective with CR#11, this field represents the benefit enhancement
indicator that identifies claims that qualify for a specific
claims processing edit.

NOTE: There are 5 occurrences of this field on a claim, but each

value can only be represented once.

NOTE2: The 5 occurrences of this field are found at the claim level on all institutional claim types and at the line level on Carrier claims.

DB2   ALIAS : LINE_NG_ACO_5_CD
SAS   ALIAS : LNGACO5
STANDARD ALIAS : LINE_NG_ACO_IND_5_CD

LENGTH   : 1

SOURCE   : CWF

CODE TABLE   : NG_ACO_IND_TB

243. Line Representative Payee (RP) Indicator Code
         1   2967   2967   CHAR

Effective with CR#11, this field will be used to designate by-passing of the prior authorization processing for claims with a representative payee when an 'R' is present in the field.

NOTE: Data will not start coming in until April 2016. This field was added to the January 2016 release because our workload (FA fix) will not allow us to implement another CR in April.

DB2   ALIAS : LINE_RP_IND_CD
SAS   ALIAS : LRPIND
STANDARD ALIAS : LINE_RP_IND_CD

LENGTH   : 1

SOURCE   : CWF

CODE TABLE   : RP_IND_TB

244. Line Residual Payment Indicator Code
         1   2968   2968   CHAR

Effective with CR#11, this field is used by CWF claims processing for the purpose of bypassing its normal MSP editing that would otherwise apply for ongoing responsibility for medicals (ORM) or worker's compensation Medicare Set-Aside Arrangements (WCMSA). Normally, CWF does not allow a secondary payment on MSP involving ORM or WCMSA, so the residual payment indicator will be used to allow CWF to make an exception to its normal routine.

DB2   ALIAS : LINE_RSDL_PMT_CD
SAS   ALIAS : LRSDLPMT
STANDARD ALIAS : LINE_RSDL_PMT_IND_CD

LENGTH   : 1

SOURCE   : CWF

CODE TABLE   : RSDL_PMT_IND_TB

245. Carrier Line Medicare Diabetes Prevention Program (MDPP) National Provider Identifier (NPI) Number
                10   2969   2978   CHAR

Effective with CR#13 (January 2018 release), this field represents
the National Provider Identifier (NPI) of the Medicare Diabetes
Prevention Program (MDPP) Coach.

NOTE: Even though this field is added during the January 2018
release, data will not be in this field until July 2018.

DB2   ALIAS : LINE_MDPP_NPI_NUM
SAS   ALIAS : MDPPNPI

LENGTH   : 10

DERIVATIONS :
Workaround to use from April 2018 to
June 29, 2018:

DERIVATION RULES:
For carrier claims with a demo code
(CLM_DEMO_ID_NUM) = '82'use the rendering
physician NPI (CARR_LINE_PRFRMG_NPI_NUM)
as the MDPP Coach NPI.

COMMENTS :
(CMS CR10074) -- CWF April 2018 Release
Data won't be available in NCH/NMUD until July 2018

SOURCE   : CWF

246. Carrier Line Provider Validation Code
                2   2979   2980   CHAR

Effective with CR#14 (April 2019 release), this field is used to
inform the Common Working File (CWF) to perform an edit check
to ensure that the provider that was submitted on the Prior
Authorization (PA) request is the same provider on the claim.

DB2   ALIAS : UNDEFINED
SAS   ALIAS : LVLDTNCD

LENGTH   : 2

CODE TABLE   : CARR_LINE_PRVDR_VLDTN_TB

247. Line Voluntary Service Indicator Code
                1   2981   2981   CHAR

Effective with Version L (January 2021 release), this line level

field will be used to identify if the service (Procedure Code) was voluntary or required.

NOTE:
Data will not start coming in for this field until the July release (July 6, 2021)

Valid values:
V = A Voluntary procedure code
Blank = A Required procedure code

DB2   ALIAS : UNDEFINED
SAS   ALIAS : LVLNTRY
STANDARD ALIAS : LINE_VLNTRY_SRVC_IND_CD

LENGTH   : 1

SOURCE   : CWF

CODE TABLE   : LINE_VLNTRY_SRVC_IND_TB

248.
      968   2982   3949   CHAR

DB2   ALIAS : H_FILLER_10

LENGTH   : 968

249. End of Record Code
      3   24191   24193   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

QUERY: RIFQQ11, RIFQQ21 ON DB2T
***********END OF MAIN REPORT FOR RECORD:

CARR_CLM_REC***********

 TABLE OF CODES APPENDIX FOR RECORD: CARR_CLM_REC, STATUS: PROD, VERSION: 21006
 PRINTED: 04/26/2021, USER: F43D, DATA SOURCE: CA REPOSITORY ON DB2T

BENE_CWF_LOC_TB   Beneficiary Common Working File Location Table

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

BENE_IDENT_TB   Beneficiary Identification Code (BIC) Table

    Social Security Administration:

    A = Primary claimant
    B = Aged wife, age 62 or over (1st
         claimant)
    B1 = Aged husband, age 62 or over (1st
         claimant)
    B2 = Young wife, with a child in her care
         (1st claimant)
    B3 = Aged wife (2nd claimant)
    B4 = Aged husband (2nd claimant)
    B5 = Young wife (2nd claimant)
    B6 = Divorced wife, age 62 or over (1st
         claimant)
    B7 = Young wife (3rd claimant)
    B8 = Aged wife (3rd claimant)
    B9 = Divorced wife (2nd claimant)
    BA = Aged wife (4th claimant)
    BD = Aged wife (5th claimant)
    BG = Aged husband (3rd claimant)
    BH = Aged husband (4th claimant)
    BJ = Aged husband (5th claimant)
    BK = Young wife (4th claimant)
    BL = Young wife (5th claimant)
    BN = Divorced wife (3rd claimant)
    BP = Divorced wife (4th claimant)
    BQ = Divorced wife (5th claimant)
    BR = Divorced husband (1st claimant)
    BT = Divorced husband (2nd claimant)
    BW = Young husband (2nd claimant)

BY = Young husband (1st claimant)

C1-C9,CA-CZ = Child (includes minor, student
   or disabled child)

D = Aged widow, 60 or over (1st claimant)

D1 = Aged widower, age 60 or over (1st
  claimant)

D2 = Aged widow (2nd claimant)

D3 = Aged widower (2nd claimant)

D4 = Widow (remarried after attainment of
  age 60) (1st claimant)

D5 = Widower (remarried after attainment of
  age 60) (1st claimant)

D6 = Surviving divorced wife, age 60 or over
  (1st claimant)

D7 = Surviving divorced wife (2nd claimant)

D8 = Aged widow (3rd claimant)

D9 = Remarried widow (2nd claimant)

DA = Remarried widow (3rd claimant)

DD = Aged widow (4th claimant)

DG = Aged widow (5th claimant)

DH = Aged widower (3rd claimant)

DJ = Aged widower (4th claimant)

DK = Aged widower (5th claimant)

DL = Remarried widow (4th claimant)

DM = Surviving divorced husband (2nd
  claimant)

DN = Remarried widow (5th claimant)

DP = Remarried widower (2nd claimant)

DQ = Remarried widower (3rd claimant)

DR = Remarried widower (4th claimant)

DS = Surviving divorced husband (3rd
  claimant)

DT = Remarried widower (5th claimant)

DV = Surviving divorced wife (3rd claimant)

DW = Surviving divorced wife (4th claimant)

DX = Surviving divorced husband (4th
  claimant)

DY = Surviving divorced wife (5th claimant)

DZ = Surviving divorced husband (5th
  claimant)

E = Mother (widow) (1st claimant)

E1 = Surviving divorced mother (1st
  claimant)

E2 = Mother (widow) (2nd claimant)

E3 = Surviving divorced mother (2nd
  claimant)

E4 = Father (widower) (1st claimant)

E5 = Surviving divorced father (widower)
  (1st claimant)

E6 = Father (widower) (2nd claimant)

E7 = Mother (widow) (3rd claimant)

E8 = Mother (widow) (4th claimant)

E9 = Surviving divorced father (widower)
  (2nd claimant)

EA = Mother (widow) (5th claimant)

EB = Surviving divorced mother (3rd claimant)

EC = Surviving divorced mother (4th claimant)

ED = Surviving divorced mother (5th claimant

EF = Father (widower) (3rd claimant)

EG = Father (widower) (4th claimant)

EH = Father (widower) (5th claimant)

EJ = Surviving divorced father (3rd claimant)

EK = Surviving divorced father (4th claimant)

EM = Surviving divorced father (5th claimant)

F1 = Father

F2 = Mother

F3 = Stepfather

F4 = Stepmother

F5 = Adopting father

F6 = Adopting mother

F7 = Second alleged father

F8 = Second alleged mother

J1 = Primary prouty entitled to HIB (less than 3 Q.C.) (general fund)

J2 = Primary prouty entitled to HIB (over 2 Q.C.) (RSI trust fund)

J3 = Primary prouty not entitled to HIB (less than 3 Q.C.) (general fund)

J4 = Primary prouty not entitled to HIB (over 2 Q.C.) (RSI trust fund)

K1 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)

K2 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)

K3 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)

K4 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)

K5 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)

K6 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)

K7 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)

K8 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)

K9 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)

KA = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)

KB = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)

KC = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)

KD = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (4th claimant)

KE = Prouty wife entitled to HIB (over 2 Q.C (4th claimant)

KF = Prouty wife not entitled to HIB (less than 3 Q.C.)(4th claimant)

KG = Prouty wife not entitled to HIB (over 2 Q.C.)(4th claimant)

KH = Prouty wife entitled to HIB (less than 3 Q.C.)(5th claimant)

KJ = Prouty wife entitled to HIB (over 2 Q.C.) (5th claimant)

KL = Prouty wife not entitled to HIB (less than 3 Q.C.)(5th claimant)

KM = Prouty wife not entitled to HIB (over 2 Q.C.) (5th claimant)

M = Uninsured-not qualified for deemed HIB

M1 = Uninsured-qualified but refused HIB

T = Uninsured-entitled to HIB under deemed or renal provisions

TA = MQGE (primary claimant)

TB = MQGE aged spouse (first claimant)

TC = MQGE disabled adult child (first claimant)

TD = MQGE aged widow(er) (first claimant)

TE = MQGE young widow(er) (first claimant)

TF = MQGE parent (male)

TG = MQGE aged spouse (second claimant)

TH = MQGE aged spouse (third claimant)

TJ = MQGE aged spouse (fourth claimant)

TK = MQGE aged spouse (fifth claimant)

TL = MQGE aged widow(er) (second claimant)

TM = MQGE aged widow(er) (third claimant)

TN = MQGE aged widow(er) (fourth claimant)

TP = MQGE aged widow(er) (fifth claimant)

TQ = MQGE parent (female)

TR = MQGE young widow(er) (second claimant)

TS = MQGE young widow(er) (third claimant)

TT = MQGE young widow(er) (fourth claimant)

TU = MQGE young widow(er) (fifth claimant)

TV = MQGE disabled widow(er) fifth claimant

TW = MQGE disabled widow(er) first claimant

TX = MQGE disabled widow(er) second claimant

TY = MQGE disabled widow(er) third claimant

TZ = MQGE disabled widow(er) fourth claimant

T2-T9 = Disabled child (second to ninth claimant)

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

Railroad Retirement Board:

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

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

45 = Parent of employee
15 = Parent of annuitant
85 = Parent of pensioner
11 = Survivor joint annuitant
   (reduced benefits taken to insure benefits
   for surviving spouse)

BENE_MDCR_STUS_TB   CWF Beneficiary Medicare Status Table

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

BENE_PRMRY_PYR_TB   Beneficiary Primary Payer Table

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

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

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

types 7/1/96)

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

        Prior to 12/90

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

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

BENE_RACE_TB   Beneficiary Race Table

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

BENE_SEX_IDENT_TB   Beneficiary Sex Identification Table

   1 = Male
   2 = Female
   0 = Unknown

BETOS_TB   BETOS Table

   M1A = Office visits - new
   M1B = Office visits - established
   M2A = Hospital visit - initial
   M2B = Hospital visit - subsequent
   M2C = Hospital visit - critical care
   M3 = Emergency room visit
   M4A = Home visit
   M4B = Nursing home visit
   M5A = Specialist - pathology
   M5B = Specialist - psychiatry
   M5C = Specialist - opthamology

M5D = Specialist - other
M6 = Consultations
P0 = Anesthesia
P1A = Major procedure - breast
P1B = Major procedure - colectomy
P1C = Major procedure - cholecystectomy
P1D = Major procedure - turp
P1E = Major procedure - hysterectomy
P1F = Major procedure - explor/decompr/excisdisc
P1G = Major procedure - Other
P2A = Major procedure, cardiovascular-CABG
P2B = Major procedure, cardiovascular-Aneurysm repair
P2C = Major Procedure, cardiovascular-Thromboendarterectomy
P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA)
P2E = Major procedure, cardiovascular-Pacemaker insertion
P2F = Major procedure, cardiovascular-Other
P3A = Major procedure, orthopedic - Hip fracture repair
P3B = Major procedure, orthopedic - Hip replacement
P3C = Major procedure, orthopedic - Knee replacement
P3D = Major procedure, orthopedic - other
P4A = Eye procedure - corneal transplant
P4B = Eye procedure - cataract removal/lens insertion
P4C = Eye procedure - retinal detachment
P4D = Eye procedure - treatment of retinal lesions
P4E = Eye procedure - other
P5A = Ambulatory procedures - skin
P5B = Ambulatory procedures - musculoskeletal
P5C = Ambulatory procedures - inguinal hernia repair
P5D = Ambulatory procedures - lithotripsy
P5E = Ambulatory procedures - other
P6A = Minor procedures - skin
P6B = Minor procedures - musculoskeletal
P6C = Minor procedures - other (Medicare fee schedule)
P6D = Minor procedures - other (non-Medicare fee schedule)
P7A = Oncology - radiation therapy
P7B = Oncology - other
P8A = Endoscopy - arthroscopy
P8B = Endoscopy - upper gastrointestinal
P8C = Endoscopy - sigmoidoscopy
P8D = Endoscopy - colonoscopy
P8E = Endoscopy - cystoscopy
P8F = Endoscopy - bronchoscopy
P8G = Endoscopy - laparoscopic cholecystectomy
P8H = Endoscopy - laryngoscopy
P8I = Endoscopy - other
P9A = Dialysis services (medicare fee schedule)
P9B = Dialysis services (non-medicare fee schedule)
I1A = Standard imaging - chest
I1B = Standard imaging - musculoskeletal
I1C = Standard imaging - breast
I1D = Standard imaging - contrast gastrointestinal
I1E = Standard imaging - nuclear medicine
I1F = Standard imaging - other
I2A = Advanced imaging - CAT/CT/CTA: brain/head/neck

I2B = Advanced imaging - CAT/CT/CTA: other
I2C = Advanced imaging - MRI/MRA: brain/head/neck
I2D = Advanced imaging - MRI/MRA: other
I3A = Echography/ultrasonography - eye
I3B = Echography/ultrasonography - abdomen/pelvis
I3C = Echography/ultrasonography - heart
I3D = Echography/ultrasonography - carotid arteries
I3E = Echography/ultrasonography - prostate, transrectal
I3F = Echography/ultrasonography - other
I4A = Imaging/procedure - heart including cardiac
                    catheterization
I4B = Imaging/procedure - other
T1A = Lab tests - routine venipuncture (non Medicare
            fee schedule)
T1B = Lab tests - automated general profiles
T1C = Lab tests - urinalysis
T1D = Lab tests - blood counts
T1E = Lab tests - glucose
T1F = Lab tests - bacterial cultures
T1G = Lab tests - other (Medicare fee schedule)
T1H = Lab tests - other (non-Medicare fee schedule)
T2A = Other tests - electrocardiograms
T2B = Other tests - cardiovascular stress tests
T2C = Other tests - EKG monitoring
T2D = Other tests - other
D1A = Medical/surgical supplies
D1B = Hospital beds
D1C = Oxygen and supplies
D1D = Wheelchairs
D1E = Other DME
D1F = Prosthetic/Orthotic devices
D1G = Drugs Administered through DME
O1A = Ambulance
O1B = Chiropractic
O1C = Enteral and parenteral
O1D = Chemotherapy
O1E = Other drugs
O1F = Hearing and speech services
O1G = Immunizations/Vaccinations
Y1 = Other - Medicare fee schedule
Y2 = Other - non-Medicare fee schedule
Z1 = Local codes
Z2 = Undefined codes

CARR_CLM_ENTRY_TB   Carrier Claim Entry Table

    1 = Original debit; void of original debit
      (If CLM_DISP_CD = 3, code 1 means
      voided original debit)
    3 = Full credit
    5 = Replacement debit
    9 = Accrete bill history only (internal;

effective 2/22/91)

CARR_CLM_HOSPC_OVRRD_IND_TB   Carrier Claim Hospice Override Indicator Table

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

CARR_CLM_MCO_OVRRD_IND_TB   Carrier Claim MCO Override Indicator Table

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

CARR_CLM_PMT_DNL_TB   Carrier Claim Payment Denial Table

  Valid values effective 1/2011 (2-byte values are
  replacing the character values)
  0 = Denied
  1 = Physician/supplier
  2 = Beneficiary
  3 = Both physician/supplier and beneficiary
  4 = Hospital (hospital based physicians)
  5 = Both hospital and beneficiary
  6 = Group practice prepayment plan
  7 = Other entries (e.g. Employer, union)
  8 = Federally funded
  9 = PA service
  A = Allowed
  B = Benefits Exhausted
  C = Non-convered Care
  D = Denied due to demonstration involvement
    (eff. 5/97)
  E = MSP Cost Avoided - First Claim Development
  F = MSP Cost Avoided - Trauma Code Development
  G = Secondary Claims Investigation
  H = Self Reports
  J = 411.25
  K = Insurer Voluntary Reporting
  L = Clinical Lab Improvement Amendment (CLIA)
  M = Multiple submittal (i.e. duplicate line item)
  N = Medical Necessity
  O = Other
  P = Physician ownership denial (eff 3/92)
  Q = MSP Cost Avoided - Employer Voluntary Reporting
  R = Reprocessed adjustment based on subsequent
    reprocessing of claim
  S = Secondary Payer

T = MSP cost avoided - IEQ contractor
   (eff. 7/96)
U = MSP cost avoided - HMO rate cell
   adjustment (eff. 7/96)
V = MSP cost avoided - litigation
   settlement (eff. 7/96)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data
   match project
Z = Zero payment, allowed test
00= MSP cost avoided - COB Contractor
12= MSP cost avoided - BC/BS Voluntary Agreements
13= MSP cost avoided - Office of Personnel Management
14= MSP cost avoided - Workman's Compensation (WC) Datamatch
15= MSP cost avoided - Workman's Compensation Insurer Voluntary
   Data Sharing Agreements (WC VDSA) (eff. 4/2006)
16= MSP cost avoided - Liability Insurer VDSA (eff.4/2006)
17= MSP cost avoided - No-Fault Insurer VDSA (eff.4/2006)
18= MSP cost avoided - Pharmacy Benefit Manager Data Sharing
   Agreement (eff.4/2006)
19 = MSP cost avoided - Worker's Compensation Medicare Set-Aside
    Arrangement (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)
39 = MSP Cost Avoided - GHP Recovery
41 = MSP Cost Avoided - NGHP Non-ORM
42 = MSP Cost Avoided - NGHP ORM Recovery
43 = MSP Cost Avoided - COBC/Medicare Part C/Medicare Advantage
NOTE: Effective 4/1/02, the Carrier claim payment denial
code was expanded to a 2-byte field. The NCH instituted
a crosswalk from the 2-byte code to a 1-byte character
code. Below are the character codes (found in NCH &
NMUD). At some point, NMUD will carry the 2-byte code
but NCH will continue to have the 1-byte character
code.

! = MSP cost avoided - COB Contractor ('00' 2-byte code)
@ = MSP cost avoided - BC/BS Voluntary Agreements
   ('12' 2-byte code)
= MSP cost avoided - Office of Personnel Management
   ('13' 2-byte code)
$ = MSP cost avoided - Workman's Compensation (WC) Datamatch
   ('14' 2-byte code)
* = MSP cost avoided - Workman's Compensation Insurer
   Voluntary Data Sharing Agreements (WC VDSA)
   ('15' 2-byte code) (eff. 4/2006)
(= MSP cost avoided - Liability Insurer VDSA
   ('16' 2-byte code) (eff. 4/2006)
) = MSP cost avoided - No-Fault Insurer VDSA
   ('17' 2-byte code) (eff. 4/2006)

+ = MSP cost avoided - Pharmacy Benefit Manager Data
   Sharing Agreement ('18' 2 -byte code) (eff. 4/2006)
< = MSP cost avoided - MIR Group Health Plan
   ('21' 2-byte code) (eff. 1/2009)
> = MSP cost avoided - MIR non-Group Health Plan
   ('22' 2-byte code) (eff. 1/2009)
% = MSP cost avoided - Recovery Audit Contractor -
   - California ('25' 2-byte code) (eff. 10/2005)
& = MSP cost avoided - Recovery Audit Contractor -
   Florida ('26' 2-byte code) (eff. 10/2005)

CARR_CLM_PRVDR_ASGNMT_IND_TB   Carrier Claim Provider Assignment Code Table

A = Assigned claim
N = Non-assigned claim

CARR_LINE_CLIA_ALERT_IND_TB   Carrier Line CLIA Alert Indicator Code Table

(EFFECTIVE 9/92 BUT NOT STORED UNTIL 10/93)
0 = NO ALERT
1 = 77X9
2 = 77XA
3 = 77X5
4 = 77X6
5 = 77X7
6 = 77X8
7 = 77XB

CARR_LINE_HPSA_SCRCTY_IND_TB   Carrier Line HPSA/Scarcity Indicator Code Table

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

CARR_LINE_MTUS_IND_TB   Carrier Line Miles/Time/Units Indicator Table

0 = Values reported as zero (no allowed
   activities)
1 = Transportation (ambulance) miles
2 = Anesthesia time units
3 = Services

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

CARR_LINE_PRVDR_TYPE_TB   Carrier Line Provider Type Table

0 = Clinics, groups, associations, Intervention, or
    other entities for which the carrier's own ID
    number has been assigned.
1 = Physicians or suppliers billing as solo-practi-
    tioners for whom SS numbers are shown in the
    physician ID code field.
2 = Physicians or suppliers billing as solo-
    practitioners for the carrier's own physician
    ID code is shown.
3 = Suppliers (other sole)
4 = Suppliers (other than sole proprietorship) for
    whom the carrier's own code has been shown.
5 = Institutional providers and independent laboratories
    for whom E1 numbers are used in coding the ID field.
6 = Institutional providers and independent laboratories
    for whom the carrier's own ID number is shown.
7 = Clinics, groups, associations, or partnerships, for
    which EI numbers are used in coding the ID field.
8 = Other entities for whom E1 numbers are used in
    coding the ID field

CARR_LINE_PRVDR_VLDTN_TB   Carrier Line Provider Validation Code Table

RP = Rendering Provider
OP = Operating Physician
CP = Ordering/Referring Physician
AP = Attending Physician
FA = Facility

CARR_LINE_RDCD_PHYSN_ASTNT_TB   Carrier Line Part B Reduced Physician Assistant Table

BLANK = Adjustment situation (where
CLM_DISP_CD equal 3)
0 = N/A
1 = 65%
    A) Physician assistants assisting in
      surgery
    B) Nurse midwives
2 = 75%
    A) Physician assistants performing

services in a hospital (other than
assisting surgery)
B) Nurse practitioners and clinical
nurse specialists performing
services in rural areas
C) Clinical social worker services
3 = 85%
A) Physician assistant services for
other than assisting surgery
B) Nurse practitioners services

CARR_NUM_TB   Carrier Number/MAC Table

00510 = Alabama - CAHABA (eff. 1983; term. 05/2009)
(replaced by MAC #10102 -- see below)
00511 = Georgia - CAHABA (eff. 1998; term. 06/2009)
(replaced by MAC #10202 -- see below)
00512 = Mississippi - CAHABA (eff. 2000)
00520 = Arkansas BC/BS (eff. 1983)
00521 = New Mexico - Arkansas BC/BS (eff. 1998; term. 02/2008)
(replaced by MAC #04202 -- see below)
00522 = Oklahoma - Arkansas BC/BS (eff. 1998; term. 02/2008)
(replaced by MAC #04302 -- see below)
00523 = Missouri East - Arkansas BC/BS (eff. 1999; term. 02/2008)
(replaced by MAC #05392 -- see below)
00524 = Rhode Island - Arkansas BC/BS (eff. 2004; term. 01/2009)
(replaced by MAC #14402 -- see below)
00528 = Louisiana - Arkansas BS (eff. 1984)
00542 = California BS (eff. 1983; term. 05/2009)
00550 = Colorado BS (eff. 1983; term. 11/1994)
00570 = Delaware - Pennsylvania BS (eff. 1983;
term. 07/1997)
00580 = District of Columbia - Pennsylvania BS
(eff. 1983; term. 08/1997)
00590 = Florida - First Coast (eff. 1983; term. 01/2009)
(replaced by MAC #09102 -- see below)
00591 = Connecticut - First Coast (eff. 2000; term. 07/2008)
(replaced by MAC #13102 -- see below)
00621 = Illinois BS - HCSC (eff. 1983; term. 08/1997)
00623 = Michigan - Illinois Blue Shield (eff. 1995;
term. 08/1997)
00630 = Indiana - Administar (eff. 1983) (term. 08/19/2012)
(replaced by MAC #08102 -- see below)
00635 = DMERC-B - Administar (eff. 1993; term. 06/2006)
(replaced by MAC #17003 -- see below)
00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 11/1996)
00645 = Nebraska - Iowa BS (eff. 1985; term. 11/1994)
00650 = Kansas BCBS (eff. 1983) (term. 02/2008)
(replaced by MAC #05202 -- see below)
00651 = Missouri - Kansas BCBS (eff. 1983; term. 02/2008)
(replaced by MAC #05202 -- see below)
00655 = Nebraska - Kansas BC/BS (eff. 1988; term. 02/2008)

(replaced by MAC #05402 -- see below)
00660 = Kentucky - Administar (eff. 1983; term. 04/2011)
00662 = PFDC (Floyd Epps) (terminated)
00663 = FQHC Pilot Demo (CAFM - Ayers-Ramsey)
    (term. 11/2011)
00690 = Maryland BS (terminated)
00691 = CAREFIRST - CWF (terminated)

00700 = Massachusetts BS (eff. 1983; term. 11/1996)
00710 = Michigan BS (eff. 1983; term. 09/2000)
00720 = Minnesota BS (eff. 1983; term. 09/2000)
00740 = Western Missouri - Kansas BS (eff. 1983;
    term. 06/1997)
    (replaced by MAC #05302 -- see below)
00751 = Montana BC/BS (eff. 1983; term. 11/2006)
    (replaced by MAC # 03202 -- see below)
00770 = New Hampshire/Vermont Physician Services
    (eff. 1983; term. 12/1988)
00780 = New Hampshire - Massachusetts BS
    (eff. 1985; term. 04/1997)
00781 = Vermont - Massachusetts BS
    (eff. 1985; term. 06/1997)

00801 = New York - Healthnow (eff. 1983; term. 08/2008)
    (replaced by MAC #13282 -- see below)
00803 = New York - Empire BS (eff. 1983; term. 07/2008)
    (replaced by MAC #13202 -- see below)
00804 = New York - Rochester BS (term. 02/1999)
    (replaced by MAC # 12402 -- see below)
00805 = New Jersey - Empire BS (eff. 3/99; term. 11/2008)
    (replaced by MAC # 12402 -- see below)
00811 = DMERC (A) - Healthnow (eff. 2000; term. 06/2006)
    (replaced by MAC #16003 -- see below)
00820 = North Dakota - Noridian (eff. 1983; term. 11/2006)
    (replaced by MAC #03302 -- see below)
00823 = Utah - Noridian (eff. 12/1/2005; term. 11/2006)
    (replaced by MAC #03502 -- see below)
00824 = Colorado - Noridian (eff. 1995; term. 02/2008)
    (term. 2008)
    (replaced by MAC #04102 -- see below)
00825 = Wyoming - Noridian (eff. 1990; term. 11/2006)
    (replaced by MAC #03602 -- see below)
00826 = Iowa - Noridian (eff. 1999; term. 01/2008)
    (replaced by MAC #05102 -- see below)
00831 = Alaska - Noridian (eff. 1998)
00832 = Arizona - Noridian (eff. 1998; term. 11/2006)
    (replaced by MAC # 03102 -- see below)
00833 = Hawaii - Noridian (eff. 1998; term. 07/2008)
    (replaced by MAC # 01202 -- see below)
00834 = Nevada - Noridian (eff. 1998; term. 07/2008)
    (replaced by MAC # 01302 -- see below)
00835 = Oregon - Noridian (eff. 1998)
00836 = Washington - Noridian (eff. 1998)
00860 = New Jersey - Pennsylvania BS (eff. 1988;

term. 02/1998)

00865 = Pennsylvania - Highmark (eff. 1983; term. 12/2008)
    (replaced by MAC # 12502 -- see below)
00870 = Rhode Island BS (eff. 1983; term. 02/1999)
00880 = South Carolina - Palmetto (eff. 1983; term. 06/2011)
00881 = South Carolina BS-P&E (terminated)
00882 = RRB - South Carolina PGBA (eff. 2000)
00883 = Ohio - Palmetto (eff. 2002; term. 06/2011)
00884 = West Virginia - Palmetto (eff. 2002; term. 06/2011)
00885 = DMERC C - Palmetto (eff. 1993; term. 05/2006)
    (replaced by MAC #18003 -- see below)
00888 = PLAMETTO DRUGS (terminated)
00889 = South Dakota - Noridian (eff. 4/1/2006; term. 11/2006)
    (replaced by MAC # 03402 -- see below)

00900 = Texas - Trailblazer (eff. 1983; term. 06/2008)
    (replaced by MAC # 04402 -- see below)
00901 = Maryland - Trailblazer (eff. 1995; term. 07/2008)
    (replaced by MAC # 12302 -- see below)
00902 = Delaware - Trailblazer (eff. 1998; term. 07/2008)
    (replaced by MAC # 12102 -- see below)
00903 = District of Columbia - Trailblazer (eff. 1998;
    term. 07/2008)
    (replaced by MAC # 12202 -- see below)
00904 = Virginia - Trailblazer (eff. 2000; term. 03/2011)
    (replaced by MAC # 11302 -- see below)
00910 = Utah BS (eff. 1983; term. 09/2006)
00930 = Washington BS (Washington Phy. Ser.) (term. 07/1998)
0093Q = Washington-Whatcom County BS (term. 10/1998)
0093R = Washington-Yakima County BS (term. 09/2000)
00931 = Washington-Lewis County BS
00932 = Washington BS
00934 = Washington-Chelan County BS
00935 = Washington-Kisap County BS (term. 12/1994)
00936 = Washington-Spokane County BS
0093B = Washington-Clallam County BS (terminated)
0093C = Washington-Clark County BS (terminated)
0093D = Washington-Columbia County BS (terminated)
0093E = Washington-CO WLITZ County BS (terminated)
0093F = Washington-Grays Harbor County BS (terminated)
0093G = Washington-Jefferson County BS (terminated)
0093H = Washington-Kittitas County BS (terminated)
0093I = Washington-Lewis County BS (terminated)
0093J = Washington-Pacific County BS (terminated)
0093K = Washington-Tacoma BS (terminated)
0093L = Washington-Skagit County BS (terminated)
0093M = Washington-Snohomish County BS (terminated)
0093N = Washington-Thurston County BS (terminated)
0093P = Washington-Walla Walla County BS (term. 11/2000)

00950 = Wisconsin - Milwaukee Surgical (term. 07/1997)
00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)
00952 = Illinois - Wisconsin Phy Svc (eff. 1999)
00953 = Michigan - Wisconsin Phy Svc (eff. 1999)

(term. 07/15/2012)
(replaced by MAC #08202 -- see below)
00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
00960 = WPS Part D GAP (CAFM)(Truffer)
(eff. 01/2010)
00973 = Puerto Rico - Triple S, Inc. (eff. 1983;
term. 02/2009)
(replaced by MAC # 09302 -- see below)
00974 = Virgin Islands - Triple S, Inc. (term. 02/2009)
01020 = Alaska - AETNA (eff. 1983; term. 07/1997)
01030 = Arizona - AETNA (eff. 1983; term. 07/1997)
01040 = Georgia - AETNA (eff. 1988; term. 07/1997)
01070 = Connecticut - AETNA (term. 07/1997)
01120 = Hawaii - AETNA (eff. 1983; term. 1997)
01290 = Nevada - AETNA (eff. 1983; term. 10/1994)
01360 = New Mexico - AETNA (eff. 1986; term. 07/1998)
01370 = Oklahoma - AETNA (eff. 1983; term. 02/1996)
01380 = Oregon - AETNA (eff. 1983; term. 09/2000)
01390 = Washington - AETNA (eff. 1994; term. 09/2000)
02050 = California - TOLIC (eff. 1983; term. 09/1991)
02051 = OCCIDENTAL - P&E (eff. 1983; term. 12/1998)
02831 = WEST.CONSORT.OCCIDENTAL-ALASKA (term. 07/2002)
02832 = WEST.CONSORT.OCCIDENTAL-ALASKA (term. 07/2002)
02833 = WEST.CONSORT.OCCIDENTAL-ALASKA
02834 = WEST.CONSORT.OCCIDENTAL-ALASKA (term. 11-1988)
02835 = WEST.CONSORT.OCCIDENTAL-ALASKA
02836 = WEST.CONSORT.OCCIDENTAL-ALASKA (term. 12-1988)

03070 = Connecticut General Life Insurance Co.
(eff. 1983; term. 04/1997)

04110 = GEORGIA - JOHN HANCOCK (term. 04/1997)
04220 = MASSACHUSETTS - JOHN HANCOCK (term. 04/1997)

05130 = Idaho - CIGNA (eff. 1983)
05320 = New Mexico - Equitable Insurance
(eff. 1983; term. 1985)
05330 = NEW YORK - Equitable
05440 = Tennessee - CIGNA (eff. 1983; term. 08/2009)
(replaced by MAC #10302 - see below)
05530 = Wyoming - Equitable Insurance (eff. 1983)
(term. 1989)
05535 = North Carolina - CIGNA (eff. 1988)
05655 = DMERC-D Alaska - CIGNA (eff. 1993; term. 09/2006)
(replaced by MAC #19003 -- see below)
06140 = ILLINOIS - CONTINENTAL CASUALTY (term. 11/2008)

07180 = Kentucky - Metropolitan (term. 11/2000)
07330 = New York - Metropolitan (term. 08/1994)
08190 = Louisiana - Pan American

09200 = Maine-Union Mutual (terminated)

10070 = RRB-United Healthcare (term. 02/2004)

10071 = RRB-United Healthcare (terminated)
10072 = RRB-United Healthcare (terminated)
10073 = RRB-United Healthcare (terminated)
10074 = RRB-United Healthcare (term. 09/2000)
10075 = RRB-United Healthcare (terminated)
10076 = RRB-United Healthcare (terminated)
10230 = Connecticut - Metra Health (eff. 1986)
    (terminated)
10240 = Minnesota - Metra Health (eff. 1983)
    (term. 08/1994)
10250 = Mississippi - Metra Health (eff. 1983)
    (term. 09/2000)
10490 = Virginia - Metra Health (eff. 1983)
    (term. 05/1997)
10555 = DMERC A - United Healthcare
    (eff. 1993) (term. 12/1993)
11260 = General American Life of Missouri
    (eff. 1983; term. 1998)
14330 = New York - GHI (eff. 1983; term. 07/2008)
    (replaced by MAC #13292 -- see below)
16360 = Ohio - Nationwide Insurance Co. (eff. 1983)
    (term. 2002)
16510 = West Virginia - Nationwide Insurance Co.
    (eff. 1983) (term. 2002)
21200 = Maine - Massachusetts BS
    (eff. 1983) (term. 1998)
25370 = Okalhoma Dept of Public Welfare (terminated)
31140 = N. California - National Heritage Ins.
    (eff. 1997; term. 08/2008)
    (replaced by MAC #01102 -- see below)
31142 = Maine - National Heritage Ins.
    (eff. 1998; term. 05-2009)
    (replaced with MAC # 14102 - see below)
31143 = Massachusetts - National Heritage Ins.
    (eff. 1998; term. 05-2009)
    (replaced with MAC # 14202 - see below)
31144 = New Hampshire - National Heritage Ins.
    (eff. 1998; term. 05-2009)
    (replaced with MAC # 14302 - see below)
31145 = Vermont - National Heritage Ins.
    (eff. 1998; term. 05-2009)
31146 = So. California - NHIC (eff. 2000; term. 08/2008)
41260 = Missouri-General American (terminated)

80884 = Contractor ID for Physician Risk Adjust-
    ment Data (data not sent through CWF;
    but through Palmetto)

88001 = Retiree Drugs Subsidy Program (terminated)
88002 = Retiree Drugs Subsidy Program (ViPS) (CAFM)
    (terminated)

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  Medicare Administrative Contractors (MACs)

JURISDICTION 1 -- Part B MACs

01002 = J1 Roll-up
01102 = California (eff. 9/1/08)
      (replaces carrier #00832)
01192 = Palmetto GBA J1 (S CA) (eff. 09/01/2008)
01202 = Hawaiia (eff. 8/1/08)
      (replaces carrier #00833)
01302 = Nevada (eff. 8/1/08)
      (replaces carrier #00834)

02002 = JF Roll-up (2/3)
02102 = Alaska - Noridian Admin Svcs (eff. 02/01/2012)
02202 = Idaho - Noridian Admin Svcs (eff. 02/01/2012)
02302 = Oregon - Noridian Admin Svcs (eff. 02/01/2012)
02402 = Washington - Noridian Admin Svcs (eff. 02/01/2012)

JURISDICTION 3 -- Part B MACs

03002 = JF Roll-up (2/3) (orig. J3)
03102 = Arizona (eff. 12/1/06)
      (replaces carrier #00832)
03202 = Montana (eff. 12/1/06)
      (replaces carrier #00751)
03302 = N. Dakota (eff. 12/1/06)
      (replaces carrier #00820)
03402 = S. Dakota (eff. 12/1/06)
      (replaces carrier #00889)
03502 = Utah (eff. 12/1/06)
      (replaces carrier #00823)
03602 = Wyoming (eff. 12/1/06)
      (replaces carrier #00825)

JURISDICTION 4 -- Part B MACs

04002 = J4 Roll-up
04102 = Colorado (eff. 03/01/2008)
      (replaces carrier #00550)
      (terminated)
04202 = New Mexico (eff. 03/01/2008)
      (replaces carrier #00521)
04302 = Oklahoma (eff. 03/01/2008)
      (replaces carrier #00522)
04402 = Texas (eff. 06/01/2008)
      (replaces carrier #00900)

JH Roll-up (4/7)
04112 = Colorado - Novitas Solutions JH
      (eff. 11/17/2012)
04212 = New Mexico - Novitas Solutions JH
      (eff. 11/17/2012)
04312 = Oklahoma - Novitas Solutions JH
      (eff. 11/17/2012)

04412 = Texas - Novitas Solutions JH
        (eff. 11/17/2012)

JURISDICTION 5 -- Part B MACs

05002 = J5 Roll-up
05102 = Iowa (eff.2/1/08)
        (replaces carrier #00826)
05202 = Kansas (eff. 3/1/08)
        (replaces carrier #00650)
05302 = W. Missouri (eff. 3/1/08)
        (replaces carrier #00651 or 00740)
05392 = E. Missouri (eff. 6/1/08)
        (replaces carrier #00523)
05402 = Nebraska (eff. 3/1/08)
        (replaces carrier #00655)

06002 = J6 Roll-up
06102 = Illinois
06202 = Minnesota
06302 = Wisconsin

07002 = JH Roll-up (4/7)
07102 = Arkansas - Novitas Solutions JH
        (eff. 08/11/2012) (CR7812)
07202 = Louisiana - Novitas Solutions JH
        (eff. 08/11/2012)
07302 = Mississipppi - Novitas Solutions JH
        (eff. 10/20/2012)

JURISDICTION 8 -- Part B MACs

08002 = J8 Roll-up
08102 = Indiana (eff.8/20/2012)
        (replaces carrier #00630)
08202 = Michigan (eff.7/16/2012)
        (replaces carrier #00953)

JURISDICTION 9 -- Part B MACs

09002 = J9 Roll-up
09102 = Florida - First Coast (eff. 02/2009)
        (replaces carrier #00590)
09202 = Puerto Rico - First Coast (eff.03/2009)
        (replaces carrier #00973)
09302 = Virgin Island - First Coast (eff.03/2009)
        (replaces carrier #00974)

JURISDICTION 10 -- Part B MACs

10002 = J10 Roll-up
10102 = Alabama (eff.5/4/09)
        (replaces carrier #00510)
10202 = Georgia (eff.8/3/09)

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    (replaces carrier #00511)
10302 = Tennessee (eff.9/1/09)
    (replaces carrier #05440)


COB Contractor Numbers in CWF


11100 = MSP/COB Contr. 6000 COB Contractor
11101 = MSP/COB Contr. 6010 Initial Enrollment Questionaire (IEQ)
11102 = MSP/COB Contr. 6020 IRS/SSA/CMS/Data Match.
11103 = MSP/COB Contr. 6030 HMO Rate Call
11104 = MSP/COB Contr. 6040 Litigation Settlement
11105 = MSP/COB Contr. 6050 Employer Voluntary Reporting
11106 = MSP/COB Contr. 6060 Insurer Voluntary Reporting
11107 = MSP/COB Contr. 6070 First Claim Development
11108 = MSP/COB Contr. 6080 Trauma Code Development
11109 = MSP/COB Contr. 6090 Secondary Claims Investigation
11110 = MSP/COB Contr. 7000 Self Reports
11111 = MSP/COB Contr. 7010 411.25
11112 = MSP/COB Contr. 7012 BCBS Voluntary Agreements
11113 = MSP/COB Contr. 7013 OPM Data Match (OPM)
11114 = MSP/COB Contr. 7014 State Workers' Compensation
11115 = MSP/COB Contr. 7015 WC Insurer Vol Data Sharing Agreement
11116 = MSP/COB Contr. 7016 Liabilty Ins Vol Data Sharing Agreement
11117 = MSP/COB Contr. 7017 Vol Data Sharing Agreement (No...
11118 = MSP/COB Contr. 7018 Pharmacy Benefit Manager Data
11119 = MSP/COB Contr. 7019 Workers' Compensation Medicare ...
11120 = MSP/COB Contr. 7020 To be determined
11121 = MSP/COB Contr. 7021 MIR Group Health Plan
11122 = MSP/COB Contr. 7022 MIR non-Group Health Plan
11123 = MSP/COB Contr. 7023 To be determined
11124 = MSP/COB Contr. 7024 To be determined
11125 = MSP/COB Contr. 7025 Recovery Audit Contractor - California
11126 = MSP/COB Contr. 7026 Recovery Audit Contractor - Florida
11127 = MSP/COB Contr. 7027 To be determined
11139 = MSP/COB Contr. 7039 Group Health PlanRecovery
    (eff. 01/01/2013)  (CR7906)
11140 = MSP/COB Contr.
11141 = MSP/COB Contr. 7041 Non-Group Health Plan Non-ORM
    (eff. 01/01/2013)  (CR7906)
    = MSP/COB Contr. 7041 COB/MSPRC
    (redefined (description) via CR7906)
11142 = MSP/COB Contr. 7042 Non-Group Health Plan Recovery
    (eff. 01/01/2013)  (CR7906)
11143 = MSP/COB Contr. 7043 COBC/Medicare Part C/Medicare Advantage
11144 = MSP/COB Contr. 7044 To be determined
11199 = MSP/COB Contr. 7099 To be determined


JURISDICTION 11 -- Part B MACs


11002 = J11 Roll-up
11202 = South Carolina -
    Palmetto Gov. Benefits Admin. (PGBA)
11302 = Virginia (eff.3/19/2011)
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Palmetto Gov. Benefits Admin. (PGBA)
        (replaces carrier #00904)
11402 = West Virginia (eff.6/18/2011)
        Palmetto Gov. Benefits Admin. (PGBA)
11502 = North Carolina (eff.5/28/2011)
        Palmetto Gov. Benefits Admin. (PGBA)

JURISDICTION 12 -- Part B MACs

12002 = J12 Roll-up
12102 = Delaware (eff. 7/11/2008)
        (replaces carrier # 00902)
12202 = District of Columbia (eff. 7/11/2008)
        (replaces carrier # 00903)
NOTE: Includes Montgomery & Prince Georges
        Counties in Maryland and Fairfax
        Counties and the City of Alexandria, VA
12302 = Maryland (eff. 7/11/2008)
        (replaces carrier # 00901)
12402 = New Jersey (eff. 11/14/2008)
        (replaces carrier # 00805)
12502 = Pennsylvania (eff. 12/12/2008)
        (replaces carrier # 00865)

JURISDICTION 13 -- Part B MACs

13002 = J13 Roll-up
13102 = Connecticut (eff. 8/1/2008)
        (replaces carrier # 00591)
13202 = E. New York (eff. 7/18/2008)
        (replaces carrier # 00803)
13282 = W. New York (eff. 9/1/2008)
        (replaces carrier # 00801)
13292 = New York (Queens) (eff. 7/18/2008)
        (replaces carrier # 14330)

JURISDICTION 14 -- Part B MACs

14002 = J14 Roll-up
14102 = Maine (eff. 6/1/2009)
        (replaces carrier # 31142)
14202 = Massachusetts (eff. 6/1/2009)
        (replaces carrier # 31143)
14302 = N. Hampshire (eff. 6/1/2009)
        (replaces carrier # 31144)
14402 = Rhode Island (eff. 5/1/2009)
        (replaces carrier # 00524)
14502 = Vermont (eff. 6/1/2009)
        (replaces carrier # 31145)

15002 = J15 Roll-up
15102 = Kentucky (eff. 4/30/2011)
        CGS Government Sservices
15202 = Ohio (eff. 06/15/2011)

CGS Government Sservices

Durable Medical Equipment (DME) MACs

16003 = National Heritage Insurance Company (NHIC) (A)
    (eff. 7/1/06)
    (replaces carrier #00811)
17003 = Administar Federal, Inc. (B)
    (eff. 7/1/06)
    (replaces carrier # 00635)
18003 = Connecticut General (CIGNA) (C)
    (eff. 06/2006)
    (replaces carrier #00885)
19003 = Noridan Mutual Ins. Co (D)
    (eff. 10/1/06)
    (replaces carrier #05655)

33333 = MSP/COB Contr, 4000 Litigation Settlement
44410 = STC Testing
55555 = MSP/COB Contr, 3000 HMO Rate Cell Adjustment
66001 = Noridian Competitive Acquisition Program
66666 = MSP/COB Contr.
77001 = Program Safeguard Contractor (PSC)
    (Mike Lopatin)
77002 = Program Safeguard Contractor (PSC)
77003 = Program Safeguard Contractor (PSC)
77004 = Program Safeguard Contractor (PSC)
77005 = Program Safeguard Contractor (PSC)
77006 = Program Safeguard Contractor (PSC)
77007 = Program Safeguard Contractor (PSC)
77008 = Program Safeguard Contractor (PSC)
77009 = Program Safeguard Contractor (PSC)
77010 = Program Safeguard Contractor (PSC)
77011 = Program Safeguard Contractor (PSC)
77012 = Program Safeguard Contractor (PSC)

77013 = Zone Program Integrity Contractor (ZPICs)
    (Tara Ross)
77014 = Zone Program Integrity Contractor (ZPICs)
77015 = Zone Program Integrity Contractor (ZPICs)
77016 = Zone Program Integrity Contractor (ZPICs)
77017 = Zone Program Integrity Contractor (ZPICs)
77018 = Zone Program Integrity Contractor (ZPICs)
77019 = Zone Program Integrity Contractor (ZPICs)
77020 = Zone Program Integrity Contractor (ZPICs)
77021 = Zone Program Integrity Contractor (ZPICs)
77022 = Zone Program Integrity Contractor (ZPICs)
77023 = Zone Program Integrity Contractor (ZPICs)
77024 = Zone Program Integrity Contractor (ZPICs)
77025 = Zone Program Integrity Contractor (ZPICs)
77026 = Zone Program Integrity Contractor (ZPICs)
77027 = Zone Program Integrity Contractor (ZPICs)
77028 = Zone Program Integrity Contractor (ZPICs)

77777 = MSP/COB Contr. 1000 IRS/SSA/HCFA Data Match

78001 = Medicare Drug Integrity Contractor (MEDIC)
    (Tara Ross)
78002 = MEDIC Contractor
78003 = MEDIC Contractor
78004 = MEDIC Contractor
78005 = MEDIC Contractor
78006 = MEDIC Contractor
78007 = MEDIC Contractor
78008 = MEDIC Contractor
78009 = MEDIC Contractor
78010 = MEDIC Contractor
78011 = MEDIC Contractor
78012 = MEDIC Contractor
78013 = MEDIC Contractor
78014 = MEDIC Contractor
78015 = MEDIC Contractor

79001 = MSP Recovery Contractor
88888 = MSP/COB Contr. 5000 Voluntary Agreements

99999 = MSP/COB Contr. 2000 Initial Questionaire

Note: (CA) - 31140 & 31146
    (MO) - 00523 & 00651
    (NY) - 801 & 803 & 14330

Alaska-Oregon Aetna-Total (term. 09/2000)
Arizona-Nevada Aetna-Total (term. 09/2000)
Highmark-Total (term. 09/2000)
MASSACHUSETTS BS-Total (term. 09/2000)
MASSACHUSETTS BS TRI-STATE-Total (term. 09/2000)
New Mexico-Oklahoma-Total (terminated)
West.Consort.Occidental-Total (term. 09/2000)

CLM_ADJ_RSN_TB	Claim Adjustment Reason Code

1 = Deductible Amount
    Start: 01/01/1995
2 = Coinsurance Amount
    Start: 01/01/1995
3 = Co-payment Amount
    Start: 01/01/1995
4 = The procedure code is inconsistent with the
    modifier used or a required modifier is
    missing. Note: Refer to the 835 Healthcare
    Policy Identification Segment (loop 2110
    Service Payment Information REF), if
    present.
    Start: 01/01/1995

5 = The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995

6 = The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995

7 = The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995

8 = The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995

9 = The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995

10 = The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995

11 = The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 Last Modified: 09/20/2009

12 = The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995

13 = The date of death precedes the date of service. Start: 01/01/1995

14 = The date of birth follows the date of service.

Start: 01/01/1995

15 = The authorization number is missing, invalid, or does not apply to the billed services or provider.
Start: 01/01/1995

16 = Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Start: 01/01/1995

17 = Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
Start: 01/01/1995
Stop: 07/01/2009

18 = Duplicate claim/service. This change effective 1/1/2013: Exact duplicate claim/service (Use only with Group Code OA)
Start: 01/01/1995

19 = This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
Start: 01/01/1995

20 = This injury/illness is covered by the liability carrier.
Start: 01/01/1995

21 = This injury/illness is the liability of the no-fault carrier.
Start: 01/01/1995

22 = This care may be covered by another payer per coordination of benefits.
Start: 01/01/1995

23 = The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
Start: 01/01/1995

24 = Charges are covered under a capitation agreement/managed care plan.
Start: 01/01/1995

25 = Payment denied. Your Stop loss deductible has not been met.
Start: 01/01/1995
Stop: 04/01/2008

26 = Expenses incurred prior to coverage.
Start: 01/01/1995

27 = Expenses incurred after coverage terminated
Start: 01/01/1995

28 = Coverage not in effect at the time the service was provided.
Start: 01/01/1995

Stop: 10/16/2003
Notes: Redundant to codes 26&27.
29 = The time limit for filing has expired.
Start: 01/01/1995
30 = Payment adjusted because the patient has
not met the required eligibility, spend
down, waiting, or residency requirements.
Start: 01/01/1995
Stop: 02/01/2006
31 = Patient cannot be identified as our insured
Start: 01/01/1995
32 = Our records indicate that this dependent is
not an eligible dependent as defined.
Start: 01/01/1995
33 = Insured has no dependent coverage.
Start: 01/01/1995
34 = Insured has no coverage for newborns.
Start: 01/01/1995
35 = Lifetime benefit maximum has been reached.
Start: 01/01/1995
36 = Balance does not exceed co-payment amount.
Start: 01/01/1995
Stop: 10/16/2003
37 = Balance does not exceed deductible.
Start: 01/01/1995
Stop: 10/16/2003
38 = Services not provided or authorized by
designated (network/primary care) providers.
Start: 01/01/1995
Stop: 01/01/2013
39 = Services denied at the time authorization/
pre-certification was requested.
Start: 01/01/1995
40 = Charges do not meet qualifications for
emergent/urgent care. Note: Refer to the
835 Healthcare Policy Identification
Segment (loop 2110 Service Payment
Information REF), if present.
Start: 01/01/1995
41 = Discount agreed to in Preferred Provider
contract.
Start: 01/01/1995
Stop: 10/16/2003
42 = Charges exceed our fee schedule or maximum
allowable amount. (Use CARC 45)
Start: 01/01/1995
Stop: 06/01/2007
43 = Gramm-Rudman reduction.
Start: 01/01/1995
Stop: 07/01/2006
44 = Prompt-pay discount.
Start: 01/01/1995
45 = Charge exceeds fee schedule/maximum
allowable or contracted/legislated fee

arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)
Start: 01/01/1995

46 = This (these) service(s) is (are) not covered.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 96.

47 = This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
Start: 01/01/1995
Stop: 02/01/2006

48 = This (these) procedure(s) is (are) not covered.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 96.

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

51 = These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe /order/perform the service billed.
Start: 01/01/1995
Stop: 02/01/2006

53 = Services by an immediate relative or a member of the same household are not covered.
Start: 01/01/1995

54 = Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification

Segment (loop 2110 Service Payment
Information REF), if present.
Start: 01/01/1995

55 = Procedure/treatment is deemed experimental/
investigational by the payer. Note: Refer
to the 835 Healthcare Policy Identification
Segment (loop 2110 Service Payment
Information REF), if present.
Start: 01/01/1995

56 = Procedure/treatment has not been deemed
'proven to be effective' by the payer.
Note: Refer to the 835 Healthcare Policy
Identification Segment (loop 2110 Service
Payment Information REF), if present.
Start: 01/01/1995

57 = Payment denied/reduced because the payer
deems the information submitted does not
support this level of service, this many
services, this length of service, this
dosage, or this day's supply.
Start: 01/01/1995
Stop: 06/30/2007
Notes: Split into codes 150, 151, 152, 153
and 154.

58 = Treatment was deemed by the payer to have
been rendered in an inappropriate or
invalid place of service. Note: Refer to
the 835 Healthcare Policy Identification
Segment (loop 2110 Service Payment
Information REF), if present.
Start: 01/01/1995

59 = Processed based on multiple or concurrent
procedure rules. (For example multiple
surgery or diagnostic imaging, concurrent
anesthesia.) Note: Refer to the 835
Healthcare Policy Identification Segment
(loop 2110 Service Payment Information REF),
if present.
Start: 01/01/1995

60 = Charges for outpatient services are not
covered when performed within a period of
time prior to or after inpatient services.
Start: 01/01/1995

61 = Penalty for failure to obtain second
surgical opinion. Note: Refer to the 835
Healthcare Policy Identification Segment
(loop 2110 Service Payment Information REF),
if present.
Start: 01/01/1995

62 = Payment denied/reduced for absence of,
or exceeded, pre-certification/
authorization.
Start: 01/01/1995
Stop: 04/01/2007

63 = Correction to a prior claim.
   Start: 01/01/1995
   Stop: 10/16/2003
64 = Denial reversed per Medical Review.
   Start: 01/01/1995
   Stop: 10/16/2003
65 = Procedure code was incorrect. This payment
   reflects the correct code.
   Start: 01/01/1995
   Stop: 10/16/2003
66 = Blood Deductible.
   Start: 01/01/1995
67 = Lifetime reserve days. (Handled in QTY,
   QTY01=LA)
   Start: 01/01/1995
   Stop: 10/16/2003
68 = DRG weight. (Handled in CLP12)
   Start: 01/01/1995
   Stop: 10/16/2003
69 = Day outlier amount.
   Start: 01/01/1995
70 = Cost outlier - Adjustment to compensate for
   additional costs.
   Start: 01/01/1995
71 = Primary Payer amount.
   Start: 01/01/1995
   Stop: 06/30/2000
   Notes: Use code 23.
72 = Coinsurance day. (Handled in QTY, QTY01=CD)
   Start: 01/01/1995
   Stop: 10/16/2003
73 = Administrative days.
   Start: 01/01/1995
   Stop: 10/16/2003
74 = Indirect Medical Education Adjustment.
   Start: 01/01/1995
75 = Direct Medical Education Adjustment.
   Start: 01/01/1995
76 = Disproportionate Share Adjustment.
   Start: 01/01/1995
77 = Covered days. (Handled in QTY, QTY01=CA)
   Start: 01/01/1995
   Stop: 10/16/2003
78 = Non-Covered days/Room charge adjustment.
   Start: 01/01/1995
79 = Cost Report days. (Handled in MIA15)
   Start: 01/01/1995
   Stop: 10/16/2003
80 = Outlier days. (Handled in QTY, QTY01=OU)
   Start: 01/01/1995
   Stop: 10/16/2003
81 = Discharges.
   Start: 01/01/1995
   Stop: 10/16/2003

82 = PIP days.
Start: 01/01/1995
Stop: 10/16/2003
83 = Total visits.
Start: 01/01/1995
Stop: 10/16/2003
84 = Capital Adjustment. (Handled in MIA)
Start: 01/01/1995
Stop: 10/16/2003
85 = Patient Interest Adjustment (Use Only Group
code PR)
Start: 01/01/1995
Notes: Only use when the payment of
interest is the responsibility of the
patient.
86 = Statutory Adjustment.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Duplicative of code 45.
87 = Transfer amount.
Start: 01/01/1995
Stop: 01/01/2012
88 = Adjustment amount represents collection
against receivable created in prior
overpayment.
Start: 01/01/1995
Stop: 06/30/2007
89 = Professional fees removed from charges.
Start: 01/01/1995
90 = Ingredient cost adjustment. Note: To be
used for pharmaceuticals only.
Start: 01/01/1995
91 = Dispensing fee adjustment.
Start: 01/01/1995
92 = Claim Paid in full.
Start: 01/01/1995
Stop: 10/16/2003
93 = No Claim level Adjustments.
Start: 01/01/1995
Stop: 10/16/2003
Notes: As of 004010, CAS at the claim level
is optional.
94 = Processed in Excess of charges.
Start: 01/01/1995
95 = Plan procedures not followed.
Start: 01/01/1995
96 = Non-covered charge(s). At least one Remark
Code must be provided (may be comprised of
either the NCPDP Reject Reason Code, or
Remittance Advice Remark Code that is not
an ALERT.) Note: Refer to the 835
Healthcare Policy Identification Segment
(loop 2110 Service Payment Information REF),
if present.

Start: 01/01/1995

97 = The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

98 = The hospital must file the Medicare claim for this inpatient non-physician service.
Start: 01/01/1995
Stop: 10/16/2003

99 = Medicare Secondary Payer Adjustment Amount.
Start: 01/01/1995
Stop: 10/16/2003

100 = Payment made to patient/insured/responsible party/employer.
Start: 01/01/1995

101 = Predetermination: anticipated payment upon completion of services or claim adjudication.
Start: 01/01/1995

102 = Major Medical Adjustment.
Start: 01/01/1995

103 = Provider promotional discount (e.g., Senior citizen discount).
Start: 01/01/1995

104 = Managed care withholding.
Start: 01/01/1995

105 = Tax withholding.
Start: 01/01/1995

106 = Patient payment option/election not in effect.
Start: 01/01/1995

107 = The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

108 = Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

109 = Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
Start: 01/01/1995

110 = Billing date predates service date.
Start: 01/01/1995

111 = Not covered unless the provider accepts assignment.
Start: 01/01/1995

112 = Service not furnished directly to the
    patient and/or not documented.
    Start: 01/01/1995
113 = Payment denied because service/procedure
    was provided outside the United States or
    as a result of war.
    Start: 01/01/1995
    Stop: 06/30/2007
    Notes: Use Codes 157, 158 or 159.
114 = Procedure/product not approved by the Food
    and Drug Administration.
    Start: 01/01/1995
115 = Procedure postponed, canceled, or delayed.
    Start: 01/01/1995
116 = The advance indemnification notice signed
    by the patient did not comply with
    requirements.
    Start: 01/01/1995
117 = Transportation is only covered to the
    closest facility that can provide the
    necessary care.
    Start: 01/01/1995
118 = ESRD network support adjustment.
    Start: 01/01/1995
119 = Benefit maximum for this time period or
    occurrence has been reached.
    Start: 01/01/1995
120 = Patient is covered by a managed care plan.
    Start: 01/01/1995
    Stop: 06/30/2007
    Notes: Use code 24.
121 = Indemnification adjustment - compensation
    for outstanding member responsibility.
    Start: 01/01/1995
122 = Psychiatric reduction.
    Start: 01/01/1995
123 = Payer refund due to overpayment.
    Start: 01/01/1995
    Stop: 06/30/2007
    Notes: Refer to implementation guide for
    proper handling of reversals.
124 = Payer refund amount - not our patient.
    Start: 01/01/1995
    Stop: 06/30/2007
    Notes: Refer to implementation guide for
    proper handling of reversals.
125 = Submission/billing error(s). At least one
    Remark Code must be provided (may be
    comprised of either the NCPDP Reject Reason
    Code, or Remittance Advice Remark Code that
    is not an ALERT.)
    Start: 01/01/1995
126 = Deductible -- Major Medical
    Start: 02/28/1997

Stop: 04/01/2008
Notes: Use Group Code PR and code 1.
127 = Coinsurance -- Major Medical
Start: 02/28/1997
Stop: 04/01/2008
Notes: Use Group Code PR and code 2.
128 = Newborn's services are covered in the
mother's Allowance.
Start: 02/28/1997
129 = Prior processing information appears
incorrect. At least one Remark Code must
be provided (may be comprised of either the
NCPDP Reject Reason Code, or Remittance
Advice Remark Code that is not an ALERT.)
Start: 02/28/1997
130 = Claim submission fee.
Start: 02/28/1997
131 = Claim specific negotiated discount.
Start: 02/28/1997
132 = Prearranged demonstration project
adjustment.
Start: 02/28/1997
133 = The disposition of the claim/service is
pending further review. This change
effective 1/1/2013: The disposition of the
claim/service is pending further review.
(Use only with Group Code OA)
Start: 02/28/1997
134 = Technical fees removed from charges.
Start: 10/31/1998
135 = Interim bills cannot be processed.
Start: 10/31/1998
136 = Failure to follow prior payer's coverage
rules. (Use Group Code OA). This change
effective 7/1/2013: Failure to follow prior
payer's coverage rules. (Use only with
Group Code OA)
Start: 10/31/1998
137 = Regulatory Surcharges, Assessments,
Allowances or Health Related Taxes.
Start: 02/28/1999
138 = Appeal procedures not followed or time
limits not met.
Start: 06/30/1999
139 = Contracted funding agreement - Subscriber
is employed by the provider of services.
Start: 06/30/1999
140 = Patient/Insured health identification
number and name do not match.
Start: 06/30/1999
141 = Claim spans eligible and ineligible periods
of coverage.
Start: 06/30/1999
Stop: 07/01/2012

142 = Monthly Medicaid patient liability amount.
   Start: 06/30/2000
143 = Portion of payment deferred.
   Start: 02/28/2001
144 = Incentive adjustment, e.g. preferred
   product/service.
   Start: 06/30/2001
145 = Premium payment withholding
   Start: 06/30/2002
   Stop: 04/01/2008
   Notes: Use Group Code CO and code 45.
146 = Diagnosis was invalid for the date(s) of
   service reported.
   Start: 06/30/2002
147 = Provider contracted/negotiated rate expired
   or not on file.
   Start: 06/30/2002
148 = Information from another provider was not
   provided or was insufficient/incomplete.
   At least one Remark Code must be provided
   (may be comprised of either the NCPDP
   Reject Reason Code, or Remittance Advice
   Remark Code that is not an ALERT.)
   Start: 06/30/2002
149 = Lifetime benefit maximum has been reached
   for this service/benefit category.
   Start: 10/31/2002
150 = Payer deems the information submitted does
   not support this level of service.
   Start: 10/31/2002
151 = Payment adjusted because the payer deems
   the information submitted does not support
   this many/frequency of services.
   Start: 10/31/2002
152 = Payer deems the information submitted does
   not support this length of service. Note:
   Refer to the 835 Healthcare Policy
   Identification Segment (loop 2110 Service
   Payment Information REF), if present.
   Start: 10/31/2002
153 = Payer deems the information submitted does
   not support this dosage.
   Start: 10/31/2002
154 = Payer deems the information submitted does
   not support this day's supply.
   Start: 10/31/2002
155 = Patient refused the service/procedure.
   Start: 06/30/2003
156 = Flexible spending account payments. Note:
   Use code 187.
   Start: 09/30/2003
   Stop: 10/01/2009
157 = Service/procedure was provided as a result
   of an act of war.

Start: 09/30/2003
158 = Service/procedure was provided outside of
    the United States.
    Start: 09/30/2003
159 = Service/procedure was provided as a result
    of terrorism.
    Start: 09/30/2003
160 = Injury/illness was the result of an
    activity that is a benefit exclusion.
    Start: 09/30/2003
161 = Provider performance bonus
    Start: 02/29/2004
162 = State-mandated Requirement for Property and
    Casualty, see Claim Payment Remarks Code
    for specific explanation.
    Start: 02/29/2004
163 = Attachment referenced on the claim was not
    received.
    Start: 06/30/2004
164 = Attachment referenced on the claim was not
    received in a timely fashion.
    Start: 06/30/2004
165 = Referral absent or exceeded.
    Start: 10/31/2004
166 = These services were submitted after this
    payers responsibility for processing claims
    under this plan ended.
    Start: 02/28/2005
167 = This (these) diagnosis(es) is (are) not
    covered. Note: Refer to the 835 Healthcare
    Policy Identification Segment (loop 2110
    Payment Information REF), if present.
    Start: 06/30/2005
168 = Service(s) have been considered under the
    patient's medical plan. Benefits are not
    available under this dental plan.
    Start: 06/30/2005
169 = Alternate benefit has been provided.
    Start: 06/30/2005
170 = Payment is denied when performed/billed by
    this type of provider. Note: Refer to the
    835 Healthcare Policy Identification
    Segment (loop 2110 Service Payment
    Information REF), if present.
    Start: 06/30/2005
171 = Payment is denied when performed/billed by
    this type of provider in this type of
    facility. Note: Refer to the 835 Healthcare
    Policy Identification Segment (loop 2110
    Service Payment Information REF), if
    present.
    Start: 06/30/2005
172 = Payment is adjusted when performed/billed
    by a provider of this specialty. Note:

Refer to the 835 Healthcare Policy
Identification Segment (loop 2110 Service
Payment Information REF), if present.
Start: 06/30/2005

173 = Service was not prescribed by a physician.
This change effective 7/1/2013: Service/
equipment was not prescribed by a
physician.
Start: 06/30/2005

174 = Service was not prescribed prior to
delivery.
Start: 06/30/2005

175 = Prescription is incomplete.
Start: 06/30/2005

176 = Prescription is not current.
Start: 06/30/2005

177 = Patient has not met the required
eligibility requirements.
Start: 06/30/2005

178 = Patient has not met the required spend
down requirements.
Start: 06/30/2005

179 = Patient has not met the required waiting
requirements. Note: Refer to the 835
Healthcare Policy Identification Segment
(loop 2110 Service Payment Information REF)
, if present.
Start: 06/30/2005

180 = Patient has not met the required residency
requirements.
Start: 06/30/2005

181 = Procedure code was invalid on the date of
service.
Start: 06/30/2005

182 = Procedure modifier was invalid on the date
of service.
Start: 06/30/2005

183 = The referring provider is not eligible to
refer the service billed. Note: Refer to
the 835 Healthcare Policy Identification
Segment (loop 2110 Service Payment
Information REF), if present.
Start: 06/30/2005

184 = The prescribing/ordering provider is not
eligible to prescribe/order the service
billed. Note: Refer to the 835 Healthcare
Policy Identification Segment (loop 2110
Service Payment Information REF), if
present.
Start: 06/30/2005

185 = The rendering provider is not eligible to
perform the service billed. Note: Refer
to the 835 Healthcare Policy Identification
Segment (loop 2110 Service Payment

Information REF), if present.
Start: 06/30/2005
Last Modified: 09/20/2009

186 = Level of care change adjustment.
Start: 06/30/2005

187 = Consumer Spending Account payments
(includes but is not limited to Flexible
Spending Account, Health Savings Account,
Health Reimbursement Account, etc.)
Start: 06/30/2005

188 = This product/procedure is only covered when
used according to FDA recommendations.
Start: 06/30/2005

189 = 'Not otherwise classified' or 'unlisted'
procedure code (CPT/HCPCS) was billed when
there is a specific procedure code for this
procedure/service
Start: 06/30/2005

190 = Payment is included in the allowance for a
Skilled Nursing Facility (SNF) qualified
stay.
Start: 10/31/2005

191 = Not a work related injury/illness and thus
not the liability of the workers'
compensation carrier Note: If adjustment is
at the Claim Level, the payer must send and
the provider should refer to the 835
Insurance Policy Number Segment (Loop 2100
Other Claim Related Information REF
qualifier 'IG') for the jurisdictional
regulation. If adjustment is at the Line
Level, the payer must send and the provider
should refer to the 835 Healthcare Policy
Identification Segment (loop 2110 Service
Payment information REF)
Start: 10/31/2005

192 = Non standard adjustment code from paper
remittance. Note: This code is to be used
by providers/payers providing Coordination
of Benefits information to another payer in
the 837 transaction only. This code is only
used when the non-standard code cannot be
reasonably mapped to an existing Claims
Adjustment Reason Code, specifically
Deductible, Coinsurance and Co-payment.
Start: 10/31/2005

193 = Original payment decision is being
maintained. Upon review, it was determined
that this claim was processed properly.
Start: 02/28/2006

194 = Anesthesia performed by the operating
physician, the assistant surgeon or the
attending physician.
Start: 02/28/2006

195 = Refund issued to an erroneous priority payer for this claim/service.
Start: 02/28/2006

196 = Claim/service denied based on prior payer's coverage determination.
Start: 06/30/2006
Stop: 02/01/2007
Notes: Use code 136.

197 = Precertification/authorization/notification absent.
Start: 10/31/2006

198 = Precertification/authorization exceeded.
Start: 10/31/2006

199 = Revenue code and Procedure code do not match.
Start: 10/31/2006

200 = Expenses incurred during lapse in coverage
Start: 10/31/2006

201 = Workers' Compensation case settled. Patient is responsible for amount of this claim/ service through WC 'Medicare set aside arrangement' or other agreement. (Use group code PR). This change effective 7/1/2013: Workers Compensation case settled. Patient is responsible for amount of this claim/ service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR)
Start: 10/31/2006

202 = Non-covered personal comfort or convenience services.
Start: 02/28/2007

203 = Discontinued or reduced service.
Start: 02/28/2007

204 = This service/equipment/drug is not covered under the patient's current benefit plan
Start: 02/28/2007

205 = Pharmacy discount card processing fee
Start: 07/09/2007

206 = National Provider Identifier - missing.
Start: 07/09/2007

207 = National Provider identifier - Invalid format
Start: 07/09/2007

208 = National Provider Identifier - Not matched.
Start: 07/09/2007

209 = Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA) This change effective 7/1/2013: Per regulatory or other agreement. The provider. cannot collect this amount from the patient

However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)
Start: 07/09/2007

210 = Payment adjusted because pre-certification/ authorization not received in a timely fashion
Start: 07/09/2007

211 = National Drug Codes (NDC) not eligible for rebate, are not covered.
Start: 07/09/2007

212 = Administrative surcharges are not covered
Start: 11/05/2007

213 = Non-compliance with the physician self referral prohibition legislation or payer policy.
Start: 01/27/2008

214 = Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only
Start: 01/27/2008

215 = Based on subrogation of a third party settlement
Start: 01/27/2008

216 = Based on the findings of a review organization
Start: 01/27/2008

217 = Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only)
Start: 01/27/2008

218 = Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) To be used for Workers' Compensation only

Start: 01/27/2008

219 = Based on extent of injury. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).
Start: 01/27/2008

220 = The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Property and Casualty only)
Start: 01/27/2008

221 = Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). This change effective 7/1/2013: Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property & Casualty only)
Start: 01/27/2008

222 = Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 06/01/2008

223 = Adjustment code for mandated federal, state
or local law/regulation that is not already
covered by another code and is mandated
before a new code can be created.
Start: 06/01/2008

224 = Patient identification compromised by
identity theft. Identity verification
required for processing this and future
claims.
Start: 06/01/2008

225 = Penalty or Interest Payment by Payer (Only
used for plan to plan encounter reporting
within the 837)
Start: 06/01/2008

226 = Information requested from the Billing/
Rendering Provider was not provided or was
insufficient/incomplete. At least one
Remark Code must be provided (may be
comprised of either the NCPDP Reject Reason
Code, or Remittance Advice Remark Code that
is not an ALERT.) This change effective
7/1/2013: Information requested from the
Billing/Rendering Provider was not provided
or not provided timely or was insufficient/
incomplete. At least one Remark Code must
be provided (may be comprised of either the
NCPDP Reject Reason Code, or Remittance
Advice Remark Code that is not an ALERT.)
Start: 09/21/2008

227 = Information requested from the patient/
insured/responsible party was not provided
or was insufficient/incomplete. At least
one Remark Code must be provided (may be
comprised of either the NCPDP Reject Reason
Code, or Remittance Advice Remark Code that
is not an ALERT.)
Start: 09/21/2008

228 = Denied for failure of this provider,
another provider or the subscriber to
supply requested information to a previous
payer for their adjudication
Start: 09/21/2008

229 = Partial charge amount not considered by
Medicare due to the initial claim Type of
Bill being 12X. Note: This code can only
be used in the 837 transaction to convey
Coordination of Benefits information when
the secondary payer's cost avoidance policy
allows providers to bypass claim submission
to a prior payer. Use Group Code PR. This
change effective 7/1/2013: Partial charge
amount not considered by Medicare due to
the initial claim Type of Bill being 12X.

Note: This code can only be used in the
837 transaction to convey Coordination of
Benefits information when the secondary
payer's cost avoidance policy allows
providers to bypass claim submission to a
prior payer. (Use only with Group Code PR)
Start: 01/25/2009

230 = No available or correlating CPT/HCPCS code
to describe this service. Note: Used only
by Property and Casualty.
Start: 01/25/2009

231 = Mutually exclusive procedures cannot be
done in the same day/setting. Note: Refer
to the 835 Healthcare Policy Identification
Segment (loop 2110 Service Payment
Information REF), if present.
Start: 07/01/2009

232 = Institutional Transfer Amount. Note -
Applies to institutional claims only and
explains the DRG amount difference when the
patient care crosses multiple institutions.
Start: 11/01/2009

233 = Services/charges related to the treatment
of a hospital-acquired condition or
preventable medical error.
Start: 01/24/2010

234 = This procedure is not paid separately. At
least one Remark Code must be provided
(may be comprised of either the NCPDP
Reject Reason Code, or Remittance Advice
Remark Code that is not an ALERT.)
Start: 01/24/2010

235 = Sales Tax
Start: 06/06/2010

236 = This procedure or procedure/modifier
combination is not compatible with another
procedure or procedure/modifier combination
provided on the same day according to the
National Correct Coding Initiative. This
change effective 7/1/2013: This procedure
or procedure/modifier combination is not
compatible with another procedure or
procedure/modifier combination provided on
the same day according to the National
Correct Coding Initiative or workers
compensation state regulations/ fee
schedule requirements.
Start: 01/30/2011

237 = Legislated/Regulatory Penalty. At least one
Remark Code must be provided (may be
comprised of either the NCPDP Reject Reason
Code, or Remittance Advice Remark Code that
is not an ALERT.)
Start: 06/05/2011

238 = Claim spans eligible and ineligible periods
of coverage, this is the reduction for the
ineligible period (use Group Code PR). This
change effective 7/1/2013: Claim spans
eligible and ineligible periods of coverage
, this is the reduction for the ineligible
period. (Use only with Group Code PR)
Start: 03/01/2012
239 = Claim spans eligible and ineligible periods
of coverage. Rebill separate claims.
Start: 03/01/2012
240 = The diagnosis is inconsistent with the
patient's birth weight. Note: Refer to the
835 Healthcare Policy Identification
Segment (loop 2110 Service Payment
Information REF), if present.
Start: 06/03/2012
241 = Low Income Subsidy (LIS) Co-payment Amount
Start: 06/03/2012
242 = Services not provided by network/primary
care providers.
Start: 06/03/2012
243 = Services not authorized by network/primary
care providers.
Start: 06/03/2012
244 = Payment reduced to zero due to litigation.
Additional information will be sent
following the conclusion of litigation.
To be used for Property & Casualty only.
Start: 09/30/2012
245 = Provider performance program withhold.
Start: 09/30/2012
246 = This non-payable code is for required
reporting only.
Start: 09/30/2012
247 = Deductible for Professional service
rendered in an Institutional setting and
billed on an Institutional claim.
Start: 09/30/2012
Notes: For Medicare Bundled Payment use
only, under the Patient Protection and
Affordable Care Act (PPACA).
248 = Coinsurance for Professional service
rendered in an Institutional setting and
billed on an Institutional claim.
Start: 09/30/2012
Notes: For Medicare Bundled Payment use
only, under the Patient Protection and
Affordable Care Act (PPACA).
249 = This claim has been identified as a
readmission. (Use only with Group Code CO)
Start: 09/30/2012
250 = The attachment content received is
inconsistent with the expected content.

Start: 09/30/2012

251 = The attachment content received did not
    contain the content required to process
    this claim or service.
    Start: 09/30/2012

252 = An attachment is required to adjudicate
    this claim/service. At least one Remark
    Code must be provided (may be comprised of
    either the NCPDP Reject Reason Code, or
    Remittance Advice Remark Code that is not
    an ALERT).
    Start: 09/30/2012

A0 = Patient refund amount.
    Start: 01/01/1995

A1 = Claim/Service denied. At least one Remark
    Code must be provided (may be comprised of
    either the NCPDP Reject Reason Code, or
    Remittance Advice Remark Code that is not
    an ALERT.)
    Start: 01/01/1995

A2 = Contractual adjustment.
    Start: 01/01/1995
    Stop: 01/01/2008
    Notes: Use Code 45 with Group Code 'CO' or
    use another appropriate specific adjustment
    code.

A3 = Medicare Secondary Payer liability met.
    Start: 01/01/1995
    Stop: 10/16/2003

A4 = Medicare Claim PPS Capital Day Outlier
    Amount.
    Start: 01/01/1995
    Stop: 04/01/2008

A5 = Medicare Claim PPS Capital Cost Outlier
    Amount.
    Start: 01/01/1995

A6 = Prior hospitalization or 30 day transfer
    requirement not met.
    Start: 01/01/1995

A7 = Presumptive Payment Adjustment
    Start: 01/01/1995

A8 = Ungroupable DRG.
    Start: 01/01/1995

B1 = Non-covered visits.
    Start: 01/01/1995

B2 = Covered visits.
    Start: 01/01/1995
    Stop: 10/16/2003

B3 = Covered charges.
    Start: 01/01/1995
    Stop: 10/16/2003

B4 = Late filing penalty.
    Start: 01/01/1995

B5 = Coverage/program guidelines were not met

or were exceeded.
Start: 01/01/1995

B6 = This payment is adjusted when performed/
billed by this type of provider, by this
type of provider in this type of facility,
or by a provider of this specialty.
Start: 01/01/1995
Stop: 02/01/2006

B7 = This provider was not certified/eligible
to be paid for this procedure/service on
this date of service. Note: Refer to the
835 Healthcare Policy Identification
Segment (loop 2110 Service Payment
Information REF), if present.
Start: 01/01/1995

B8 = Alternative services were available, and
should have been utilized. Note: Refer to
the 835 Healthcare Policy Identification
Segment (loop 2110 Service Payment
Information REF), if present.
Start: 01/01/1995

B9 = Patient is enrolled in a Hospice.
Start: 01/01/1995

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.
Start: 01/01/1995

B11 = The claim/service has been transferred to
the proper payer/processor for processing.
Claim/service not covered by this payer/
processor.
Start: 01/01/1995

B12 = Services not documented in patients'
medical records.
Start: 01/01/1995

B13 = Previously paid. Payment for this claim/
service may have been provided in a
previous payment.
Start: 01/01/1995

B14 = Only one visit or consultation per
physician per day is covered.
Start: 01/01/1995

B15 = This service/procedure requires that a
qualifying service/procedure be received
and covered. The qualifying other service/
procedure has not been received/adjudicated
. Note: Refer to the 835 Healthcare Policy
Identification Segment (loop 2110 Service
Payment Information REF), if present.
Start: 01/01/1995

B16 = 'New Patient' qualifications were not met.
Start: 01/01/1995

B17 = Payment 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.
Start: 01/01/1995
Stop: 02/01/2006
B18 = This procedure code and modifier were
invalid on the date of service.
Start: 01/01/1995
Stop: 03/01/2009
B19 = Claim/service adjusted because of the
finding of a Review Organization.
Start: 01/01/1995
Stop: 10/16/2003
B20 = Procedure/service was partially or fully
furnished by another provider.
Start: 01/01/1995
B21 = The charges were reduced because the
service/care was partially furnished by
another physician.
Start: 01/01/1995
Stop: 10/16/2003
B22 = This payment is adjusted based on the
diagnosis.
Start: 01/01/1995
B23 = Procedure billed is not authorized per
your Clinical Laboratory Improvement
Amendment (CLIA) proficiency test.
Start: 01/01/1995
D1 = Claim/service denied. Level of subluxation
is missing or inadequate.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if
necessary.
D2 = Claim lacks the name, strength, or dosage
of the drug furnished.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if
necessary.
D3 = Claim/service denied because information to
indicate if the patient owns the equipment
that requires the part or supply was
missing.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if
necessary.
D4 = Claim/service does not indicate the period
of time for which this will be needed.
Start: 01/01/1995
Stop: 10/16/2003

Notes: Use code 16 and remark codes if
necessary.
D5 = Claim/service denied. Claim lacks
individual lab codes included in the test.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if
necessary.
D6 = Claim/service denied. Claim did not include
patient's medical record for the service.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if
necessary.
D7 = Claim/service denied. Claim lacks date of
patient's most recent physician visit.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if
necessary.
D8 = Claim/service denied. Claim lacks
indicator that 'x-ray is available for
review.'
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if
necessary.
D9 = Claim/service denied. Claim lacks invoice
or statement certifying the actual cost
of the lens, less discounts or the type of
intraocular lens used.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if
necessary.
D10 = Claim/service denied. Completed physician
financial relationship form not on file.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 17.
D11 = Claim lacks completed pacemaker
registration form.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 17.
D12 = Claim/service denied. Claim does not
identify who performed the purchased
diagnostic test or the amount you were
charged for the test.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 17.
D13 = Claim/service denied. Performed by a
facility/supplier in which the ordering/

referring physician has a financial
interest.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 17.
D14 = Claim lacks indication that plan of
treatment is on file.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 17.
D15 = Claim lacks indication that service was
supervised or evaluated by a physician.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 17.
D16 = Claim lacks prior payer payment information
Start: 01/01/1995
Stop: 06/30/2007
Notes: Use code 16 with appropriate claim
payment remark code âN4ã.
D17 = Claim/Service has invalid non-covered days.
Start: 01/01/1995
Stop: 06/30/2007
Notes: Use code 16 with appropriate claim
payment remark code.
D18 = Claim/Service has missing diagnosis
information.
Start: 01/01/1995
Stop: 06/30/2007
Notes: Use code 16 with appropriate claim
payment remark code.
D19 = Claim/Service lacks Physician/Operative or
other supporting documentation
Start: 01/01/1995
Stop: 06/30/2007
Notes: Use code 16 with appropriate claim
payment remark code.
D20 = Claim/Service missing service/product
information.
Start: 01/01/1995
Stop: 06/30/2007
Notes: Use code 16 with appropriate claim
payment remark code.
D21 = This (these) diagnosis(es) is (are) missing
or are invalid
Start: 01/01/1995
Stop: 06/30/2007
D22 = Reimbursement was adjusted for the reasons
to be provided in separate correspondence.
(Note: To be used for Workers' Compensation
only) - Temporary code to be added for time
frame only until 01/01/2009. Another code
to be established and/or for 06/2008
meeting for a revised code to replace or

strategy to use another existing code
Start: 01/27/2008
Stop: 01/01/2009

D23 = This dual eligible patient is covered by
Medicare Part D per Medicare Retro-
Eligibility. At least one Remark Code must
be provided (may be comprised of either the
NCPDP Reject Reason Code, or Remittance
Advice Remark Code that is not an ALERT.)
Start: 11/01/2009
Stop: 01/01/2012

W1 = Workers' compensation jurisdictional fee
schedule adjustment. Note: If adjustment
is at the Claim Level, the payer must send
and the provider should refer to the 835
Class of Contract Code Identification
Segment (Loop 2100 Other Claim Related
Information REF). If adjustment is at the
Line Level, the payer must send and the
provider should refer to the 835 Healthcare
Policy Identification Segment (loop 2110
Service Payment information REF).
Start: 02/29/2000

W2 = Payment reduced or denied based on workers'
compensation jurisdictional regulations or
payment policies, use only if no other code
is applicable. Note: If adjustment is at
the Claim Level, the payer must send and
the provider should refer to the 835
Insurance Policy Number Segment (Loop 2100
Other Claim Related Information REF
qualifier 'IG') for the jurisdictional
regulation. If adjustment is at the Line
Level, the payer must send and the provider
should refer to the 835 Healthcare Policy
Identification Segment (loop 2110 Service
Payment information REF). To be used for
Workers' Compensation only.
Start: 10/17/2010

W3 = The Benefit for this Service is included
in the payment/allowance for another
service/procedure that has been performed
on the same day. Note: Refer to the 835
Healthcare Policy Identification Segment
(loop 2110 Service Payment Information REF),
if present. For use by Property and
Casualty only.
Start: 09/30/2012

W4 = Workers' Compensation Medical Treatment
Guideline Adjustment.
Start: 09/30/2012

Y1 = Payment denied based on Medical Payments
Coverage (MPC) or Personal Injury
Protection (PIP) Benefits jurisdictional

regulations or payment policies, use only
if no other code is applicable. Note: If
adjustment is at the Claim Level, the payer
must send and the provider should refer to
the 835 Insurance Policy Number Segment
(Loop 2100 Other Claim Related Information
REF qualifier 'IG') for the jurisdictional
regulation. If adjustment is at the Line
Level, the payer must send and the provider
should refer to the 835 Healthcare Policy
Identification Segment (loop 2110 Service
Payment information REF). To be used for
P&C Auto only.
Start: 09/30/2012

Y2 = Payment adjusted based on Medical Payments
Coverage (MPC) or Personal Injury
Protection (PIP) Benefits jurisdictional
regulations or payment policies, use only
if no other code is applicable. Note: If
adjustment is at the Claim Level, the payer
must send and the provider should refer to
the 835 Insurance Policy Number Segment
(Loop 2100 Other Claim Related Information
REF qualifier 'IG') for the jurisdictional
regulation. If adjustment is at the Line
Level, the payer must send and the provider
should refer to the 835 Healthcare Policy
Identification Segment (loop 2110 Service
Payment information REF). To be used for
P&C Auto only.
Start: 09/30/2012

Y3 = Medical Payments Coverage (MPC) or Personal
Injury Protection (PIP) Benefits
jurisdictional fee schedule adjustment.
Note: If adjustment is at the Claim Level,
the payer must send and the provider should
refer to the 835 Class of Contract Code
Identification Segment (Loop 2100 Other
Claim Related Information REF). If
adjustment is at the Line Level, the payer
must send and the provider should refer to
the 835 Healthcare Policy Identification
Segment (loop 2110 Service Payment
information REF). To be used for P&C Auto
only.
Start: 09/30/2012

CLM_BENE_ID_TYPE_TB   Claim Beneficiary Identifier Type Table

M = MBI
H = HICN

CLM_CARE_IMPRVMT_MODEL_TB   Claim Care Improvement Model Table

   61 = CLAIM CARE IMPROVEMENT MODEL 1
   62 = CLAIM CARE IMPROVEMENT MODEL 2
   63 = CLAIM CARE IMPROVEMENT MODEL 3
   64 = CLAIM CARE IMPROVEMENT MODEL 4

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_FPS_MSN_CD_TB   Claim FPS MSN Code Table

   Section 1 Ambulance
   1.1　= Payment for transportation is allowed
      only to the closest facility that can
      provide the necessary care.
   1.10　= Air ambulance is not covered since you
      were not taken to the airport by
      ambulance.
   1.11　= The information provided does not support

the need for an air ambulance.
The approved amount is based on ground
ambulance.

1.2   = Payment is denied because the ambulance
company is not approved by Medicare.
1.3   = Ambulance service to a funeral home is
not covered.
1.4   = Transportation in a vehicle other than
an ambulance is not covered.
1.5   = Transportation to a facility to be closer
to home or family is not covered.
1.6   = This service is included in the allowance
for the ambulance transportation.
1.7   = Ambulance services to or from a doctor's
office are not covered.
1.8   = This service is denied because you
refused to be transported.
1.9   = Payment for ambulance services does not
include mileage when you were not in the
ambulance.

Section 10 Foot Care
10.1 = Shoes are only covered as part of a leg
brace.

Section 11 Transfer of Claims or Parts of Claims
11.1 = Your claim has been forwarded to the
correct Medicare contractor for
processing. You will receive a notice
from them.
11.10 = We have identified you as a Railroad
Retirement Board (RRB) Medicare
beneficiary. You must send your claim
for these services for processing to the
RRB carrier Palmetto GBA, at PO Box
10066, Augusta, GA 30999.
11.11 = This claim/service is not payable under
our claims jurisdiction. We have notified
your provider to send your claim for
these services to the United Mine
Workers of America for processing.
11.2 = This information is being sent to
Medicaid. They will review it to see if
additional benefits can be paid.
11.3 = Our records show that you are enrolled in
a Medicare health plan. Your provider
must bill this service to the plan.
11.4 = Our records show that you are enrolled in
a Medicare health plan. Your claim was
sent to the plan for processing.
11.5 = This claim will need to be submitted to
(another carrier, a Durable Medical
Equipment Medicare Administrative
Contractor (DME MAC), or Medicaid agency)

11.6 = We have asked your provider to submit this claim to the proper Medicare Administrative Contractor (MAC). That MAC is (name and address).
NOTE: Due to different systems' capabilities, DMACs may omit the final sentence in this message, "That MAC is (name and address)," whenever this message is used. Part A and Part B MACs are expected to use the complete message. This instruction also applies to the Spanish translation of the message.

11.7 = This claim/service is not payable under our claims jurisdiction area. We have notified your provider that they must forward the claim/service to the correct carrier for processing.

11.8 = This claim will need to be submitted to the Region B Durable Medical Equipment Regional Carrier.

11.9 = This claim/service is not payable under our claims jurisdiction. We have notified your provider to send your claim for these services to the Railroad Retirement Board Medicare carrier.

Section 12 Hearing Aids
12.1 = Hearing aids are not covered.

Section 13 Skilled Nursing Facility
13.1 = No qualifying hospital stay dates were shown for this skilled nursing facility stay.

13.10 = Medicare Part B doesn't pay for items or services provided by this type of healthcare provider since our records show that you were receiving Medicare Part A benefits in a skilled nursing facility on this date.

13.11 = You have ___ days(s) remaining of your total 100 days of skilled nursing facility benefits for this benefit period

13.12 = Medicare Part B doesn't pay separately for this item/service. Payment for this item/service should be included in another Medicare benefit. The hospital/ nursing facility must bill for this Medicare service.

13.2 = Skilled nursing facility benefits are only available after a hospital stay of at least 3 days.

13.3 = Information provided does not support the need for skilled nursing facility care.

13.4 = Information provided does not support the

need for continued care in a skilled
nursing facility.

13.5 = You were not admitted to the skilled
nursing facility within 30 days of your
hospital discharge.

13.6 = Rural primary care skilled nursing
facility benefits are only available
after a hospital stay of at least 2 days.

13.7 = Normally, care is not covered when
provided in a bed that is not certified
by Medicare. However, since you received
covered care, we have decided that you
will not have to pay the facility for
anything more than Medicare coinsurance
and noncovered items.

13.8 = The skilled nursing facility should file
a claim for Medicare benefits because
you were an inpatient.

13.9 = Medicare Part B does not pay for this
item or service since our records show
that you were in a skilled nursing
facility on this date.

Section 14 Laboratory

14.1 = The laboratory is not approved for this
type of test.

14.10 = Medicare does not allow a separate
payment for EKG readings.

14.11 = A travel allowance is paid only when a
covered specimen collection fee is billed

14.12 = Payment for transportation can only be
made if an X-ray or EKG is performed.

14.13 = The laboratory was not approved for this
test on the date it was performed.

14.2 = Medicare approved less for this
individual test because it can be done
as part of a complete group of tests.

14.3 = Services or items not approved by the
Food and Drug Administration are not
covered.

14.4 = Payment denied because the claim did not
show who performed the test and/or the
amount charged.

14.5 = Payment denied because the claim did not
show if the test was purchased by the
physician or if the physician performed
the test.

14.6 = This test must be billed by the
laboratory that did the work.

14.7 = This service is paid at 100% of the
Medicare approved amount.

14.8 = Payment cannot be made because the
physician has a financial relationship
with the laboratory.

14.9 = Medicare cannot pay for this service for
       the diagnosis shown on the claim.

Section Medical Necessity
15.1 = The information provided does not support
       the need for this many services or items.
15.10 = Medicare does not pay for more than one
       assistant surgeon for this procedure.
15.11 = Medicare does not pay for an assistant
       surgeon for this procedure/surgery.
15.12 = Medicare does not pay for two surgeons
       for this procedure.
15.13 = Medicare does not pay for team surgeons
       for this procedure.
15.14 = Medicare does not pay for acupuncture.
15.15 = Payment has been reduced because
       information provided does not support the
       need for this item as billed.
15.16 = Your claim was reviewed by our medical
       staff.
15.17 = We have approved this service at a
       reduced level.
15.18 = Medicare does not cover this service at
       home.
15.19 = Local Coverage Determinations (LCDs) help
       Medicare decide what is covered. An LCD
       was used for your claim. You can compare
       your case to the LCD, and send
       information from your doctor if you
       think it could change our decision.
       Call 1-800-MEDICARE (1-800-633-4227) for
       a copy of the LCD.
15.2 = The information provided does not support
       the need for this equipment.
15.20 = The following policies were used when we
       made this decision: _____
15.21 = The information provided does not support
       the need for this many services or items
       in this period of time but you do not
       have to pay this amount.
15.22 = The information provided does not support
       the need for this many services or items
       in this period of time so Medicare will
       not pay for this item or service.
15.3 = The information provided does not support
       the need for the special features of this
       equipment.
15.4 = The information provided does not support
       the need for this service or item.
15.5 = The information provided does not support
       the need for similar services by more
       than one doctor during the same time
       period.
15.6 = The information provided does not support

the need for this many services or items
within this period of time.
15.7 = The information provided does not support
the need for more than one visit a day.
15.8 = The information provided does not support
the level of service as shown on the
claim.
15.9 = The Quality Improvement Organization did
not approve this service.
15.96 = Medicare does not pay for this
investigational device(s).
15.97 = Medicare cannot pay for this
investigational device because the
approved period for the investigational
device in the FDA clinical trial has not
begun.
15.98 = Medicare cannot pay for this
investigational device because the
approved period for the investigational
device in the FDA clinical trial has
expired.
15.99 = Medicare does not pay for this many
services on the same day. You cannot be
billed for this service.

Section 16 Miscellaneous
16.1 = The service cannot be approved because
the date on the claim shows it was billed
before it was provided.
16.10 = Medicare does not pay for this item or
service.
16.11 = Payment was reduced for late filing. You
cannot be billed for the reduction.
16.12 = Outpatient mental health services are
paid at 50% of the approved charges.
16.13 = The code(s) your provider used is/are not
valid for the date of service billed.
16.14 = The attached check replaces your previous
check (#____) dated (_____).
16.15 = The attached check replaces your previous
check.
16.16 = As requested, this is a duplicate copy of
your Medicare Summary Notice.
See "Message Expiration Date" and
"Message Notes" columns ------->
16.17 = Medicare only pays for these services if
you get them with total parenteral
nutrition.
16.18 = Medicare won't pay for services provided
before certified parenteral/enteral
nutrition therapy started.
16.19 = The amount Medicare pays for a
parenteral/enteral nutrition supply is
based on the level of care you need

(based on your diagnosis).

16.2 = This service cannot be paid when provided in this location/facility.

16.20 = The approved payment for calories/grams is the most Medicare may allow for the diagnosis stated.

16.21 = The procedure code was changed to reflect the actual service rendered.

16.22 = Medicare does not pay for services when no charge is indicated.

16.23 = This check is for the amount you overpaid

16.24 = Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, the service must be provided by a doctor licensed to practice in the United States.

16.25 = Medicare does not pay for this much equipment, or this many services or supplies.

16.26 = Medicare does not pay for services or items related to a procedure that has not been approved or billed.

16.27 = This service is not covered since our records show you were in the hospital at this time.

16.28 = Medicare does not pay for services or equipment that you have not received.

16.29 = Payment is included in another service you have received.

16.3 = The claim did not show that this service or item was prescribed by your doctor.

16.30 = Services billed separately on this claim have been combined under this procedure.

16.31 = You are responsible to pay the primary physician care the agreed monthly charge.

16.32 = Medicare does not pay separately for this service.

16.33 = Your payment includes interest because Medicare exceeded processing time limits.

16.34 = You should not be billed for this service . You are only responsible for any deductible and coinsurance amounts listed in the "You May Be Billed" column. This message should be revised to read "Maximum You May Be Billed" (in place of "You May Be Billed") when your MAC implements the new MSN design. See "Message Implementation Date" and "Message Notes."

16.35 = You do not have to pay this amount.

16.36 = If you have already paid it, you are entitled to a refund from this provider.

16.37 = Please see the back of this notice.

See "Message Expiration Date" and
"Message Notes" columns

16.38 = Charges are not incurred for leave of
absence days.

16.39 = Only one provider can be paid for this
service per calendar month. Payment has
already been made to another provider for
this service.

16.4 = This service requires prior approval by
the Quality Improvement Organization.

16.40 = Only one inpatient service per day is
allowed.

16.41 = Payment is being denied because you
refused to request reimbursement under
your Medicare benefits.

16.42 = The provider's determination of
noncoverage is correct.

16.43 = This service cannot be approved without a
treatment plan and supervision of a
doctor.

16.44 = Routine care is not covered.

16.45 = You cannot be billed separately for this
item or service. You do not have to pay
this amount.

16.46 = Medicare payment limits do not affect a
Native American's right to free care at
Indian Health Institutions.

16.47 = When deductible is applied to outpatient
psychiatric services, you may be billed
for up to the approved amount. The "You
May Be Billed" column will tell you the
correct amount to pay your provider.
This message should be revised to read
"Maximum You May Be Billed" (in place of
"You May Be Billed" when your MAC
implements the new MSN design.

16.48 = Medicare does not pay for this item or
service for this condition.

16.49 = This claim/service is not covered because
alternative services were available, and
should have been utilized.

16.5 = This service cannot be approved without a
treatment plan by a physical or
occupational therapist.

16.50 = The doctor or supplier may not bill more
than the Medicare allowed amount.

16.51 = This service is not covered prior to July
1, 2001.

16.52 = This service was denied because coverage
for this service is provided only after a
documented failed trial of pelvic muscle
exercise training.

16.53 = The amount Medicare paid the provider for
this claim is ($_____).

16.54 = This service is not covered prior to
        January 1, 2002.
16.55 = The provider billed this charge as
        non-covered.
16.56 = Claim denied because information from the
        Social Security Administration indicates
        that you have been deported.
16.57 = Medicare Part B does not pay for this
        item or service since our records show
        that you were in a Medicare health plan
        on this date. Your provider must bill
        this service to the Medicare health plan.
16.58 = The provider billed this charge as
        non-covered. You do not have to pay this
        amount.
16.59 = Medicare doesn't pay for missed
        appointments.
16.6 = This item or service cannot be paid
        unless the provider accepts assignment.
16.60 = Want to see your MSN right away? Access
        your Original Medicare claims directly at
        www.MyMedicare.gov, usually within 24
        hours after Medicare processes the claim.
        You can also order duplicate MSNs, track
        your preventive services, and print an
        "On the Go" report to share with your
        provider.
16.61 = Outpatient mental health services are
        paid at 55% of the approved amount.
16.62 = Outpatient mental health services are
        paid at 60% of the approved amount
16.63 = Outpatient mental health services are
        paid at 65% of the approved amount.
16.64 = IMPORTANT: Starting in March 2010,
        Medicare will begin to mail Part A and
        Part B MSNs in the same envelope when
        possible.
16.66 = Medicare doesn't pay for DMEPOS items or
        services when provided by a hospital or
        physician if there is no matching date of
        discharge or date of service.
16.67 = Medicare doesn't pay for services or
        items when provided by a hospital when
        there is no matching date of discharge.
16.7 = Your provider must complete and submit
        your claim.
16.71 = Your provider must complete and submit
        your claim.
16.72 = This claim was denied because it was
        Submitted with a non-affirmative prior
        authorization request.
16.73 = This claim has received a payment
        reduction because it did not first go
        through the prior authorization process.

16.74 = This claim is denied because there is no
record of a prior authorization request
to support this record.
16.76 = This service/item was not covered because
you have exceeded the lifetime limit for
getting this service/item.
16.77 = This service/item was not covered because
it was not provided as part of a
qualifying trial/study.
16.8 = Payment is included in another service
received on the same day.
16.9 = This allowance has been reduced by the
amount previously paid for a related
procedure.
16.98 = The amount you paid to the provider for
this claim was more than the required
payment. You should be receiving a refund
of $_____ from your provider, which is
the difference between what you paid and
what you should have paid.
16.99 = The amount owed you is $_____.
Medicare no longer routinely issues
payment under $1 This amount due will be
included on a future check issued to you.
If you want this money issued immediately
, please contact us at the address and
phone number shown at the bottom of this
page.

Section 17 Non Physician Services
17.1 = Services performed by a private duty
nurse are not covered.
17.10 = The allowance has been reduced because
the anesthesiologist medically directed
concurrent procedures.
17.11 = This item or service cannot be paid as
billed.
17.12 = This service is not covered when provided
by an independent therapist.
17.13 = Each year, Medicare pays for a limited
amount of physical therapy and speech-
language pathology services and a
separate amount of occupational therapy
services. Medically necessary therapy
over these limits is covered when
approved by Medicare.
17.14 = Charges for maintenance therapy are not
covered.
17.15 = This service cannot be paid unless
certified by your physician every (___)
days.
17.16 = The hospital should file a claim for
Medicare benefits because these services
were performed in a hospital setting.

17.17 = Medicare already paid for an initial
visit for this service with this
physician, another physician in his group
practice, or a provider. Your doctor or
provider must use a different code to
bill for subsequent visits.
17.18 = ($) has been applied during this calendar
year (CCYY) towards the ($) limit on
outpatient physical therapy and speech-
language pathology benefits.
17.19 = ($) has been applied during this calendar
year (CCYY) towards the ($) limit on
outpatient occupational therapy benefits.
17.2 = This anesthesia service must be billed by
a doctor.
17.21 = The items or service was denied because
Medicare can't pay for services ordered
by or referred by this provider at this
time" for this message number.
17.25 = Medicare does not pay for services of a
nurse practitioner/clinical nurse
specialist for this place and/or date of
service.
17.3 = This service was denied because you did
not receive it under the direct
supervision of a doctor.
17.33 = Medicare does not pay for services by a
noncertified nonphysician practitioner.
17.4 = Services performed by an audiologist are
not covered except for diagnostic
procedures.
17.5 = Your provider's employer must file this
claim and agree to accept assignment.
17.6 = Full payment was not made for this
service(s) because the yearly limit has
been met.
17.7 = This service must be performed by a
licensed clinical social worker.
17.8 = Payment was denied because the maximum
benefit allowance has been reached.
17.9 = Medicare (Part A/Part B) pays for this
service. The provider must bill the
correct Medicare contractor.

Section 18 Preventive Care
18.1 = Routine examinations and related services
aren't covered.
18.10 = Expired
18.11 = Expired
18.12 = Screening mammograms are covered annually
for women 40 years of age and older.
18.13 = This service isn't covered for people
under 50 years old.
18.14 = Service is being denied because it has

not been (12/24/48) months since your
last (test/procedure) of this kind.

18.15 = Medicare only covers this procedure for
people considered to be at high risk for
colorectal cancer.

18.16 = This service is being denied because
payment has already been made for a
similar procedure within a set time frame

18.17 = Medicare pays for a screening Pap test
and a screening pelvic examination once
every 2 years unless high risk factors
are present.

18.18 = Medicare does not pay for this service
separately since payment of it is
included in our allowance for other
services you received on the same day.

18.19 = This service isn't covered until after
your 50th birthday.

18.2 = This immunization and/or preventive care
is not covered.

18.20 = Expired

18.21 =

18.22 = This service was denied because Medicare
only allows the Welcome to Medicare
preventive visit within the first 12
months you have Part B coverage.

18.23 = You pay 25% of the Medicare-approved
amount for this service.

18.24 = This service was denied. Medicare doesn't
cover an Annual Wellness Visit within the
first 12 months of your Medicare Part B
coverage. Medicare does cover a one-time
Welcome to Medicare preventive visit with
in the first 12 months.

18.25 = Your Annual Wellness Visit has been
approved. You will qualify for another
Annual Wellness Visit 12 months after the
date of this visit.

18.26 = This service was denied because it
occurred too soon after your last covered
Annual Wellness Visit. Medicare only
covers one Annual Wellness Visit within
a 12 month period.

18.27 = This service was denied because it
occurred too soon after your Initial
Preventive Physical Exam.

18.3 = Screening mammography is not covered for
women under 35 years of age.

18.4 = This service is being denied because it
has not been (__) months since your last
examination of this kind.

18.5 = Medicare will pay for another screening
mammogram in 12 months.

18.6 = A screening mammography is covered only

once for women age 35 - 39.
18.7 = Screening pap tests are covered only once
        every 24 months unless high risk factors
        are present.
18.8 = Deleted during EOMB-MSN transition.
18.9 = Deleted during EOMB-MSN transition.
18.94 = Medicare pays for screening Pap smear
        and/or screening pelvic examination
        (including a clinical breast examination)
        only once every 2 years unless high risk
        factors are present.

Section 19 Hospital Based Physician Services
19.1 = Services of a hospital-based specialist
        are not covered unless there is an
        agreement between the hospital and the
        specialist.
19.2 = Payment was reduced because this service
        was performed in a hospital outpatient
        setting rather than a provider's office.
19.3 = Only one hospital visit or consultation
        per provider is allowed per day.

Section 2 Blood
2.1 = The first three pints of blood used in
       each year are not covered.
2.2 = Charges for replaced blood are not covered

Section 20 Benefit Limits
20.1 = You have used all of your benefit days
        for this period.
20.10 = This service was denied because Medicare
        only pays up to 10 hours of diabetes
        education training during the initial
        12-month period. Our records show you
        have already obtained 10 hours of
        training.
20.11 = This service was denied because Medicare
        pays for two hours of follow-up diabetes
        education training during a calendar year
        . Our records show you have already
        obtained two hours of training for this
        calendar year.
20.12 = This service was denied because Medicare
        only covers this service once a lifetime.
20.13 = This service was denied because Medicare
        only pays up to three hours of medical
        nutrition therapy during a calendar year.
        Our records show you have already
        received three hours of medical nutrition
        therapy.
20.14 = This service was denied because Medicare
        only pays two hours of follow-up for
        medical nutrition therapy during a

calendar year. Our records show you have already received two hours of follow-up services for this calendar year.

20.2 = You have reached your limit of 190 days of psychiatric hospital services.

20.3 = You have reached your limit of 60 lifetime reserve days.

20.4 = (__) of the Benefit Days Used were charged to your Lifetime Reserve Day benefit.

20.5 = These services cannot be paid because your benefits are exhausted at this time.

20.6 = Days used has been reduced by the primary group insurer's payment.

20.7 = You have (___) day(s) remaining of your 190-day psychiatric limit.

20.8 = Days are being subtracted from your total inpatient hospital benefits for this benefit period.

20.9 = Services after (mm/dd/yy) cannot be paid because your benefits were exhausted.

20.91 = This service was denied. Medicare covers a one-time initial preventative physical exam (Welcome to Medicare physical exam) if you get it within the first 12 months of the effective date of your Medicare Part B coverage.

Section 21 Restrictions to Coverage

21.1 = Services performed by an immediate relative or a member of the same household are not covered.

21.10 = A surgical assistant is not covered for this place and/or date of service.

21.11 = This service was not covered by Medicare at the time you received it.

21.12 = This hospital service was not covered because the attending physician was not eligible to receive Medicare benefits at the time the service was performed.

21.13 = This surgery was not covered because the attending physician was not eligible to receive Medicare benefits at the time the service was performed.

21.14 = Medicare cannot pay for this investigational device because the FDA clinical trial period has not begun.

21.15 = Medicare cannot pay for this investigational device because the FDA clinical trial period has ended.

21.16 = Medicare does not pay for this investigational device.

21.17 = Your provider submitted noncovered charges. You are responsible for paying

these charges.

21.18 = This item or service is not covered when performed or ordered by this provider.

21.19 = This provider decided to dropout of Medicare. No payment can be made for this service. You are responsible for this charge. Under Federal law, your doctor cannot charge you more than the limiting charge amount.

21.2 = The provider of this service is not eligible to receive Medicare payments.

21.20 = This provider decided to dropout of Medicare. No payment can be made for this service. You are responsible for this charge.

21.21 = This service was denied because Medicare only covers this service under certain circumstances.

21.22 = Medicare does not pay for this service because it is considered investigational and/or experimental in these circumstances.

21.23 = Your claim is being denied because the physician noted on the claim has been deceased for more than 15 months.

21.24 = This service is not covered for patients over age 60.

21.25 = This service was denied because Medicare only covers this service in certain settings.

21.26 = Claim denied because services were provided by an Opt-Out physician or practitioner. No Medicare payment may be made.

21.27 = Services provided by a Medicare sanctioned/excluded provider. No Medicare payment may be made.

21.3 = This provider was not covered by Medicare when you received this service.

21.30 = The provider decided to drop out of Medicare. No payment can be made for this service. You are responsible for this charge.

21.31 = This service was not covered by Medicare at the time you recieved it.

21.32 = This service was denied because Medicare only covers this service under certain circumstances.

21.4 = Services provided outside the United States are not covered. See your Medicare Handbook for services received in Canada and Mexico.

21.5 = Services needed as a result of war are not covered.

21.6 = This item or service is not covered when performed, referred or ordered by this provider.
21.7 = This service should be included on your inpatient bill.
21.8 = Services performed using equipment that has not been approved by the Food and Drug Administration are not covered.
21.9 = Payment cannot be made for unauthorized service outside the managed care plan.

Section 22 Split Claims
22.1 = Your claim was separated for processing. The remaining services may appear on a separate notice.

Section 23 Surgery
23.1 = The cost of care before and after the surgery or procedure is included in the approved amount for that service.
23.10 = Payment has been reduced because this procedure was terminated before anesthesia was started.
23.11 = Payment cannot be made because the surgery was canceled or postponed.
23.12 = Payment has been reduced because the surgery was canceled after you were prepared for surgery.
23.13 = Because you were prepared for surgery and anesthesia was started, full payment is being made even though the surgery was canceled.
23.14 = The assistant surgeon must file a separate claim for this service.
23.15 = The approved amount is less because the payment is divided between two doctors.
23.16 = An additional amount is not allowed for this service when it is performed on both the left and right sides of the body.
23.17 = Medicare won't cover these services because they are not considered medically necessary.
23.2 = Cosmetic surgery and related services are not covered.
23.3 = Medicare does not pay for surgical supports except primary dressings for skin grafts.
23.4 = A separate charge is not allowed because this service is part of the major surgical procedure.
23.5 = Payment has been reduced because a different doctor took care of you before and/or after the surgery.
23.6 = This surgery was reduced because it was

performed with another surgery on the
same day.

23.7 = Payment cannot be made for an assistant
surgeon in a teaching hospital unless a
resident doctor was not available.

23.8 = This service is not payable because it is
part of the total maternity care charge.

23.9 = Payment has been reduced because the
charges billed did not include post-
operative care.

Section 24 'Help Stop Fraud' messages

24.1 = Protect your Medicare number as you would
a credit card number.

24.10 = Always read the front and back of your
Medicare Summary Notice.

24.11 = Beware of Medicare scams, such as offers
of free milk or cheese for your Medicare
number.

24.12 = Read your Medicare Summary Notice
carefully for accuracy of dates, services
, and amounts billed to Medicare.

24.13 = Be sure you understand anything you are
asked to sign.

24.14 = Be sure any equipment or services you
received were ordered by your doctor.

24.15 = Review your Medicare Summary Notice and
report items and services that you did
not receive to Medicare's Fraud Hotline
at 1-866-417-2078.
FLORIDA - SPECIFIC MESSAGE

24.16 = Report items and services that you did
not receive to Medicare's Fraud Hotline
at 1-866-417-2078.
FLORIDA - SPECIFIC MESSAGE

24.19 = You may see some claims that have been
adjusted. For an explanation see the
General Information section
See Expiration Date and Message Notes
------->

24.2 = Beware of telemarketers or advertisements
offering free or discounted Medicare
items and services.

24.22 = You can make a difference! Last year,
tax-payers saved $4 billion-the largest
sum ever recovered in a single year-
thanks in large part to people who came
forward and reported suspicious activity.
See "Message Implementation Date" and
"Message Notes" columns. ---->

24.3 = Beware of door-to-door solicitors
offering free or discounted Medicare
items or services.

24.4 = Only your physician can order medical

equipment for you.

24.5 = Always review your Medicare Summary
      Notice for correct information about the
      items or services you received.
24.6 = Do not sell your Medicare number or
      Medicare Summary Notice.
24.7 = Do not accept free medical equipment you
      don't need.
24.8 = Beware of advertisements that read,
      "This item is approved by Medicare", or
      "No out-of-pocket expenses."
24.9 = Be informed - Read your Medicare Summary
      Notice.
      See "Message Expiration Date" and
      "Message Notes" columns ----->

Section 25 Time Limit for filing
25.1 = This claim was denied because it was
      filed after the time limit.
25.2 = You can be billed only 20% of the charges
      that would have been approved.
25.3 = The time limit for filing your claim has
      expired, therefore appeal rights are not
      applicable for this claim.

Section 26 Vision
26.1 = Eye refractions are not covered.
26.2 = Eyeglasses or contact lenses are only
      covered after cataract surgery or if the
      natural lens of your eye is missing.
26.3 = Only one pair of eyeglasses or contact
      lenses is covered after cataract surgery
      with lens implant.
26.4 = This service is not covered when
      performed by this provider.
26.5 = This service is covered only in
      conjunction with cataract surgery.
26.6 = Payment was reduced because the service
      was terminated early.

Section 27 Hospice
27.1 = This service is not covered because you
      are enrolled in a hospice.
27.10 = The documentation indicates that the
      service level of continuous home care
      wasn't reasonable and necessary.
      Therefore, payment will be adjusted to
      the routine home care rate.
27.11 = The provider has billed in error for the
      routine home care items or services
      received.
27.12 = The documentation indicates that your
      respite level of care exceeded five
      consecutive days. Therefore, payment

for every day beyond the 5th day will be
paid at the routine home care rate.

27.13 = According to Medicare hospice
requirements, this service is not covered
because the service was provided by a
non-attending physician.

27.2 = Medicare will not pay for inpatient
respite care when it exceeds five
consecutive days at a time.

27.3 = The physician certification requesting
hospice services was not received timely.

27.4 = The documentation received indicates that
the general inpatient care level of
services were not necessary for care
related to the terminal illness.
Therefore, payment will be adjusted to
the routine home care rate.

27.5 = Payment for the day of discharge from the
hospital will be made to the hospice
agency at the routine home care rate.

27.6 = The documentation indicates the level of
care was at the respite level not the
general inpatient level of care.
Therefore, payment will be adjusted to
the routine home care rate.

27.7 = According to Medicare hospice
requirements, the hospice election
consent was not signed timely.

27.8 = The documentation submitted does not
support that your illness is terminal.

27.9 = The documentation indicates your
inpatient level of care was not
reasonable and necessary. Therefore,
payment will be adjusted to the routine
home care rate.

27.99 = Medicare allows your doctor to charge for
developing a plan of treatment for your
home health or hospice services.

Section 28 Mandatory

28.1 = Because you have Medicaid, your provider
must agree to accept assignment.

Section 29 MSP

29.1 = Secondary payment cannot be made because
the primary insurer information was
either missing or incomplete.

29.10 = These services cannot be paid because you
received them on or before you received
a liability insurance payment for this
injury or illness.

29.11 = Our records show that an automobile
medical, liability, or no-fault insurance
plan is primary for these services.

Submit this claim to the primary payer.

29.12 = Our records show that these services may be covered under the Black Lung Program. Contact the U.S. Department of Labor, Federal Black Lung Program, P.O. Box 8302 , London, KY 40742-8302

29.13 = Medicare does not pay for these services because they are payable by another government agency. Submit this claim to that agency.

29.14 = Medicare's secondary payment is ($_____) . This is the difference between the primary insurer's approved amount of ($_____) and the primary insurer's paid amount of ($_____).

29.15 = Medicare's secondary payment is ($_____) . This is the difference between Medicare's approved amount of ($_____) and the primary insurer's paid amount of ($_____).

29.16 = Your primary insurer approved and paid ($_____) on this claim. Therefore, no secondary payment will be made by Medicare.

29.17 = Your provider agreed to accept ($_____) as payment in full on this (claim/service). Your primary insurer has already paid ($_____) so Medicare's payment is the difference between the two amounts.

29.18 = The amount listed in the "You May Be Billed" column assumes that your primary insurer paid the provider. If your primary insurer paid you, then you are responsible to pay the provider the amount your primary insurer paid to you plus the amount in the "You May Be Billed " column.
This message should be revised to read "If your primary insurer paid you for this claim, you are responsible to pay that amount to your provider plus the amount in the "Maximum You May Be Billed" column."
See "Message Implementation Date" and "Message Notes" columns.

29.19 = If your primary insurer paid your provider for this claim, you now only need to pay your provider the difference between the amount charged and the amount your primary insurer paid.

29.2 = No payment was made because your primary insurer's payment satisfied the provider's bill.

29.20 = If your primary insurer paid your

provider for this claim, you only need to pay the difference between the amount your provider agreed to accept and the amount your primary insurer paid.

29.21 = If your primary insurer made payment on this claim, you may be billed the difference between the amount charged and your primary insurer's payment.

29.22 = If your primary insurer paid the provider , you need to pay the provider the difference between the limiting charge amount and the amount the primary insurer paid your provider.

29.23 = No payment can be made because payment was already made by either worker's compensation or the Federal Black Lung Program.

29.24 = No payment can be made because payment was already made by another government entity.

29.25 = Medicare paid all covered services not paid by other insurer.

29.26 = The primary payer is _____ .

29.27 = Your primary group's payment satisfied Medicare deductible and coinsurance.

29.28 = Your responsibility on this claim has been reduced by the amount paid by your primary insurer.

29.29 = Your provider is allowed to collect a total of ($_____) on this claim. Your primary insurer paid ($_____) and Medicare paid ($_____). You are responsible for the unpaid portion of ($_____).

29.3 = Medicare benefits are reduced because some of these expenses have been paid by your primary insurer.

29.30 = ($_____) of the money approved by your primary insurer has been credited to your Medicare Part B (A) deductible. You do not have to pay this amount.

29.31 = Resubmit this claim with the missing or correct information.

29.32 = Medicare's secondary payment is ($_____) . This is the difference between Medicare's limiting charge amount of ($_____) and the primary insurer's paid amount of ($_____).

29.33 = Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury(ies).

29.34 = The claim for this item/service was

submitted by your complementary insurer on your behalf.

29.35 = Per statute, Medicare only accepts claims from your complementary insurer when Medicare is the primary payer.

29.71 = Medicare benefits are being paid on the condition that if you receive payment from liability insurance, an automobile medical insurance policy or plan, or any other no-fault insurance, you must repay Medicare.

29.4 = In the future, if you send claims to Medicare for secondary payment, please send them to (carrier MSP address).

29.5 = Our records show that Medicare is your secondary payer. This claim must be sent to your primary insurer first.

29.6 = Our records show that Medicare is your secondary payer. Services provided outside your prepaid health plan are not covered. We will pay this time only since you were not previously notified.

29.7 = Medicare cannot pay for this service because it was furnished by a provider who is not a member of your employer prepaid health plan. Our records show that you were informed of this rule.

29.8 = This claim is denied because the service(s) may be covered by the worker's compensation plan. Ask your provider to submit a claim to that plan.

29.9 = Since your primary insurance benefits have been exhausted, Medicare will be primary on this accident related service.

Section 3 Chiropractic

3.1 = This service is covered only when recent x-rays support the need for the service.

3.7 = Medicare does not pay for this unless a sympton or sign of a problem is stated on the claim.

3.18 = This represents an adjustment of a previously processed claim. If an underpayment was made, the attached check pays the total claim allowed minus the amount originally paid. If an overpayment requiring a refund was made and a refund has not already been submitted, you will be contacted by letter from the Medicare claims office.

Section 30 Reasonable Charge and Fee Schedule

30.1 = The approved amount is based on a special payment method.

30.2 = The facility fee allowance is greater than the billed amount.

30.3 = Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than ($_____) . If you have already paid more than this amount, you are entitled to a refund from the provider.

30.4 = A change in payment methods has resulted in a reduced or zero payment for this procedure.

30.41 = What Medicare pays for a service or item may be higher than the billed amount. This amount is correct. Medicare pays this provider less than the billed amount on other claims since payment rates are set in advance for certain services and averaged out over an entire year.

30.5 = This amount is the difference in billed amount and Medicare approved amount.

Section 31 Adjustments

31.1 = This is a adjustment to a previously processed claim and/or deductible record.

31.10 = This is an adjustment to a previously processed charge (s). This notice may not reflect the charges as they were originally submitted.

31.11 = The previous notice we sent stated that your doctor could not charge more than ($_____). This additional payment allows your doctor to bill you the full amount charged.

31.12 = The previous notice we sent stated the amount you could be charged for this service. This additional payment changed that amount. Your doctor cannot charge you more than ($_____).

31.13 = The Medicare paid amount has been reduced by ($_____) previously paid for this claim.

31.14 = This payment is the result of an Administrative Law Judge's decision.

31.15 = An adjustment was made based on a redetermination.

31.16 = An adjustment was made based on a reconsideration.

31.17 = This is an internal adjustment. No action is required on your part.

31.18 = This adjustment has resulted in an overpayment to your provide/supplier. Your provider/supplier has been requested to repay $_____ to Medicare. You do not have to pay this amount.

31.19 = If you do not agree with the Medicare approved amount(s), you may ask for a reconsideration. You must request a reconsideration within 180 days of the date of receipt of this notice. You may present any new evidence which could affect your decision. Call us at the number in the Customer Service block if you need more information about the reconsideration process.
This message should be revised to read, "If you disagree with the Medicare-approved amount, you may ask for a redetermination within 120 days of receipt of this notice. Call 1-800-MEDICARE if you need information on the redetermination process." when your MAC implements the new MSN design. See "Message Implementation Date" and "Message Notes" colums. ----->

31.2 = A payment adjustment was made based on a telephone review.

31.3 = This notice is being sent to you as the result of a reopening request.

31.4 = This notice is being sent to you as the result of a fair hearing request.

31.5 = If you do not agree with the Medicare approved amount(s) and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the limit you may combine amounts on other claims that have been reviewed. At the hearing, you may present any new evidence which could affect the decision. Call us at the number in the Customer Service block if you need more information about the hearing process.

31.6 = A payment adjustment was made based on a Quality Improvement Organization request.

31.7 = This claim was previously processed under an incorrect Medicare claim number or name. Our records have been corrected.

31.8 = This claim was adjusted to reflect the correct provider.

31.9 = This claim was adjusted because there was an error in billing.

31.95 = Per our telephone call, no payment can be made on your review request. The approved amount is the total allowance we can make for this service.

31.96 = Per our telephone call, no payment can be made on your review request. Medicare

does not separately pay for these charges because the cost of related care before and after the surgery/procedure is part of the approved amount for the surgery/ procedure.

31.97 = Per our telephone call, no payment can be made on your review request. Medicare does not pay for this many services within this period of time.

31.98 = Per our telephone call, no payment can be made on your review request. Medicare does not pay for routine foot care.

31.99 = As a result of the Hearing Officer's decision, no additional payment can be made.

Section Overpayments/Offsets

32.1 = ($_____) of this payment has been withheld to recover a previous overpayment.

32.2 = You should not be billed separately by your physician(s) for services provided during this inpatient stay.

32.3 = Medicare has paid $_____ for hospital and doctor services. You shouldn't be billed separately by your doctor(s) for services you got during this inpatient stay.

Section 33 Ambulatory Surgical Centers

33.1 = The ambulatory surgical center must bill for this service.

Section 34 Patient Paid/Split Payments

34.1 = Of the total ($_____) paid on this claim , we are paying you ($_____) because you paid your provider more than your 20% coinsurance on Medicare approved services. The remaining ($_____) was paid to the provider.

34.2 = The amount in the "You May Be Billed" column has been reduced by the amount you paid the provider at the time the services were rendered.
This message should be revised to read "Maximum You May Be Billed" (in place of "You May Be Billed") when your MAC implements the new MSN design.
See "Message Implementation Date" and "Message Notes" columns. ------>

34.3 = After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a

refund. Please contact your provider.

34.4 = We are paying you ($_____) because the amount you paid the provider was more than you may be billed for Medicare approved charges.

34.5 = The amount owed you is ($_____). Medicare does not routinely issue checks for amounts under $1.00. This amount due will be included in your next check. If you want this money issued immediately , please contact us at the address or phone number in the Customer Service Information box. The last sentence of this message should be revised to read, "If you want this money issued immediately, please call 1-800-MEDICARE (1-800-633-4227)." when your MAC implements the new MSN design. See "Message Implementation Date" and Message Notes" columns.

34.6 = Your check includes ($_____) which was withheld on a prior claim.

34.7 = This check includes an amount less than $1.00 that was withheld on a prior claim.

34.8 = The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of ($_____) from your provider, which is the difference between what you paid and what you should have paid.

34.9 = If you already paid the supplier/provider , the supplier/provider must refund any amount that exceeds the Medicare approved amount.

Section 35 Supplemental Coverage/Medigap

35.1 = This information is being sent to your private insurer(s). Send any questions regarding your benefits to them.

35.2 = We have sent your claim to your Medigap insurer. Send any questions regarding your benefits to them.

35.3 = A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer.

35.4 = A copy of this notice will not be forwarded to your Medigap insurer because your provider does not participate in the Medicare program. Please submit a copy of this notice to your Medigap insurer.

35.5 = We did not send this claim to your

private insurer. They have indicated no
additional payment can be made. Send any
questions regarding your benefits to them

35.6 = Your supplemental policy is not a Medigap
policy under Federal and State law or
regulation. It is your responsibility to
file a claim directly with your insurer.

35.7 = Please do not submit this notice to them
(add-on to other messages as appropriate).

Section 36 Limitation of Liability

36.1 = Our records show that you were informed
in writing, before receiving the service
that Medicare would not pay. You are
liable for this charge. If you do not
agree with this statement, you may ask
for a review.

36.2 = You didn't know this service isn't
covered so you don't have to pay. If you
paid and do not receive a refund from
your provider, you have 6 months to send
a copy of this notice, your provider's
bill, and proof that you paid to the
address on the last page of this notice.
Future services of this type won't be
paid.

36.3 = Your provider was told that you're owed
a refund for this service. If you don't
get a refund within 30 days of getting
this notice, send a copy of this notice
to the address on the last page. Refunds
may be delayed if your provider appeals
this decision.

36.4 = You are getting a refund because your
provider didn't tell you in writing that
Medicare wouldn't pay for this service.
In the future, you will have to pay for
the service.

36.5 = You are getting a refund because your
provider didn't tell you in writing that
Medicare would approve a reduced level/
amount of services. In the future, you
will have to pay for the service.

36.6 = Medicare is paying this claim, this time
only, because it appears that neither you
nor the provider knew that the service(s)
would be denied. You will have to pay for
future services of this type.

36.7 = This code is for informational/reporting
purposes only. You should not be charged
for this code. If there is a charge, you
do not have to pay the amount.

Section 37 Deductible/Coinsurance

37.1 = This approved amount has been applied toward your deductible.

37.10 = You have now met ($_____) of your ($_____) Part A deductible for this benefit period.

37.11 = You have met the Part B deductible for (year).

37.12 = You have met the Part A deductible for this benefit period.

37.13 = You have met the blood deductible for (year).

37.14 = You have met ($_____) pint(s) of your blood deductible for (year).

37.15 = After your deductible and coinsurance were applied, the amount Medicare paid was reduced due to Federal, State and local rules.

37.16 = You have now met $_____ of your $_____ Part B deductible for calendar year _____.

37.17 = The "Maximum You May Be Billed" column includes $_____ for your Part B deductible, $_____ for your Part B coinsurance, $_____ for your Part A deductible, and $_____ for your Part A coinsurance and/or lifetime reserve coinsurance.
*If your MAC will implement the new MSN design AFTER 07/01/13, use the following language for this message from 07/01/13 until your MAC DOES implement the new MSN design: The "You May Be Billed" column includes $_____ for your Part B deductible, $_____ for your Part B coinsurance, $_____ for your Part A deductible, and $_____ for your Part A coinsurance and/or lifetime reserve coinsurance.

37.2 = ($_____) of this approved amount has been applied toward your deductible.

37.3 = ($_____) was applied to your inpatient deductible.

37.4 = ($_____) was applied to your inpatient coinsurance.

37.5 = ($_____) was applied to your skilled nursing facility coinsurance.

37.6 = ($_____) was applied to your blood deductible.

37.7 = Part B cash deductible does not apply to these services.

37.8 = This coinsurance amount reflects the amount that you are required to pay for outpatient mental health treatment services under the Medicare program.

37.9 = You have now met ($_____) of your
($_____) Part B deductible for (year).

Section 38 General Information
38.1 = Discontinued 2002
38.10 = Compare the services you receive with
those that appear on your Medicare
Summary Notice. If you have questions,
call your doctor or provider. If you feel
further investigation is needed due to
possible fraud or abuse, call the phone
number in the Customer Service
Information Box.
The last sentence of this message should
be revised to read, "If you feel further
investigation is needed due to possible
fraud or abuse, call 1-800-MEDICARE
(1-800-633-4227)." when your MAC
implements the new MSN design.
See "Message Implementation Date" and
Message Notes" columns. ----->
38.11 = Preventive Messages:

January - Cervical Health

January is cervical health month. The
Pap test is the most effective way to
screen for cervical cancer. Medicare
helps pay for screening Pap tests every
two years. For more information on Pap
tests, call your Medicare carrier.

January - National Glaucoma Awareness
Month (Optional)
Glaucoma may cause blindness. Medicare
helps pay for a yearly dilated eye exam
for people at high risk for Glaucoma.
African-Americans over 50 and people with
diabetes or a family history of glaucoma
are at higher risk. Talk to your doctor
to learn if this exam is right for you.

February - General Preventive Services
Medicare helps pay for many preventive
services including flu and pneumococcal
shots, tests for cancer, diabetes
monitoring supplies and others. Call
1-800-MEDICARE (1-800-633-4227) for more
information.

March - National Colorectal Cancer
Awareness Month
Colorectal cancer is the second leading
cancer killer in the United States.

Medicare helps pay for colorectal cancer
screening tests. Talk to your doctor
about screening options that are right
for you.

April - General Preventive Services
Medicare helps pay for many preventive
services including flu and pneumococcal
shots, tests for cancer, diabetes
monitoring supplies and others. Call
1-800-MEDICARE (1-800-633-4227) for more
information.

May - National Osteoporosis Month
Do you know how strong your bones are?
Medicare helps pay for bone mass
measurement tests to measure the strength
of bones for people at risk of
osteoporosis. Talk to your doctor to
learn if this test is right for you.

May - Breast Cancer Awareness (to
coordinate with Mother's Day) - Optional
Early detection is the best protection
from breast cancer. Get a mammogram.
Not just once, but for a lifetime.
Medicare helps pay for screening
mammograms.

June - General Preventive Services
Message:
Medicare helps pay for many preventive
services including flu and pneumococcal
shots, tests for cancer, diabetes
monitoring supplies and others. Call
1-800-MEDICARE (1-800-633-4227) for more
information.

July- Glaucoma Awareness
Glaucoma may cause blindness. Medicare
helps pay for a yearly dilated eye exam
for people at high risk for Glaucoma.
African-American people over 50, and
people with diabetes or a family history
of glaucoma are at higher risk. Talk to
your doctor to learn if this exam is
right for you.

August - National Immunization Awareness
Month (Contractors may elect to print
this message during a different month of
their choosing, but the message about
the pneumococcal shot must be printed one
month of each year.)

Get a pneumococcal shot. You may only
need it once in a lifetime. Contact your
health care provider about getting this
shot. You pay nothing if your health
care provider accepts Medicare assignment

September - Cold and Flu Campaign
During this flu season, get your flu shot
. Contact your health care provider for
the flu shot. Get the flu shot, not the
flu. You pay nothing if your health care
provider accepts Medicare assignment.

September - Prostate Cancer Awareness
Month - Optional
Prostate cancer is the second leading
cause of cancer deaths in men. Medicare
covers prostate screening tests once
every 12 months for men with Medicare who
are over age 50.

October - Breast Cancer Awareness Month
Early detection is your best protection.
Schedule your mammogram today, and
remember that Medicare helps pay for
screening mammograms.

October - Continuation of Cold/Flu
Campaign (optional)
If you have not received your flu shot,
it is not too late. Please contact your
health care provider about getting the
flu shot.

November - American Diabetes Month
Medicare covers expanded benefits to help
control diabetes

Section 38 General Information
38.12 = If you appeal this drug claim
        determination, send it to the Medicare
        contractor who processed your doctor's
        claim for giving you the drug.
38.13 = If you aren't due a payment check from
        Medicare, your Medicare Summary Notices
        (MSN) will now be mailed to you on a
        quarterly basis. You will no longer get
        a monthly statement in the mail for these
        types of MSNs. You will now get a
        statement every 90 days summarizing all
        of your Medicare claims. Your provider
        may send you a bill that you may need to
        pay before you get your MSN. When you
        get your MSN, look to see if you paid

more than the MSN says is due. If you paid more, call your provider about a refund. If you have any questions about the bill from your provider, you should call your provider.

38.14 = Have limited income? Social Security can help with prescription drug costs. For more information on Extra Help with prescription drug costs and how to apply, visit www.socialsecurity.gov on the web or call 1-800-772-1213. TTY users should call 1-800-325-0778.

38.15 = If the coinsurance amount you paid is more than the amount shown on your notice , you are entitled to a refund. Please contact your provider.

38.18 = ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2007. The limits are $1,740 in 2006 and $1780 in 2007 for PT and SLP combined and $1,740 in 2006 and $1780 in 2007 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE. You have the right to request an itemized statement which details each Medicare item or service which you have received from your physician, hospital, or any other health supplier or health professional. Please contact them directly, in writing, if you would like an itemized statement. Beneficiaries needing or receiving home health care may qualify for the new Home Health Independence Demonstration and have the freedom to leave home more often while remaining eligible for Medicare home health services. To qualify, you must meet several criteria, have a permanent disabling condition, and live in Colorado, Massachusetts, or Missouri. For more information, ask your home health agency about the "Home Health Independence Demonstration"; call 1(800)

MEDICARE (1-800-633-4227); or visit our website at: www.cms.hhs.gov/researchers/ demos/homehealthindependence.asp

38.18 = ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2007. The limits are $1,740 in 2006 and $1780 in 2007 for PT and SLP combined and $1,740 in 2006 and $1780 in 2007 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE.

38.19 = Medicare Open Enrollment is from October 15 to December 7. This is when you can compare and change your health and drug plan coverage. If you're happy with your current plan, you don't have to do anything. Call 1-800-MEDICARE (1 800-633-4227) for more information.

38.2 = Discontinued

38.20 = You have the right to request an itemized statement which details each Medicare item or service you have received from a physician, hospital, or any other healthcare provider or supplier. Contact your provider to get an itemized statement.

38.22 = Planning to retire? Does your current insurance pay before Medicare pays? Call Medicare within the 6 months before you retire to update your records. Make sure your health care bills get paid correctly

38.23 = Save tax dollars by getting your "Medicare & You" handbook electronically. Visit www.mymedicare.gov to sign up.

38.24 = Please have your complete Medicare number with you when you call so your record can be located. To protect your privacy, this MSN doesn't include your entire number.

38.25 = This item or service is being denied. Medicare won't pay for a Medical Nutrition Therapy service and Diabetes Self Management Training item or service performed on the same date for the same

person with Medicare.

38.26 = Your claims may have been adjusted since Medicare changed how it pays for certain services in 2010. You can compare claims that have been changed to previous statements you received in the past. Your provider may owe you a refund or you may have to pay more coinsurance. Call your provider or 1-800-MEDICARE.

38.27 = Get a pneumococcal shot. You may only need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment

38.28 = Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.

38.3 = If you change your address, contact the Social Security Administration by calling 1-800-772-1213.

38.31 = To report a change of address, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

38.32 = Welcome to your new Medicare Summary Notice! It has clear language, larger print, and a personal summary of your claims and deductibles. This improved notice better explains how to get help with your questions, report fraud, or file an appeal. It also includes important information from Medicare!

38.4 = You're at high risk for complications from the flu and it's very important that you get vaccinated. Please contact your healthcare provider about getting the flu vaccine.

38.5 = If you haven't gotten your flu vaccine, it isn't too late. Please contact your health care provider about getting the vaccine.

38.6 = January is cervical cancer prevention month.

38.7 = The Pap test is the most effective way to screen for cervical cancer.

38.8 = Medicare helps pay for screening Pap tests once every two years.

38.9 = Colorectal cancer is the second leading cancer killer in the United States. Medicare helps pay for screening tests that can find polyps before they become cancerous and find cancer early when treatment may work best. Medicare helps pay for screening tests. Talk to your

doctor about the screening options that
are right for you.

Section 4 End-Stage Renal Disease (ESRD)
4.1 = This charge is more than Medicare pays
      for maintenance treatment of renal
      disease.
4.10 = No more than ($_____) can be paid for
      these supplies each month.
4.11 = The amount listed in the "You May Be
      Billed" column is based on the Medicare
      approved amount. You are not responsible
      for the difference between the amount
      charged and the approved amount.
      This message should be revised to read
      "Maximum You May Be Billed" (in place of
      "You May Be Billed") when your MAC
      implements the new MSN design.
4.12 = This service has been denied/rejected
      since payment was made to your End Stage
      Renal Disease (ESRD) dialysis facility.
4.18 = Medicare cannot pay more than $_____ each
      month for these supplies. The provider
      cannot bill you for the supplies over
      this limit.
4.2 = This service is covered up to (insert
      appropriate number) months after
      transplant and release from the
      hospital.
4.3 = Prescriptions for immunosuppressive drugs
      are limited to a 30-day supply.
4.4 = Only one supplier per month may be paid
      for these supplies/services.
4.5 = Medicare pays the professional part of
      this charge to the hospital.
4.6 = Payment has been reduced by the number
      of days you were not in the usual place
      of treatment.
4.7 = Payment for all equipment and supplies
      is made through your dialysis center.
      They will bill Medicare for these
      services.
4.8 = This service cannot be paid because you
      did not choose an option for your
      dialysis equipment and supplies.
4.9 = Payment was reduced or denied because the
      monthly maximum allowance for this home
      dialysis equipment and supplies has been
      reached.

Section 41 Home Health Messages
41.1 = Medicare will only pay for this service
      when it is provided in addition to other
      services.

41.10 = Patients eligible to receive home health benefits from another government agency are not eligible to receive Medicare benefits for the same service.

41.11 = The doctor's orders for home health services were incomplete.

41.12 = According to the medical record, the provider has billed in error for these items/services.

41.13 = The provider has billed for services/ items not documented in your record.

41.14 = This service/item was billed incorrectly.

41.15 = The information provided indicates that you are able to perform personal care activities on your own.

41.16 = To receive Medicare payment, you must have a signed doctor's order before you receive the services.

41.2 = This service must be performed by a nurse who has the required psychiatric nurse credentials.

41.3 = The medical information did not support the need for continued services.

41.4 = Medicare considers this item to be inappropriate for home use.

41.5 = Medicare does not pay for comfort or convenience items.

41.6 = This item was not furnished under a plan of care established by your physician.

41.7 = This item is not considered by Medicare to be a prosthetic and/or orthotic device

41.8 = The information provided indicates that your illness or injury doesn't restrict your ability to leave your home, except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).

41.9 = Services exceeded those ordered by your physician.

Section 42 Religious Nonmedical Health Care Institutions

42.1 = You received medical care at a facility other than a religious nonmedical health care institution but that care did not revoke your election to receive benefits for religious nonmedical health care.

42.2 = Since you received medical care at a facility other than a religious nonmedical health care institution, benefits for religious nonmedical health care services have been revoked for these services unless you file a new election.

42.3 = This service is not covered since you did
         not elect to receive religious
         nonmedical health care services instead
         of regular Medicare services.
42.4 = This service is not covered because you
         received medical health care services
         which revoked your election to religious
         nonmedical health care services.
42.5 = This service is not covered because you
         requested in writing that your election
         to religious nonmedical health care
         services be revoked.

Section 5 Number/Name/Enrollment
5.1   = Our records show that you do not have
         Medicare entitlement under the number
         shown on this notice. If you do not
         agree, please contact your local Social
         Security office.
5.2   = The name or Medicare number was incorrect
         or missing. Please check your Medicare
         card. If the information on this notice
         is different from your card, contact your
         provider.
5.3   = Our records show that the date of death
         was before the date of service.
5.4   = If you cash the enclosed check, you are
         legally obligated to make payment for
         these services. If you do not wish to
         assume this obligation, please return
         this check.
5.5   = Our records show you did not have Part A
         (B) coverage when you received this
         service. If you disagree, please contact
         us at the customer service number shown
         on this notice.
5.6   = The name or Medicare number was incorrect
         or missing. Ask your provider to use the
         name or number shown on this notice for
         future claims.
5.7   = Medicare payment may not be made for the
         item or service because on the date of
         service you were not lawfully present in
         the United States.

Section 6 Drugs
6.1   = This drug is covered only when Medicare
         pays for the transplant.
6.2   = Drugs not specifically classified as
         effective by the Food and Drug
         Administration are not covered.
6.3   = Payment cannot be made for oral drugs
         that do not have the same active
         ingredients as they would have if given

by injection.

6.4 = Medicare does not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours after administration of a Medicare covered chemotherapy drug.

6.5 = Medicare cannot pay for this injection because one or more requirements for coverage were not met.

Section 43 Demonstration Project Messages

60.1 = In partnership with physicians in your area, _____ is participating in a Medicare demonstration project that uses a simplified payment method to combine all hospital and physician care related to your hospital service.

2/18/13= Even though this service is being paid in accordance with the rules and guidelines under the Competitive Bidding Demonstration, future claims may be denied when this item is provided to this patient by a non-demonstration supplier. If you would like more information egarding this project, you may contact 1-888-289-0710.

60.11 = These services are covered by a demonstration project or payment model pilot. It will pay for all services related to this hospital stay. If you have already paid a provider for any of these services, you should receive a refund.

60.12 = Your co-payment under this demonstration is the lesser of 20% of the Medicare allowed amount or 20% of the allowed amount under your drug discount card.

60.13 = This claim is being processed under a demonstration project. Services cannot be covered because you do not reside in one of the demonstration areas.

60.14 = This claim is being processed under a demonstration project. Services cannot be covered because your doctor does not have a practice in one of the demonstration areas.

60.15 = Beginning April 1, 2005 through March 31, 2007, Medicare will cover additional chiropractic services. For more information, talk to your chiropractor, call 1-800-MEDICARE, or go to http://www.cms.hhs.gov/researchers/demos/eccs/default.asp.

60.16 = This claim is being processed under a

demonstration or payment model pilot.
All hospital and doctor services related
to your hospital stay have been combined
into a single payment. You may have to
pay any unmet deductible and coinsurance
amounts.

60.2 = The total Medicare approved amount for
your hospital service is ($_____).
($_____) is the Part A Medicare amount
for hospital services and ($_____) is
the Part B Medicare amount for physician
services (of which Medicare pays 80
percent). You are responsible for any
deductible and coinsurance amounts
represented.

60.3 = Medicare has paid ($_____) for hospital
and physician services. Your Part A
deductible is ($_____). Your Part A
coinsurance is ($_____) Your Part B
coinsurance is ($_____).

60.4 = This claim is being processed under a
demonstration project.

60.5 = This claim is being processed under a
demonstration project. If you would like
more information about this project,
please contact 1-888-289-0710.

60.6 = A claim has been submitted on your behalf
indicating that you are participating in
the Medicare Coordinated Care
Demonstration project. However, our
records indicate that you are not
currently enrolled or your enrollment
has not yet been approved for the
demonstration.

60.7 = A claim has been submitted on your behalf
indicating that you are participating in
the Medicare Coordinated Care
Demonstration project. However, our
records indicate that either you have
terminated your election to participate
in the demonstration project or the dates
of service are outside the demonstration
participation dates.

60.8 = The approved amount is based on the
maximum allowance for this item under the
DMEPOS Competitive Bidding Demonstration.

60.9 = Our records indicate that this patient
began using this service(s) prior to the
current round of the DMEPOS Competitive
Bidding Demonstration. Therefore, the
approved amount is based on the allowance
in effect prior to this round of bidding
for this item.

Section 7 Duplicate Bills
7.1 = This is a duplicate of a charge already submitted.
7.15 = Medicare records show that payment for this service has already been made by another contractor.
7.2 = This is a duplicate of a claim processed by another contractor. You should receive a Medicare Summary Notice from them.
7.3 = This service/item is a duplicate of a previously processed service. You may only appeal the decision that this service/item is a duplicate. The appeals information on this notice only applies to the duplicate service issue.
7.4 = The claim for the billing fee was denied because it was submitted past the allowed time frame.
7.7 = Your physician has elected to participate in the Competitive Acquisition Program for these drugs. Claims for these drugs must be billed by the appropriate drug vendor instead of your physician.
7.8 = Your physician has elected to participate in the Competitive Acquisition Program (CAP) for Medicare Part B drugs. Medicare cannot pay for the administration of the drug(s) being billed because these drug(s) are not available from the CAP vendor.

Section 8 Durable Medical Equipment (DME)
8.1 = Your supplier is responsible for the servicing and repair of your rented equipment.
8.2 = To receive Medicare payment, you must have a doctor's prescription before you rent or purchase this equipment.
8.10 = Payment is included in the approved amount for other equipment.
8.11 = The purchase allowance has been reached. If you continue to rent this piece of equipment, the rental charges are your responsibility.
8.12 = The approved charge is based on the amount of oxygen prescribed by the doctor
8.13 = Monthly rental payments can be made for up to 15 months from the first paid rental month or until the equipment is no longer needed, whichever comes first.
8.14 = Your equipment supplier must furnish and service this item for as long as you continue to need it. Medicare will pay

for maintenance and/or servicing for
every 6 month period after the end of
the 15th paid rental month.

8.15 = Maintenance and/or servicing of this item
is not covered until 6 months after the
end of the 15th paid rental month.

8.16 = Monthly allowance includes payment for
oxygen and supplies.

8.17 = Payment for this item is included in the
monthly rental payment amount.

8.18 = Payment is denied because the supplier
did not have a written order from your
doctor prior to delivery of this item.

8.19 = Sales tax is included in the approved
amount for this item.

8.2 = To receive Medicare payment, you must
have a doctor's prescription before you
rent or purchase this equipment.

8.20 = Medicare does not pay for this equipment
or item.

8.21 = Medicare won't cover this item without a
new, revised or renewed certificate of
medical necessity.

8.22 = No further payment can be made because
the cost of repairs has added up to the
purchase price of this item.

8.23 = No payment can be made because the item
has reached the 15-month limit.
Separate payments can be made for
maintenance or servicing every 6 months.

8.24 = The claim doesn't show that you own the
equipment requiring these parts or
supplies.

8.25 = Payment cannot be made until you tell
your supplier whether you want to rent
or buy this equipment.

8.26 = Payment is reduced by 25% beginning the
4th month of rental.

8.27 = Payment is limited to 13 monthly rental
payments because you have decided to
purchase this equipment.

8.28 = Maintenance, servicing, replacement, or
repair of this item is not covered.

8.29 = Payment is allowed only for the seat lift
mechanism, not the entire chair.

8.3 = This equipment is not covered because its
primary use is not for medical purposes.

8.30 = This item is not covered because the
doctor did not complete the certificate
of medical necessity.

8.31 = Payment is denied because blood gas tests
cannot be performed by a durable medical
equipment supplier.

8.32 = This item can only be rented for 2 months

. If the item is still needed, it must
be purchased.

8.33 = This is the next to last payment for this
item.

8.34 = This is the last payment for this item.

8.35 = This item is not covered when oxygen is
not being used.

8.36 = Payment is denied because the certificate
of medical necessity on file was not in
effect for this date of service.

8.37 = An oxygen recertification form was sent
to the physician.

8.38 = This item must be rented for 2 months
before purchasing it.

8.39 = This is the 10th month of rental payment.
Your supplier should offer you the choice
of changing the rental to a purchase
agreement.

8.4 = Payment can't be made for equipment
that's the same or similar to equipment
already being used.

8.40 = We have previously paid for the purchase
of this item.

8.41 = Payment for the amount of oxygen supplied
has been reduced or denied because the
monthly limit has been reached.

8.42 = Standby equipment is not covered.

8.43 = Payment has been denied because this
equipment cannot deliver the liters per
minute prescribed by your doctor.

8.44 = Payment is based on a standard item
because information did not support the
need for a deluxe or more expensive item.

8.45 = Payment for electric wheelchairs is
allowed only if the purchase decision is
made in the first or tenth month of
rental.

8.46 = Payment is included in the allowance for
another item or service provided at the
same time.

8.47 = Supplies or accessories used with
noncovered equipment are not covered.

8.48 = Payment for this drug is denied because
the need for the equipment has not been
established.

8.49 = This allowance has been reduced because
part of this item was paid on another
claim.

8.5 = Rented equipment that is no longer needed
or used is not covered.

8.50 = Medicare can't pay for this drug/
equipment because our records show that
your supplier isn't licensed to dispense
prescription drugs, and, therefore, can't

assure the safety and effectiveness of
the drug/equipment.

8.51 = You are not liable for any additional
charge as a result of receiving an
upgraded item.

8.52 = You signed an Advanced Beneficiary Notice
(ABN). You are responsible for the
difference between the upgrade amount and
the Medicare payment.

8.53 = This item or service was denied because
the upgrade information was invalid.

8.54 = If a supplier knew that Medicare wouldn't
pay and you paid, you might get a refund
unless you signed a notice in advance.
Refunds may be delayed if the provider
appeals. Call your supplier if you don't
hear anything within 30 days.

8.55 = Medicare will process your first claim
but, from now on, you must use a
Medicare-enrolled supplier and put the
supplier ID number on your claim. For a
list of Medicare-enrolled suppliers call
1-800-MEDICARE or visit www.medicare.gov/
supplier

8.56 = Medicare can't process this claim because
you were already notified that you must
use a supplier who has a Medicare
supplier identification number, and this
supplier doesn't have one.

8.57 = Your equipment supplier must furnish and
service this item for as long as you
continue to need it. Medicare will pay
for maintenance and/or servicing for
every 3-month period after the end of
the 15th paid rental month.

8.58 = No payment can be made because the item
has reached the 15-month limit. Separate
payments can be made for maintenance or
servicing every 3 months.

8.59 = Durable Medical Equipment Regional
Carriers only pay for Epoetin Alfa and
Darbepoetin Alfa for Method II End Stage
Renal Disease home dialysis patients.

8.6 = A partial payment has been made because
the purchase allowance has been reached.
No further rental payments can be made.

8.60 = Payment is denied because there is no
hospital stay/surgery on file for
implantation of the Durable Medical
Equipment (DME) or prosthetic device.

8.61 = This supplier isn't located in your
competitive bidding area, but is required
to accept the same price as a supplier
in your area. This supplier may not

charge you more than 20% of the bid price
, plus any unmet deductibles.

8.62 = This supplier didn't win a contract for furnishing this item in the competitive bidding area where you received it. This supplier isn't allowed to charge you for this item unless you signed a written notice agreeing to pay before you got the item.

8.63 = This supplier isn't located in your competitive bidding area, but is located in a different competitive bidding area. This supplier won a contract under national competitive bidding in their area. They must accept the bid price from your area as payment in full, and may not charge you more than 20% of the bid price for your area, plus any unmet deductibles.

8.64 = Monthly payments can be made for 13 months, or until the equipment is no longer needed, whichever comes first. After the 13th month, your supplier must transfer title of this equipment to you.

8.65 = Medicare will pay for medically necessary maintenance and/or servicing as needed after the end of the 13th paid rental month.

8.66 = Medicare has paid for 36 months of rental for your oxygen equipment. Your supplier must transfer title of this equipment to you. No further rental payments will be made. We will continue to pay for delivery of oxygen contents, as appropriate, and necessary maintenance of your equipment.

8.67 = Medicare has already paid for 36 months of rental for your oxygen equipment. The supplier should have transferred the title for the equipment to you. The supplier may not collect any more money from you for this equipment, and must provide you with a refund of any money you have already paid.

8.68 = Medicare will pay for you to rent oxygen for up to 36 months (or until you no longer need the equipment). After Medicare makes 36 payments, your supplier will transfer the title of the equipment to you, and you will own the equipment.

8.69 = Medicare will pay to maintain and service your oxygen equipment. This will start six months after the supplier transfers the title of the equipment to you.

8.7 = This equipment is covered only if rented.

8.70 = The Medicare-approved amount is based on the bid price for this item under the DMEPOS competitive bidding program.

8.71 = Our records show that you began using this item before the current round of competitive bidding and you decided to keep getting this item from your current supplier. The Medicare-approved amount is based on the bid price for this item.

8.72 = This item must be provided by a contract supplier under the DMEPOS competitive bidding program. You should not be billed for this item or service. You do not have to pay this amount. There are no Medicare appeal rights related to this item.

8.73 = The claim for this service was processed according to rules of the DMEPOS competitive bidding program.

8.74 = You signed an Advanced Beneficiary Notice (ABN) saying that you wanted to get this item from a non-winning supplier under the DMEPOS Competitive Bidding Program. Therefore, Medicare will not pay for this item. You must pay the supplier in full.

8.75 = Our records show that you began using this item before competitive bidding started for this item in your area. Because you decided to keep getting this item from your current supplier, this item will be paid at the standard payment amount and not at the bid price.

8.76 = This item or service is not covered because the claim shows that it was not given in a skilled nursing facility or a nursing facility. The claim for this item or service was processed according to the rules of the DMEPOS competitive bidding program.

8.78 = Medicare has paid for 36 months for your oxygen equipment. Your supplier is required to provide the oxygen equipment and related supplies, at no charge, for the remainder of the equipment's 5 year lifetime.

8.79 = Medicare has paid 36 months of rental for your oxygen equipment. The supplier may not collect any more money from you for this equipment, and must refund any money you have already paid.

8.8 = This equipment is covered only if purchased.

8.80 = Medicare will pay for rental of this equipment for 36 months (or until you no

longer need the equipment). After 36 months, Medicare will continue to pay for delivery of liquid or gaseous contents, as long as it is still medically necessary.

8.81 = If the provider/supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment , you may be entitled to a refund of any amounts you paid. However, if the provider/supplier requests a review of this claim within 30 days, a refund is not required until we complete our review . If you paid for this service and do not hear anything about a refund within the next 30 days, contact your provider/ supplier.

8.9 = Payment has been reduced by the amount already paid for the rental of this equipment.

8.90 = You live in a Competitive Bidding Area. This is a Competitive Bidding item. The Medicare approved amount is based on the bid price for this item under the DMEPOS competitive bidding program.

8.91 = Our records show that you began using this item before the DMEPOS Competitive Bidding program began and you decided to keep renting this item from your current supplier. The Medicare-approved amount is based on the bid price for this item for the area where you live.

8.92 = You live in a Competitive Bidding Area and this item must be provided by a Medicare-contract supplier under the DMEPOS competitive bidding program. Medicare won't pay for this item and you shouldn't be billed for this item or service. You don't have to pay this amount. Medicare appeal rights don't apply to this item.

8.93 = Medicare only pays 36 monthly payments for your oxygen. After 36 months, the supplier is still responsible for providing you with that equipment for 5 years. You shouldn't pay any more copayments.

8.95 = Our records show that you began using this item before the DMEPOS Competitive Bidding program started for this item in your area. Because you decided to keep renting this item from your current

supplier, this item will be paid at the standard payment amount and not at the bid price.

8.96 = This item or service isn't covered because the claim shows that it wasn't provided in a skilled nursing facility or nursing facility. The claim for this item or service was processed according to the rules of the DMEPOS competitive bidding program.

8.97 = Starting January 1, 2011, you may have to use certain Medicare-contracted suppliers to get certain medical equipment and supplies. Visit www.medicare.gov or call 1-800-MEDICARE for details

Section 9 Failure to Furnish Information

9.1 = The information we requested was not received.

9.2 = This item or service was denied because information required to make payment was missing.

9.3 = Please ask your provider to submit a new, complete claim to us.

9.4 = This item or service was denied because information required to make payment was incorrect.

9.5 = Our records show your doctor did not order this supply or amount of supplies.

9.6 = Please ask your provider to resubmit this claim with a breakdown of the charges or services.

9.7 = We have asked your provider to resubmit the claim with the missing or correct information.

9.8 = The hospital has been asked to submit additional information, you should not be billed at this time.

9.9 = This service is not covered unless the supplier/provider files an electronic media claim (EMC).

Section 96 Jurisdiction-Specific

96.10 = Go paperless, go green! If you live in CT or NY you can stop getting paper Medicare Summary Notices (MSNs) in the mail, and get Electronic MSNs (eMSNs) online instead. To sign up, go to www.mymedicare.gov or call 1-800-MEDICARE (1-800-633-4227).
      * See Message Notes ----------->

Section 97 FISS Part A

97.xx = The entire range of 97.xx messages

have been blocked off for FISS/Part A
usage.

Section 99 Florida-Specific
99.xx = The entire range of 99.xx messages have
been blocked off for Florida usage.

CLM_MASS_ADJSTMT_IND_CD_TB   Claim Mass Adjustment Indicator Code Table

I = Mass Adjustment (Incarcerated Beneficiary)
M = Mass Adjustment (MPFS)
O = Mass Adjustment (Other)

CLM_PAPER_PRVDR_TB   Claim Paper Claim Provider Code Table

DK = Ordering Provider
DN = Referring Provider
DQ = Supervising Provider

CLM_PRVDR_VLDTN_TB   Claim Provider Validation Code Table

RP = Rendering Provider
OP = Operating Physician
CP = Ordering/Referring Physician
AP = Attending Physician
FA = Facility

CLM_PWK_TB   Claim Paperwork Code Table

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

CLM_RAC_ADJSTMT_TB   Recovery Audit Contractor (RAC) Adjustment Indicator Table

R = RAC adjusted claim

Spaces

CLM_RMTNC_ADVC_TB   Claim Remittance Advice Code Table

M1 = X-ray not taken within the past 12 months
or near enough to the start of treatment.
Start: 01/01/1997

M2 = Not paid separately when the patient is
an inpatient.
Start: 01/01/1997

M3 = Equipment is the same or similar to
equipment already being used.
Start: 01/01/1997

M4 = Alert: This is the last monthly
installment payment for this durable
medical equipment.
Start: 01/01/1997

M5 = Monthly rental payments can continue
until the earlier of the 15th month from
the first rental month, or the month when
the equipment is no longer needed.
Start: 01/01/1997

M6 = Alert: You must furnish and service this
item for any period of medical need for
the remainder of the reasonable useful
lifetime of the equipment.
Start: 01/01/1997

M7 = No rental payments after the item is
purchased, or after the total of issued
rental payments equals the purchase
price.
Start: 01/01/1997

M8 = We do not accept blood gas tests results
when the test was conducted by a medical
supplier or taken while the patient is on
oxygen.
Start: 01/01/1997

M9 = Alert: This is the tenth rental month.
You must offer the patient the choice of
changing the rental to a purchase
agreement.
Start: 01/01/1997 |

M10 = Equipment purchases are limited to the
first or the tenth month of medical
necessity.
Start: 01/01/1997

M11 = DME, orthotics and prosthetics must be
billed to the DME carrier who services
the patient's zip code.
Start: 01/01/1997

M12 = Diagnostic tests performed by a
physician

must indicate whether purchased services
are included on the claim.
Start: 01/01/1997

M13 =   Only one initial visit is covered per
specialty per medical group.
Start: 01/01/1997 |

M14 =   No separate payment for an injection
administered during an office visit, and
no payment for a full office visit if the
patient only received an injection.
Start: 01/01/1997

M15 =   Separately billed services/tests have
been bundled as they are considered
components of the same procedure.
Separate payment is not allowed.
Start: 01/01/1997

M16 =   Alert: Please see our web site,
mailings,
or bulletins for more details concerning
this policy/procedure/decision.
Start: 01/01/1997 |
Notes: (Reactivated 4/1/04, Modified
11/18/05, 4/1/07)

M17 =   Alert: Payment approved as you did not
know, and could not reasonably have been
expected to know, that this would not
normally have been covered for this
patient. In the future, you will be
liable for charges for the same
service(s) under the same or similar
conditions.
Start: 01/01/1997

M18 =   Certain services may be approved for
home
use. Neither a hospital nor a Skilled
Nursing Facility (SNF) is considered to
be a patient's home.
Start: 01/01/1997

M19 =   Missing oxygen certification/
recertification.
Start: 01/01/1997

M20 =   Missing/incomplete/invalid HCPCS.
Start: 01/01/1997

M21 =   Missing/incomplete/invalid place of
residence for this service/item provided
in a home.
Start: 01/01/1997

M22 =   Missing/incomplete/invalid number of
miles traveled.
Start: 01/01/1997

M23 =   Missing invoice.
Start: 01/01/1997

M24 =   Missing/incomplete/invalid number of
doses per vial.

Start: 01/01/1997 |

M25 = The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
Start: 01/01/1997 |
Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07, 11/1/10)

M26 = The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice.= The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.
Start: 01/01/1997 |
Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)

M27 = Alert: The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care,

and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.
Start: 01/01/1997 |
Notes: (Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07)

M28 = This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
Start: 01/01/1997

M29 = Missing operative note/report.
Start: 01/01/1997 |
Notes: (Modified 2/28/03, 7/1/2008)
Related to N233

M30 = Missing pathology report.
Start: 01/01/1997 |
Notes: (Modified 8/1/04, 2/28/03)
Related to N236

M31 = Missing radiology report.
Start: 01/01/1997 |
Notes: (Modified 8/1/04, 2/28/03) Related to N240

M32 = Alert: This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.
Start: 01/01/1997 |
Notes: (Modified 4/1/07)

M33 = Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.
Start: 01/01/1997 | Stop: 08/01/2004
Notes: Consider using M68

M34 = Claim lacks the CLIA certification number.
Start: 01/01/1997 |
Stop: 08/01/2004
Notes: Consider using MA120

M35 = Missing/incomplete/invalid pre-operative photos or visual field results.
Start: 01/01/1997 | Stop: 02/05/2005

Notes: Consider using N178

M36 = This is the 11th rental month. We cannot
pay for this until you indicate that the
patient has been given the option of
changing the rental to a purchase.
Start: 01/01/1997

M37 = Not covered when the patient is under
age 35.
Start: 01/01/1997 |
Notes: (Modified 3/8/11)

M38 = The patient is liable for the charges
for this service as you informed the
patient in writing before the service
was furnished that we would not pay for
it, and the patient agreed to pay.
Start: 01/01/1997

M39 = The patient is not liable for payment
for this service as the advance notice
of non-coverage you provided the patient
did not comply with program
requirements.
Start: 01/01/1997 |
Notes: (Modified 2/1/04, 4/1/07,
11/1/09, 11/1/12) Related to N563

M40 = Claim must be assigned and must be
filed
by the practitioner's employer.
Start: 01/01/1997

M41 = We do not pay for this as the patient
has no legal obligation to pay for this.
Start: 01/01/1997

M42 = The medical necessity form must be
personally signed by the attending
physician.
Start: 01/01/1997

M43 = Payment for this service previously
issued to you or another provider by
another carrier/intermediary.
Start: 01/01/1997 |
Stop: 01/31/2004
Notes: Consider using Reason Code 23

M44 = Missing/incomplete/invalid condition
code.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M45 = Missing/incomplete/invalid occurrence
code(s).
Start: 01/01/1997 |
Notes: (Modified 12/2/04) Related to
N299

M46 = Missing/incomplete/invalid occurrence
span code(s).
Start: 01/01/1997 |

Notes: (Modified 12/2/04) Related to
N300

M47 = Missing/incomplete/invalid internal or
document control number.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M48 = Payment for services furnished to
hospital inpatients (other than
professional services of physicians) can
only be made to the hospital. You must
request payment from the hospital rather
than the patient for this service.
Start: 01/01/1997 |
Stop: 01/31/2004
Notes: Consider using M97

M49 = Missing/incomplete/invalid value
code(s)
or amount(s).
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M50 = Missing/incomplete/invalid revenue
code(s).
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M51 = Missing/incomplete/invalid procedure
code(s).
Start: 01/01/1997 |
Notes: (Modified 12/2/04) Related to N301

M52 = Missing/incomplete/invalid "from"
date(s) of service.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M53 = Missing/incomplete/invalid days or
units
of service.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M54 = Missing/incomplete/invalid total
charges.
Start: 01/01/1997 |

M55 = We do not pay for self-administered
anti-emetic drugs that are not
administered with a covered oral
anti-cancer drug.
Start: 01/01/1997

M56 = Missing/incomplete/invalid payer
identifier.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M57 = Missing/incomplete/invalid provider
identifier.
Start: 01/01/1997 |
Stop: 06/02/2005

M58 = Missing/incomplete/invalid claim

information. Resubmit claim after
corrections.
Start: 01/01/1997 | Stop: 02/05/2005
M59 = Missing/incomplete/invalid "to" date(s)
of service.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)
M60 = Missing Certificate of Medical
Necessity.
Start: 01/01/1997 |
Notes: (Modified 8/1/04, 6/30/03)
Related to N227
M61 = We cannot pay for this as the approval
period for the FDA clinical trial has
expired.
Start: 01/01/1997
M62 = Missing/incomplete/invalid treatment
authorization code.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)
M63 = We do not pay for more than one of
these
on the same day.
Start: 01/01/1997 |
Stop: 01/31/2004
Notes: Consider using M86
M64 = Missing/incomplete/invalid other
diagnosis.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)
M65 = One interpreting physician charge can
be submitted per claim when a purchased
diagnostic test is indicated.
Please submit a separate claim for each
interpreting physician.
Start: 01/01/1997
M66 = Our records indicate that you billed
diagnostic tests subject to price
limitations and the procedure code
submitted includes a professional
component. Only the technical component
is subject to price limitations.
Please submit the technical and
professional components of this service
as separate line items.
Start: 01/01/1997
M67 = Missing/incomplete/invalid other
procedure code(s).
Start: 01/01/1997
Notes: (Modified 12/2/04) Related to
N302
M68 = Missing/incomplete/invalid attending,
ordering, rendering, supervising or
referring physician identification.

Start: 01/01/1997
Stop: 06/02/2005

M69 = Paid at the regular rate as you did not submit documentation to justify the modified procedure code.
Start: 01/01/1997 |
Notes: (Modified 2/1/04)

M70 = Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.
Start: 01/01/1997 |
Notes: (Modified 4/1/2007, 8/1/07)

M71 = Total payment reduced due to overlap of tests billed.
Start: 01/01/1997

M72 = Did not enter full 8-digit date (MM/DD/CCYY).
Start: 01/01/1997 |
Stop: 10/16/2003
Notes: Consider using MA52

M73 = The HPSA/Physician Scarcity bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components.
Start: 01/01/1997
Notes: (Modified 8/1/04)

M74 = This service does not qualify for a HPSA/Physician Scarcity bonus payment.
Start: 01/01/1997
Notes: (Modified 12/2/04)

M75 = Multiple automated multichannel tests performed on the same day combined for payment.
Start: 01/01/1997
Notes: (Modified 11/5/07)

M76 = Missing/incomplete/invalid diagnosis or condition.
Start: 01/01/1997
Notes: (Modified 2/28/03)

M77 = Missing/incomplete/invalid place of service.
Start: 01/01/1997
Last Modified: 02/28/2003
Notes: (Modified 2/28/03)

M78 = Missing/incomplete/invalid HCPCS modifier.
Start: 01/01/1997
Stop: 05/18/2006
Notes: (Modified 2/28/03,) Consider using Reason Code 4

M79 = Missing/incomplete/invalid charge.

Start: 01/01/1997
Notes: (Modified 2/28/03)

M80 = Not covered when performed during the same session/date as a previously processed service for the patient.
Start: 01/01/1997
Notes: (Modified 10/31/02)

M81 = You are required to code to the highest level of specificity.
Start: 01/01/1997
Notes: (Modified 2/1/04)

M82 = Service is not covered when patient is under age 50.
Start: 01/01/1997

M83 = Service is not covered unless the patient is classified as at high risk.
Start: 01/01/1997

M84 = Medical code sets used must be the codes in effect at the time of service
Start: 01/01/1997
Notes: (Modified 2/1/04)

M85 = Subjected to review of physician evaluation and management services.
Start: 01/01/1997

M86 = Service denied because payment already made for same/similar procedure within set time frame.
Start: 01/01/1997

M87 = Claim/service(s) subjected to CFO-CAP prepayment review.
Start: 01/01/1997

M88 = We cannot pay for laboratory tests unless billed by the laboratory that did the work.
Start: 01/01/1997
Stop: 08/01/2004
Notes: Consider using Reason Code B20

M89 = Not covered more than once under age 40.
Start: 01/01/1997

M90 = Not covered more than once in a 12 month period.
Start: 01/01/1997

M91 = Lab procedures with different CLIA certification numbers must be billed on separate claims.
Start: 01/01/1997

M92 = Services subjected to review under the Home Health Medical Review Initiative.
Start: 01/01/1997 | Stop: 08/01/2004

M93 = Information supplied supports a break in

therapy. A new capped rental period began with delivery of this equipment.
Start: 01/01/1997

M94 = Information supplied does not support a break in therapy. A new capped rental period will not begin.
Start: 01/01/1997

M95 = Services subjected to Home Health Initiative medical review/cost report audit.
Start: 01/01/1997

M96 = The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.
Start: 01/01/1997

M97 = Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
Start: 01/01/1997

M98 = Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.
Start: 01/01/1997
Stop: 01/31/2004
Notes: Consider using M99

M99 = Missing/incomplete/invalid Universal Product Number/Serial Number.
Start: 01/01/1997

M100 = We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
Start: 01/01/1997

M101 = Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.
Start: 01/01/1997
Stop: 01/31/2004
Notes: Consider using M78

M102 = Service not performed on equipment approved by the FDA for this purpose.
Start: 01/01/1997

M103 = Information supplied supports a break in therapy. However, the medical info-mation we have for this patient does not

support the need for this item
as billed. We have approved payment for
this item at a reduced level, and a new
capped rental period will begin with the
delivery of this equipment.
Start: 01/01/1997

M104 = Information supplied supports a break
in therapy. a new capped rental period
will begom wieth delivery of the
equipment. This is the maximum approved
under the fee schedule for this item or
service.
Start: 01/01/1997

M105 = Information supplied does not support a
break in therapy. The medical
information we have for this patient
does not support the need for this item
as billed. We have approved payment for
this item at a reduced level, and a new
capped rental period will not begin.
Start: 01/01/1997

M106 = Information supplied does not support a
break in therapy. A new capped rental
period will not begin. This is the
maximum approved under the fee schedule
for this item or service.
Start: 01/01/1997 |
Stop: 01/31/2004
Notes: Consider using MA 31

M107 = Payment reduced as 90-day rolling
average hematocrit for ESRD patient
exceeded 36.5%.
Start: 01/01/1997

M108 = Missing/incomplete/invalid provider
identifier for the provider who
interpreted the diagnostic test.
Start: 01/01/1997 | Stop: 06/02/2005

M109 = We have provided you with a bundled
payment for a teleconsultation. You must
send 25 percent of the teleconsultation
payment to the referring practitioner.
Start: 01/01/1997

M110 = Missing/incomplete/invalid provider
identifier for the provider from whom
you purchased interpretation services.
Start: 01/01/1997 | Stop: 06/02/2005

M111 = We do not pay for chiropractic
manipulative treatment when the patient
refuses to have an x-ray taken.
Start: 01/01/1997

M112 = Reimbursement for this item is based on
the single payment amount required under
the DMEPOS Competitive Bidding Program
for the area where the patient resides.

Start: 01/01/1997
M113 = Our records indicate that this patient
began using this item/service prior to
the current contract period for the
DMEPOS Competitive Bidding Program.
Start: 01/01/1997
M114 = This service was processed in
accordance with rules and guidelines
under the DMEPOS Competitive Bidding
Program or a Demonstration Project.
For more information regarding these
these projects, contact your local
contractor.
Start: 01/01/1997
M115 = This item is denied when provided to
this patient by a non-contract or non-
demonstration supplier.
Start: 01/01/1997
M116 = Processed under a demonstration project
or program. Project or program is
ending and additional services may not
be paid under this project or program.
Start: 01/01/1997
M117 = Not covered unless submitted via
electronic claim.
Start: 01/01/1997
M118 = Letter to follow containing further
information.
Start: 01/01/1997
Stop: 01/01/2011
M119 = Missing/incomplete/invalid/
deactivated/withdrawn National Drug
Code (NDC).
Start: 01/01/1997
M120 = Missing/incomplete/invalid provider
identifier for the substituting
physician who furnished the service(s)
under a reciprocal billing or locum
tenens arrangement.
Start: 01/01/1997
Stop: 06/02/2005
M121 = We pay for this service only when
performed with a covered cryosurgical
ablation.
Start: 01/01/1997
M122 = Missing/incomplete/invalid level of
subluxation.
Start: 01/01/1997
M123 = Missing/incomplete/invalid name,
strength, or dosage of the drug
furnished.
Start: 01/01/1997
M124 = Missing indication of whether the
patient owns the equipment that

requires the part or supply.
Start: 01/01/1997
Notes: Related to N230

M125 = Missing/incomplete/invalid information
on the period of time for which the
service/supply/equipment will be
needed.
Start: 01/01/1997 |

M126 = Missing/incomplete/invalid individual
lab codes included in the test.
Start: 01/01/1997 |

M127 = Missing patient medical record for this
service.
Start: 01/01/1997 |
Notes: Related to N237

M128 = Missing/incomplete/invalid date of the
patient's last physician visit.
Start: 01/01/1997 |
Stop: 06/02/2005

M129 = Missing/incomplete/invalid indicator of
x-ray availability for review.
Start: 01/01/1997

M130 = Missing invoice or statement certifying
the actual cost of the lens, less
discounts, and/or the type of
intraocular lens used.
Start: 01/01/1997
Notes: Related to N231

M131 = Missing physician financial
relationship form.
Start: 01/01/1997
Notes: Related to N239

M132 = Missing pacemaker registration form.
Start: 01/01/1997
Notes: Related to N235

M133 = Claim did not identify who performed
the purchased diagnostic test or the
amount you were charged for the test.
Start: 01/01/1997

M134 = Performed by a facility/supplier in
which the provider has a financial
interest.
Start: 01/01/1997

M135 = Missing/incomplete/invalid plan of
treatment.
Start: 01/01/1997

M136 = Missing/incomplete/invalid indication
that the service was supervised or
evaluated by a physician.
Start: 01/01/1997

M137 = Part B coinsurance under a
demonstration project or pilot program.
Start: 01/01/1997

M138 = Patient identified as a demonstration

participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.
Start: 01/01/1997

M139 = Denied services exceed the coverage limit for the demonstration.
Start: 01/01/1997

M140 = Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday
Start: 01/01/1997
Stop: 1/30/2004
Notes: Consider using M82

M141 = Missing physician certified plan of care.
Start: 01/01/1997
Notes: Related to N238

M142 = Missing American Diabetes Association Certificate of Recognition.
Start: 01/01/1997
Last Modified: 02/28/2003
Notes: Related to N226

M143 = The provider must update license information with the payer.
Start: 01/01/1997 |

M144 = Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
Start: 01/01/1997

MA01 = Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
Start: 01/01/1997
8/1/05, 4/1/07)

MA02 = Alert: If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice.
Start: 01/01/1997

MA03 = If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you

may ask for a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time.
Start: 01/01/1997
Stop: 10/01/2006
Last Modified: 11/18/2005
Notes: Consider using MA02 (Modified 10/31/02, 6/30/03, 8/1/05, 11/18/05)

MA04 = Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
Start: 01/01/1997

MA05 = Incorrect admission date patient status or type of bill entry on claim.
Start: 01/01/1997
Stop: 10/16/2003
Notes: Consider using MA30, MA40 or MA43

MA06 = Missing/incomplete/invalid beginning and/or ending date(s).
Start: 01/01/1997
Stop: 08/01/2004
Notes: Consider using MA31

MA07 = Alert: The claim information has also been forwarded to Medicaid for review.
Start: 01/01/1997

MA08 = Alert: Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.
Start: 01/01/1997

MA09 = Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.
Start: 01/01/1997

MA10 = Alert: The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.
Start: 01/01/1997

MA11 = Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.

Start: 01/01/1997
Stop: 01/31/2004
Notes: Consider using M32
MA12 = You have not established that you have
the right under the law to bill for
services furnished by the person(s)
that furnished this (these) service(s).
Start: 01/01/1997
MA13 = Alert: You may be subject to penalties
if you bill the patient for amounts not
reported with the PR (patient
responsibility) group code.
Start: 01/01/1997
MA14 = Alert: The patient is a member of an
employer-sponsored prepaid health plan.
Services from outside that health plan
are not covered. However, as you were
not previously notified of this, we are
paying this time. In the future, we
will not pay you for non-plan services.
Start: 01/01/1997
MA15 = Alert: Your claim has been separated to
expedite handling. You will receive a
separate notice for the other services
reported.
Start: 01/01/1997 |
MA16 = The patient is covered by the Black
Lung Program. Send this claim to the
Department of Labor, Federal Black Lung
Program, P.O. Box 828, Lanham-Seabrook
MD 20703.
Start: 01/01/1997
MA17 = We are the primary payer and have paid
at the primary rate. You must contact
the patient's other insurer to refund
any excess it may have paid due to its
erroneous primary payment.
Start: 01/01/1997
MA18 = Alert: The claim information is also
being forwarded to the patient's
supplemental insurer. Send any
questions regarding supplemental
benefits to them.
Start: 01/01/1997
MA19 = Alert: Information was not sent to the
Medigap insurer due to
incorrect/invalid information you
submitted concerning that insurer.
Please verify your information and
submit your secondary claim directly to
that insurer.
Start: 01/01/1997
MA20 = Skilled Nursing Facility (SNF) stay not
covered when care is primarily related

to the use of an urethral catheter for
convenience or the control of
incontinence.
Start: 01/01/1997

MA21 = SSA records indicate mismatch with name
and sex.
Start: 01/01/1997

MA22 = Payment of less than $1.00 suppressed.
Start: 01/01/1997

MA23 = Demand bill approved as result of
medical review.
Start: 01/01/1997

MA24 = Christian Science Sanitarium/ Skilled
Nursing Facility (SNF) bill in the same
benefit period.
Start: 01/01/1997 |

MA25 = A patient may not elect to change a
hospice provider more than once in a
benefit period.
Start: 01/01/1997

MA26 = Alert: Our records indicate that you
were previously informed of this rule.
Start: 01/01/1997 |

MA27 = Missing/incomplete/invalid entitlement
number or name shown on the claim.
Start: 01/01/1997 |

MA28 = Alert: Receipt of this notice by a
physician or supplier who did not
accept assignment is for information
only and does not make the physician or
supplier a party to the determination.
No additional rights to appeal this
decision, above those rights already
provided for by regulation/instruction,
are conferred by receipt of this
notice.
Start: 01/01/1997 |

MA29 = Missing/incomplete/invalid provider
name, city, state, or zip code.
Start: 01/01/1997 |
Stop: 06/02/2005

MA30 = Missing/incomplete/invalid type of
bill.
Start: 01/01/1997 |

MA31 = Missing/incomplete/invalid beginning
and ending dates of the period billed.
Start: 01/01/1997 |

MA32 = Missing/incomplete/invalid number of
covered days during the billing period.
Start: 01/01/1997 |

MA33 = Missing/incomplete/invalid noncovered
days during the billing period.
Start: 01/01/1997 |

MA34 = Missing/incomplete/invalid number of

coinsurance days during the billing
period.
Start: 01/01/1997
MA35 = Missing/incomplete/invalid number of
lifetime reserve days.
Start: 01/01/1997 |
MA36 = Missing/incomplete/invalid patient
name.
Start: 01/01/1997 |
MA37 = Missing/incomplete/invalid patient's
address.
Start: 01/01/1997 |
MA38 = Missing/incomplete/invalid birth date.
Start: 01/01/1997 |
Stop: 06/02/2005
MA39 = Missing/incomplete/invalid gender.
Start: 01/01/1997 |
MA40 = Missing/incomplete/invalid admission
date.
Start: 01/01/1997 |
MA41 = Missing/incomplete/invalid admission
type.
Start: 01/01/1997 |
MA42 = Missing/incomplete/invalid admission
source.
Start: 01/01/1997 |
MA43 = Missing/incomplete/invalid patient
status.
Start: 01/01/1997 |
MA44 = Alert: No appeal rights. Adjudicative
decision based on law.
Start: 01/01/1997
MA45 = Alert: As previously advised, a portion
or all of your payment is being held in
a special account.
Start: 01/01/1997
MA46 = The new information was considered but
additional payment will not be issued.
Start: 01/01/1997 |
MA47 = Our records show you have opted out of
Medicare, agreeing with the patient not
to bill Medicare for
services/tests/supplies furnished. As
result, we cannot pay this claim. The
patient is responsible for payment.
Start: 01/01/1997
MA48 = Missing/incomplete/invalid name or
address of responsible party or primary
payer.
Start: 01/01/1997
Last Modified: 02/28/2003
Notes: (Modified 2/28/03)
MA49 = Missing/incomplete/invalid six-digit
provider identifier for home health

agency or hospice for physician(s)
performing care plan oversight
services.
Start: 01/01/1997
Stop: 08/01/2004
Notes: Consider using MA76

MA50 = Missing/incomplete/invalid
Investigational Device Exemption number
for FDA-approved clinical trial
services.
Start: 01/01/1997 |

MA51 = Missing/incomplete/invalid CLIA
certification number for laboratory
services billed by physician office
laboratory.
Start: 01/01/1997 |
Stop: 02/05/2005
Notes: Consider using MA120

MA52 = Missing/incomplete/invalid date.
Start: 01/01/1997 | Stop: 06/02/2005

MA53 = Missing/incomplete/invalid Competitive
Bidding Demonstration Project
identification.
Start: 01/01/1997 |

MA54 = Physician certification or election
consent for hospice care not received
timely.
Start: 01/01/1997

MA55 = Not covered as patient received medical
health care services, automatically
revoking his/her election to receive
religious non-medical health care
services.
Start: 01/01/1997

MA56 = Our records show you have opted out of
Medicare, agreeing with the patient not
to bill Medicare for
services/tests/supplies furnished. As
result, we cannot pay this claim. The
patient is responsible for payment, but
under Federal law, you cannot charge
the patient more than the limiting
charge amount.
Start: 01/01/1997

MA57 = Patient submitted written request to
revoke his/her election for religious
non-medical health care services.
Start: 01/01/1997

MA58 = Missing/incomplete/invalid release of
information indicator.
Start: 01/01/1997 |

MA59 = Alert: The patient overpaid you for
these services. You must issue the
patient a refund within 30 days for the

difference between his/her payment and the total amount shown as patient responsibility on this notice.
Start: 01/01/1997 |

MA60 = Missing/incomplete/invalid patient relationship to insured.
Start: 01/01/1997 |

MA61 = Missing/incomplete/invalid social security number or health insurance claim number.
Start: 01/01/1997 |

MA62 = Alert: This is a telephone review decision.
Start: 01/01/1997 |

MA63 = Missing/incomplete/invalid principal diagnosis.
Start: 01/01/1997 |

MA64 = Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
Start: 01/01/1997

MA65 = Missing/incomplete/invalid admitting diagnosis.
Start: 01/01/1997 |

MA66 = Missing/incomplete/invalid principal procedure code.
Start: 01/01/1997 |
Notes: Related to N303

MA67 = Correction to a prior claim.
Start: 01/01/1997

MA68 = Alert: We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim.
Start: 01/01/1997 |

MA69 = Missing/incomplete/invalid remarks.
Start: 01/01/1997

MA70 = Missing/incomplete/invalid provider representative signature.
Start: 01/01/1997 |

MA71 = Missing/incomplete/invalid provider representative signature date.
Start: 01/01/1997 |

MA72 = Alert: The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice.

Start: 01/01/1997 |

MA73 = Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
Start: 01/01/1997

MA74 = This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
Start: 01/01/1997

MA75 = Missing/incomplete/invalid patient or authorized representative signature.
Start: 01/01/1997

MA76 = Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.
Start: 01/01/1997

MA77 = Alert: The patient overpaid you. You must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice.
Start: 01/01/1997

MA78 = The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.
Start: 01/01/1997
Stop: 01/31/2004
Notes: Consider using MA59

MA79 = Billed in excess of interim rate.
tart: 01/01/1997

MA80 = Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
Start: 01/01/1997

MA81 = Missing/incomplete/invalid provider/supplier signature.
Start: 01/01/1997 |

MA82 = Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.
Start: 01/01/1997 |
Stop: 06/02/2005

MA83 = Did not indicate whether we are the
       primary or secondary payer.
       Start: 01/01/1997 |
MA84 = Patient identified as participating in
       the National Emphysema Treatment Trial
       but our records indicate that this
       patient is either not a participant,
       or has not yet been approved for this
       phase of the study. Contact Johns
       Hopkins University, the study coordinator,
       to resolve if there was a discrepancy.
       Start: 01/01/1997
MA85 = Our records indicate that a primary
       payer exists (other than ourselves);
       however, you did not complete or enter
       accurately the insurance
       plan/group/program name or
       identification number. Enter the PlanID
       when effective.
       Start: 01/01/1997 |
       Stop: 08/01/2004
       Notes: Consider using MA92
MA86 = Missing/incomplete/invalid group or
       policy number of the insured for the
       primary coverage.
       Start: 01/01/1997 |
       Stop: 08/01/2004
       Notes: Consider using MA92
MA87 = Missing/incomplete/invalid insured's
       name for the primary payer.
       Start: 01/01/1997 |
       Stop: 08/01/2004
       Notes: Consider using MA92
MA88 = Missing/incomplete/invalid insured's
       address and/or telephone number for the
       primary payer.
       Start: 01/01/1997 |
MA89 = Missing/incomplete/invalid patient's
       relationship to the insured for the
       primary payer.
       Start: 01/01/1997 |
MA90 = Missing/incomplete/invalid employment
       status code for the primary insured.
       Start: 01/01/1997
MA91 = This determination is the result of the
       appeal you filed.
       Start: 01/01/1997
MA92 = Missing plan information for other
       insurance.
       Start: 01/01/1997
       Notes: Related to N245
       N245
MA93 = Non-PIP (Periodic Interim Payment)
       claim.

Start: 01/01/1997

MA94 = Did not enter the statement "Attending physician not hospice employee" on the claim form to certify that the rendering physician is not an employee of the hospice.
Start: 01/01/1997
Notes: (Reactivated 4/1/04, Modified 8/1/05)

MA95 = A not otherwise classified or unlisted procedure code(s) was billed but a narrative description of the procedure was not entered on the claim. Refer to item 19 on the HCFA-1500.
Start: 01/01/1997
Stop: 01/01/2004
Notes: (Deactivated 2/28/2003) (Erroneous description corrected 9/2/2008) Consider using M51

MA96 = Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
Start: 01/01/1997

MA97 = Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.
Start: 01/01/1997 |

MA98 = Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.
Start: 01/01/1997 |
Stop: 10/16/2003
Notes: Consider using MA97

MA99 = Missing/incomplete/invalid Medigap information.
Start: 01/01/1997 |

MA100 = Missing/incomplete/invalid date of current illness or symptoms
Start: 01/01/1997 |

MA101 = A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.
Start: 01/01/1997
Stop: 01/01/2011
Notes: Consider using N538

MA102 = Missing/incomplete/invalid name or provider identifier for the rendering/referring/ ordering/ supervising provider.
Start: 01/01/1997

Stop: 08/01/2004
Notes: Consider using M68
MA103 = Hemophilia Add On.
Start: 01/01/1997
MA104 = Missing/incomplete/invalid date the
patient was last seen or the provider
identifier of the attending physician.
Start: 01/01/1997
Stop: 01/31/2004
Notes: Consider using M128 or M57
MA105 = Missing/incomplete/invalid provider
number for this place of service.
Start: 01/01/1997
Stop: 06/02/2005
MA106 = PIP (Periodic Interim Payment) claim.
Start: 01/01/1997
MA107 = Paper claim contains more than three
separate data items in field 19.
Start: 01/01/1997
MA108 = Paper claim contains more than one data
item in field 23.
Start: 01/01/1997
MA109 = Claim processed in accordance with
ambulatory surgical guidelines.
Start: 01/01/1997
MA110 = Missing/incomplete/invalid information
on whether the diagnostic test(s) were
performed by an outside entity or if no
purchased tests are included on the
claim.
Start: 01/01/1997
MA111 = Missing/incomplete/invalid purchase
price of the test(s) and/or the
performing laboratory's name and
address.
Start: 01/01/1997
MA112 = Missing/incomplete/invalid group
practice information.
Start: 01/01/1997
MA113 = Incomplete/invalid taxpayer
identification number (TIN) submitted
by you per the Internal Revenue
Service. Your claims cannot be
processed without your correct TIN, and
you may not bill the patient pending
correction of your TIN. There are no
appeal rights for unprocessable claims,
but you may resubmit this claim after
you have notified this office of your
correct TIN.
Start: 01/01/1997
MA114 = Missing/incomplete/invalid information
on where the services were furnished.
Start: 01/01/1997

MA115 = Missing/incomplete/invalid physical
location (name and address, or PIN)
where the service(s) were rendered in a
Health Professional Shortage Area
(HPSA).
Start: 01/01/1997

MA116 = Did not complete the statement
'Homebound' on the claim to validate
whether laboratory services were
performed at home or in an institution.
Start: 01/01/1997
Notes: (Reactivated 4/1/04)

MA117 = This claim has been assessed a $1.00
user fee.
Start: 01/01/1997

MA118 = Coinsurance and/or deductible amounts
apply to a claim for services or
supplies furnished to a Medicare-
eligible veteran through a facility of
the Department of Veterans Affairs. No
Medicare payment issued.
Start: 01/01/1997

MA119 = Provider level adjustment for late
claim filing applies to this claim.
Start: 01/01/1997
Stop: 05/01/2008
Notes: Consider using Reason Code B4

MA120 = Missing/incomplete/invalid CLIA
certification number.
Start: 01/01/1997

MA121 = Missing/incomplete/invalid x-ray date.
Start: 01/01/1997

MA122 = Missing/incomplete/invalid initial
treatment date.
Start: 01/01/1997

MA123 = Your center was not selected to
participate in this study, therefore,
we cannot pay for these services.
Start: 01/01/1997

MA124 = Processed for IME only.
Start: 01/01/1997
Stop: 01/31/2004
Notes: Consider using Reason Code 74

MA125 = Per legislation governing this program,
payment constitutes payment in full.
Start: 01/01/1997

MA126 = Pancreas transplant not covered unless
kidney transplant performed.
Start: 10/12/2001

MA127 = Reserved for future use.
Start: 10/12/2001
Stop: 06/02/2005

MA128 = Missing/incomplete/invalid FDA approval
number.

Start: 10/12/2001

MA129 = This provider was not certified for
this procedure on this date of service.
Start: 10/12/2001
Stop: 01/31/2004
Notes: Consider using MA120 and Reason
Code B7

MA130 = Your claim contains incomplete and/or
invalid information, and no appeal
rights are afforded because the claim
is unprocessable. Please submit a new
claim with the complete/correct
information.
Start: 10/12/2001

MA131 = Physician already paid for services in
conjunction with this demonstration
claim. You must have the physician
withdraw that claim and refund the
payment before we can process your
claim.
Start: 10/12/2001

MA132 = Adjustment to the pre-demonstration
rate.
Start: 10/12/2001

MA133 = Claim overlaps inpatient stay. Rebill
only those services rendered outside
the inpatient stay.
Start: 10/12/2001

MA134 = Missing/incomplete/invalid provider
number of the facility where the patient resides.
Start: 10/12/2001

N1 = Alert: You may appeal this decision in
writing within the required time limits
following receipt of this notice by
following the instructions included in
your contract or plan benefit
documents.
Start: 01/01/2000

N2 = This allowance has been made in
accordance with the most appropriate
course of treatment provision of the
plan.
Start: 01/01/2000

N3 = Missing consent form.
Start: 01/01/2000
Notes: Related to N228

N4 = Missing/Incomplete/Invalid prior Insurance
Carrier(s) EOB.
Start: 01/01/2000

N5 = EOB received from previous payer. Claim
not on file.
Start: 01/01/2000

N6 = Under FEHB law (U.S.C. 8904(b)), we
cannot pay more for covered care than

the amount Medicare would have allowed
if the patient were enrolled in
Medicare Part A and/or Medicare Part B.
Start: 01/01/2000

N7 = Processing of this claim/service has
included consideration under Major
Medical provisions.
Start: 01/01/2000

N8 = Crossover claim denied by previous
payer and complete claim data not
forwarded. Resubmit this claim to this
payer to provide adequate data for
adjudication.
Start: 01/01/2000

N9 = Adjustment represents the estimated
amount a previous payer may pay.
Start: 01/01/2000

N10 = Payment based on the findings of a
review organization/professional
consult/manual adjudication/medical or
dental advisor.
Start: 01/01/2000

N11 = Denial reversed because of medical
review.
Start: 01/01/2000

N12 = Policy provides coverage supplemental
to Medicare. As the member does not
appear to be enrolled in the applicable
part of Medicare, the member is
responsible for payment of the portion
of the charge that would have been
covered by Medicare.
Start: 01/01/2000 |

N13 = Payment based on professional/technical
component modifier(s).
Start: 01/01/2000

N14 = Payment based on a contractual amount
or agreement, fee schedule, or maximum
allowable amount.
Start: 01/01/2000 |
Stop: 10/01/2007
Notes: Consider using Reason Code 45

N15 = Services for a newborn must be billed
separately.
Start: 01/01/2000

N16 = Family/member Out-of-Pocket maximum has
been met. Payment based on a higher
percentage.
Start: 01/01/2000

N17 = Per admission deductible.
Start: 01/01/2000
Stop: 08/01/2004
Notes: Consider using Reason Code 1

N18 = Payment based on the Medicare allowed

amount.
Start: 01/01/2000
Stop: 01/31/2004
Notes: Consider using N14

N19 = Procedure code incidental to primary
procedure.
Start: 01/01/2000

N20 = Service not payable with other service
rendered on the same date.
Start: 01/01/2000

N21 = Alert: Your line item has been
separated into multiple lines to
expedite handling.
Start: 01/01/2000

N22 = This procedure code was added/changed
because it more accurately describes
the services rendered.
Start: 01/01/2000

N23 = Alert: Patient liability may be
affected due to coordination of
benefits with other carriers and/or
maximum benefit provisions.
Start: 01/01/2000

N24 = Missing/incomplete/invalid Electronic
Funds Transfer (EFT) banking
information.
Start: 01/01/2000

N25 = This company has been contracted by
your benefit plan to provide
administrative claims payment services
only. This company does not assume
financial risk or obligation with
respect to claims processed on behalf
of your benefit plan.
Start: 01/01/2000

N26 = Missing itemized bill/statement.
Start: 01/01/2000
Related to N232

N27 = Missing/incomplete/invalid treatment
number.
Start: 01/01/2000
Last Modified: 02/28/2003
Notes: (Modified 2/28/03)

N28 = Consent form requirements not
fulfilled.
Start: 01/01/2000

N29 = Missing documentation/orders/
notes/summary/report/chart.
Start: 01/01/2000
Notes: Related to N225

N30 = Patient ineligible for this service.
Start: 01/01/2000 | Last Modified: 06/30/2003

N31 = Missing/incomplete/invalid prescribing
provider identifier.

Start: 01/01/2000

N32 = Claim must be submitted by the provider who rendered the service.
Start: 01/01/2000

N33 = No record of health check prior to initiation of treatment.
Start: 01/01/2000

N34 = Incorrect claim form/format for this service.
Start: 01/01/2000

N35 = Program integrity/utilization review decision.
Start: 01/01/2000

N36 = Claim must meet primary payer's processing requirements before we can consider payment.
Start: 01/01/2000

N37 = Missing/incomplete/invalid tooth number/letter.
Start: 01/01/2000

N38 = Missing/incomplete/invalid place of service.
Start: 01/01/2000
Stop: 02/05/2005
Notes: Consider using M77

N39 = Procedure code is not compatible with tooth number/letter.
Start: 01/01/2000

N40 = Missing radiology film(s)/image(s).
Start: 01/01/2000
Notes: Related to N242

N41 = Authorization request denied.
Start: 01/01/2000 |
Stop: 10/16/2003
Notes: Consider using Reason Code 39

N42 = No record of mental health assessment.
Start: 01/01/2000

N43 = Bed hold or leave days exceeded.
Start: 01/01/2000

N44 = Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority.
Start: 01/01/2000 |
Stop: 10/16/2003
Notes: Consider using Reason Code 137

N45 = Payment based on authorized amount.
Start: 01/01/2000

N46 = Missing/incomplete/invalid admission hour.
Start: 01/01/2000

N47 = Claim conflicts with another inpatient stay.
Start: 01/01/2000

N48 = Claim information does not agree with information received from other insurance carrier.
Start: 01/01/2000

N49 = Court ordered coverage information needs validation.
Start: 01/01/2000

N50 = Missing/incomplete/invalid discharge information.
Start: 01/01/2000

N51 = Electronic interchange agreement not on file for provider/submitter.
Start: 01/01/2000

N52 = Patient not enrolled in the billing provider's managed care plan on the date of service.
Start: 01/01/2000

N53 = Missing/incomplete/invalid point of pick-up address.
Start: 01/01/2000
Notes: (Modified 2/28/03)

N54 = Claim information is inconsistent with pre-certified/authorized services.
Start: 01/01/2000

N55 = Procedures for billing with group/referring/performing providers were not followed.
Start: 01/01/2000

N56 = Procedure code billed is not correct/valid for the services billed or the date of service billed.
Start: 01/01/2000

N57 = Missing/incomplete/invalid prescribing date.
Start: 01/01/2000
Notes: Related to N304

N58 = Missing/incomplete/invalid patient liability amount.
Start: 01/01/2000

N59 = Please refer to your provider manual for additional program and provider information.
Start: 01/01/2000

N60 = A valid NDC is required for payment of drug claims effective October 02.
Start: 01/01/2000
Stop: 01/31/2004
Notes: Consider using M119

N61 = Rebill services on separate claims.
Start: 01/01/2000

N62 = Dates of service span multiple rate periods. Resubmit separate claims.
Start: 01/01/2000

N63 = Rebill services on separate claim

lines.
Start: 01/01/2000

N64 = The "from" and "to" dates must be
different.
Start: 01/01/2000

N65 = Procedure code or procedure rate count
cannot be determined, or was not on
file, for the date of service/provider.
Start: 01/01/2000

N66 = Missing/incomplete/invalid
documentation.
Start: 01/01/2000
Stop: 02/05/2005
Notes: Consider using N29 or N225.

N67 = Professional provider services not paid
separately. Included in facility
payment under a demonstration project.
Apply to that facility for payment, or
resubmit your claim if: the facility
notifies you the patient was excluded
from this demonstration; or if you
furnished these services in another
location on the date of the patient's
admission or discharge from a
demonstration hospital. If services
were furnished in a facility not
involved in the demonstration on the
same date the patient was discharged
from or admitted to a demonstration facility,
you must report the provider
ID number for the non-demonstration
facility on the new claim.
Start: 01/01/2000

N68 = Prior payment being cancelled as we
were subsequently notified this patient
was covered by a demonstration project
in this site of service. Professional
services were included in the payment
made to the facility. You must contact
the facility for your payment. Prior
payment made to you by the patient or
another insurer for this claim must be
refunded to the payer within 30 days.
Start: 01/01/2000

N69 = PPS (Prospective Payment System) code
changed by claims processing system.
Start: 01/01/2000

N70 = Consolidated billing and payment
applies.
Start: 01/01/2000

N71 = Your unassigned claim for a drug or
biological, clinical diagnostic
laboratory services or ambulance
service was processed as an assigned

claim. You are required by law to accept assignment for these types of claims.
Start: 01/01/2000

N72 = PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records.
Start: 01/01/2000

N73 = A Skilled Nursing Facility is responsible for payment of outside providers who furnish these services/ supplies under arrangement to its residents.
Start: 01/01/2000
Stop: 01/31/2004
Notes: Consider using MA101 or N200

N74 = Resubmit with multiple claims, each claim covering services provided in only one calendar month.
Start: 01/01/2000

N75 = Missing/incomplete/invalid tooth surface information.
Start: 01/01/2000

N76 = Missing/incomplete/invalid number of riders.
Start: 01/01/2000

N77 = Missing/incomplete/invalid designated provider number.
Start: 01/01/2000

N78 = The necessary components of the child and teen checkup (EPSDT) were not completed.
Start: 01/01/2000

N79 = Service billed is not compatible with patient location information.
Start: 01/01/2000

N80 = Missing/incomplete/invalid prenatal screening information.
Start: 01/01/2000 |

N81 = Procedure billed is not compatible with tooth surface code.
Start: 01/01/2000

N82 = Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.
Start: 01/01/2000

N83 = No appeal rights. Adjudicative decision based on the provisions of a demonstration project.
Start: 01/01/2000

N84 = Alert: Further installment payments are forthcoming.
Start: 01/01/2000 |

N85 = Alert: This is the final installment payment.
Start: 01/01/2000 | Last Modified: 04/01/2007
Notes: (Modified 4/1/07, 8/1/07)

N86 = A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered.
Start: 01/01/2000

N87 = Home use of biofeedback therapy is not covered.
Start: 01/01/2000

N88 = Alert: This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care.
Start: 01/01/2000

N89 = Alert: Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
Start: 01/01/2000

N90 = Covered only when performed by the attending physician.
Start: 01/01/2000

N91 = Services not included in the appeal review.
Start: 01/01/2000

N92 = This facility is not certified for digital mammography.
Start: 01/01/2000

N93 = A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.
Start: 01/01/2000

N94 = Claim/Service denied because a more specific taxonomy code is required for adjudication.
Start: 01/01/2000

N95 = This provider type/provider specialty may not bill this service.
Start: 07/31/2001

N96 = Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.
Start: 08/24/2001

N97 = Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.
Start: 08/24/2001

N98 = Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. Improvement is measured through voiding diaries.
Start: 08/24/2001

N99 = Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.
Start: 08/24/2001

N100 = PPS (Prospect Payment System) code corrected during adjudication.
Start: 09/14/2001

N101 = Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters 'HSP' and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.
Start: 10/31/2001
Stop: 01/31/2004
Notes: Consider uisng MA105

N102 = This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.
Start: 10/31/2001

N103 = Social Security records indicate that

this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in a Federal facility, or while he or she is in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.
Start: 10/31/2001

N104 = This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.
Start: 01/29/2002

N105 = This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.
Start: 01/29/2002

N106 = Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.
Start: 01/31/2002

N107 = Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.
Start: 01/31/2002

N108 = Missing/incomplete/invalid upgrade information.
Start: 01/31/2002 |
Last Modified: 02/28/2003
Notes: (Modified 2/28/03)

N109 = This claim/service was chosen for complex review and was denied after reviewing the medical records.
Start: 02/28/2002
Last Modified: 03/01/2009
Notes: (Modified 3/1/2009)

N110 = This facility is not certified for film

mammography.
Start: 02/28/2002

N111 = No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
Start: 02/28/2002

N112 = This claim is excluded from your electronic remittance advice.
Start: 02/28/2002

N113 = Only one initial visit is covered per physician, group practice or provider.
Start: 04/16/2002

N114 = During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.
Start: 05/30/2002

N115 = This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.
Start: 05/30/2002

N116 = This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.
Start: 06/30/2002

N117 = This service is paid only once in a patient's lifetime.
Start: 07/30/2002

N118 = This service is not paid if billed more than once every 28 days.
Start: 07/30/2002

N119 = This service is not paid if billed once
     every 28 days, and the patient has
     spent 5 or more consecutive days in any
     inpatient or Skilled /nursing Facility
     (SNF) within those 28 days.
     Start: 07/30/2002
N120 = Payment is subject to home health
     prospective payment system partial
     episode payment adjustment. Patient was
     transferred/discharged/readmitted
     during payment episode.
     Start: 08/09/2002
N121 = Medicare Part B does not pay for items
     or services provided by this type of
     practitioner for beneficiaries in a
     Medicare Part A covered Skilled Nursing
     Facility (SNF) stay.
     Start: 09/09/2002
N122 = Add-on code cannot be billed by itself.
     Start: 09/12/2002
N123 = This is a split service and represents
     a portion of the units from the
     originally submitted service.
     Start: 09/24/2002
N124 = Payment has been denied for the/made
     only for a less extensive service/item
     because the information furnished does
     not substantiate the need for the (more
     extensive) service/item. The patient is
     liable for the charges for this
     service/item as you informed the
     patient in writing before the
     service/item was furnished that we
     would not pay for it, and the patient
     agreed to pay.
     Start: 09/26/2002
     "Payment has been (denied for the/made
     only for a less extensive) service/item
     because the information furnished does
     not substantiate the need for the (more
     extensive) service/item. If you have
     collected any amount from the patient,
     you must refund that amount to the
     patient within 30 days of receiving
     this notice.
     The requirements for a refund are in
     Ì1834(a)(18) of the Social Security Act
     (and in ÌÌ1834(j)(4) and 1879(h) by
     cross-reference to Ì1834(a)(18)).
     Section 1834(a)(18)(B) specifies that
     suppliers which knowingly and willfully
     fail to make appropriate refunds may be
     subject to civil money penalties and/or
     exclusion from the Medicare program. If

you have any questions about this
notice, please contact this office."
Start: 09/26/2002

N126 = Social Security Records indicate that
this individual has been deported. This
payer does not cover items and services
furnished to individuals who have been
deported.
Start: 10/17/2002

N127 = This is a misdirected claim/service for
a United Mine Workers of America (UMWA)
beneficiary. Please submit claims to
them.
Start: 10/31/2007

N128 = This amount represents the prior to
coverage portion of the allowance.
Start: 10/31/2002

N129 = Not eligible due to the patient's age.
Start: 10/31/2002

N130 = Consult plan benefit
documents/guidelines for information
about restrictions for this service.
Start: 10/31/2002

N131 = Total payments under multiple contracts
cannot exceed the allowance for this
service.
Start: 10/31/2002

N132 = Alert: Payments will cease for services
rendered by this US Government debarred
or excluded provider after the 30 day
grace period as previously notified.
Start: 10/31/2002

N133 = Alert: Services for predetermination
and services requesting payment are
being processed separately.
Start: 10/31/2002

N134 = Alert: This represents your scheduled
payment for this service. If treatment
has been discontinued, please contact
Customer Service.
Start: 10/31/2002

N135 = Record fees are the patient's
responsibility and limited to the
specified co-payment.
Start: 10/31/2002

N136 = Alert: To obtain information on the
process to file an appeal in Arizona,
call the Department's Consumer
Assistance Office at (602) 912-8444
or (800) 325-2548.
Start: 10/31/2002

N137 = Alert: The provider acting on the
Member's behalf, may file an appeal with
the Payer. The provider, acting on the

Member's behalf, may file a complaint with the State Insurance Regulatory Authority without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The address may be obtained from the State Insurance Regulatory Authority.
Start: 10/31/2002

N138 = Alert: In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.
Start: 10/31/2002

N139 = Alert: Under the Code of Federal Regulations, Chapter 32, Section 199.13 a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
Start: 10/31/2002

N140 = Alert: You have not been designated as an authorized OCONUS provider therefore are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
Start: 10/31/2002

N141 = The patient was not residing in a long-term care facility during all or part of the service dates billed.
Start: 10/31/2002

N142 = The original claim was denied. Resubmit

a new claim, not a replacement claim.
Start: 10/31/2002

N143 = The patient was not in a hospice
program
during all or part of the service dates
billed.
Start: 10/31/2002

N144 = The rate changed during the dates of
service billed.
Start: 10/31/2002

N145 = Missing/incomplete/invalid provider
identifier for this place of service.
Start: 10/31/2002
Stop: 06/02/2005

N146 = Missing screening document.
Start: 10/31/2002
Notes: Related to N243

N147 = Long term care case mix or per diem
rate cannot be determined because the
patient ID number is missing, incomplete
or invalid on the assignment request.
Start: 10/31/2002

N148 = Missing/incomplete/invalid date of last
menstrual period.
Start: 10/31/2002

N149 = Rebill all applicable services on a
single claim.
Start: 10/31/2002

N150 = Missing/incomplete/invalid model
number.
Start: 10/31/2002

N151 = Telephone contact services will not be
paid until the face-to-face contact
requirement has been met.
Start: 10/31/2002

N152 = Missing/incomplete/invalid replacement
claim information.
Start: 10/31/2002

N153 = Missing/incomplete/invalid room and
board rate.
Start: 10/31/2002

N154 = Alert: This payment was delayed for
correction of provider's mailing
address.
Start: 10/31/2002

N155 = Alert: Our records do not indicate that
other insurance is on file. Please
submit other insurance information for
our records.
Start: 10/31/2002

N156 = Alert: The patient is responsible for
the difference between the approved
treatment and the elective treatment.
Start: 10/31/2002

N157 = Transportation to/from this destination
is not covered.
Start: 02/28/2003
N158 = Transportation in a vehicle other than
an ambulance is not covered.
Start: 02/28/2003
N159 = Payment denied/reduced because mileage
is not covered when the patient is not
in the ambulance.
Start: 02/28/2003
N160 = The patient must choose an option
before a payment can be made for this
procedure/ equipment/ supply/ service.
Start: 02/28/2003
N161 = This drug/service/supply is covered
only when the associated service is
covered.
Start: 02/28/2003
N162 = Alert: Although your claim was paid,
you have billed for a test/specialty
not included in your laboratory
Certification. Your failure to correct
the laboratory certification information
will result in a denial of payment in
the near future.
Start: 02/28/2003|
N163 = Medical record does not support code
billed per the code definition.
Start: 02/28/2003
N164 = Transportation to/from this destination
is not covered.
Start: 02/28/2003
Stop: 01/31/2004
Notes: Consider using N157
N165 = Transportation in a vehicle other than
an ambulance is not covered.
Start: 02/28/2003
Stop: 01/31/2004
Notes: Consider using N158)
N166 = Payment denied/reduced because mileage
is not covered when the patient is not
in the ambulance.
Start: 02/28/2003
Stop: 01/31/2004
Notes: Consider using N159
N167 = Charges exceed the post-transplant
coverage limit.
Start: 02/28/2003
N168 = The patient must choose an option
before
a payment can be made for this
procedure/ equipment/ supply/ service.
Start: 02/28/2003
Stop: 01/31/2004

Notes: Consider using N160

N169 = This drug/service/supply is covered only when the associated service is covered.
Start: 02/28/2003
Stop: 01/31/2004
Notes: Consider using N161

N170 = A new/revised/renewed certificate of medical necessity is needed.
Start: 02/28/2003

N171 = Payment for repair or replacement is not covered or has exceeded the purchase price.
Start: 02/28/2003

N172 = The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.
Start: 02/28/2003

N173 = No qualifying hospital stay dates were provided for this episode of care.
Start: 02/28/2003

N174 = This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.
Start: 02/28/2003

N175 = Missing review organization approval.
Start: 02/28/2003
Notes: Related to N241

N176 = Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.
Start: 02/28/2003

N177 = Alert: We did not send this claim to patient's other insurer. They have indicated no additional payment can be made.
Start: 02/28/2003

N178 = Missing pre-operative photos or visual field results.
Start: 02/28/2003
Notes: Related to N244

N179 = Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
Start: 02/28/2003

N180 = This item or service does not meet the criteria for the category under which it was billed.

Start: 02/28/2003
N181 = Additional information is required from
another provider involved in this service.
Start: 02/28/2003
Last Modified: 12/01/2006
Notes: (Modified 12/1/06)
N182 = This claim/service must be billed
according to the schedule for this plan.
Start: 02/28/2003
N183 = Alert: This is a predetermination
advisory message, when this service is
submitted for payment additional
documentation as specified in plan
documents will be required to process
benefits.
Start: 02/28/2003
N184 = Rebill technical and professional
components separately.
Start: 02/28/2003
N185 = Alert: Do not resubmit this
claim/service.
Start: 02/28/2003
N186 = Non-Availability Statement (NAS)
required for this service. Contact the
nearest Military Treatment Facility
(MTF) for assistance.
Start: 02/28/2003
N187 = Alert: You may request a review in
writing within the required time limits
following receipt of this notice by
following the instructions included in
your contract or plan benefit documents.
Start: 02/28/2003
N188 = The approved level of care does not
match the procedure code submitted.
Start: 02/28/2003
N189 = Alert: This service has been paid as a
one-time exception to the plan's benefit
restrictions.
Start: 02/28/2003
N190 = Missing contract indicator.
Start: 02/28/2003
Notes: Related to N229
N191 = The provider must update insurance
information directly with payer.
Start: 02/28/2003
N192 = Patient is a Medicaid/Qualified
Medicare Beneficiary
Start: 02/28/2003
N193 = Specific federal/state/local program may
cover this service through another payer.
Start: 02/28/2003
N194 = Technical component not paid if
provider does not own the equipment

used.
Start: 02/25/2003

N195 = The technical component must be billed
    separately.
    Start: 02/25/2003

N196 = Alert: Patient eligible to apply for
    other coverage which may be primary.
    Start: 02/25/2003

N197 = The subscriber must update insurance
    information directly with payer.
    Start: 02/25/2003

N198 = Rendering provider must be affiliated
    with the pay-to provider.
    Start: 02/25/2003

N199 = Additional payment/recoupment approved
    based on payer-initiated review/audit.
    Start: 02/25/2003

N200 = The professional component must be
    billed separately.
    Start: 02/25/2003

N201 = A mental health facility is responsible
    for payment of outside providers who
    furnish these services/supplies to residents.
    Start: 02/25/2003
    Stop: 01/01/2011
    Notes: Consider using N538

N202 = Additional information/explanation will
    be sent separately
    Start: 06/30/2003

N203 = Missing/incomplete/invalid anesthesia
    time/units
    Start: 06/30/2003

N204 = Services under review for possible
    pre-existing condition. Send medical
    records for prior 12 months
    Start: 06/30/2003

N205 = Information provided was illegible
    Start: 06/30/2003

N206 = The supporting documentation does not
    match the information sent on the claim.
    Start: 06/30/2003
    Notes: (Modified 3/6/12)

N207 = Missing/incomplete/invalid weight.
    Start: 06/30/2003

N208 = Missing/incomplete/invalid DRG code
    Start: 06/30/2003

N209 = Missing/incomplete/invalid taxpayer
    identification number (TIN).
    Start: 06/30/2003

N210 = Alert: You may appeal this decision
    Start: 06/30/2003

N211 = Alert: You may not appeal this decision
    Start: 06/30/2003

N212 = Charges processed under a Point of

Service benefit
Start: 02/01/2004

N213 = Missing/incomplete/invalid
facility/discrete unit DRG/DRG exempt
status information
Start: 04/01/2004

N214 = Missing/incomplete/invalid history of
the related initial surgical
procedure(s)
Start: 04/01/2004

N215 = Alert: A payer providing supplemental
or secondary coverage shall not require
a claims determination for this service
from a primary payer as a condition of
making its own claims determination.
Start: 04/01/2004

N216 = We do not offer coverage for this type
of service or the patient is not
enrolled in this portion of our benefit
package
Start: 04/01/2004

N217 = We pay only one site of service per
provider per claim
Start: 08/01/2004

N218 = You must furnish and service this item
for as long as the patient continues to
need it. We can pay for maintenance
and/or servicing for the time period
specified in the contract or coverage manual.
Start: 08/01/2004

N219 = Payment based on previous payer's
allowed amount.
Start: 08/01/2004

N220 = Alert: See the payer's web site or
contact the payer's Customer Service
department to obtain forms and
instructions for filing a provider
dispute.
Start: 08/01/2004

N221 = Missing Admitting History and Physical
report.
Start: 08/01/2004

N222 = Incomplete/invalid Admitting History
and Physical report.
Start: 08/01/2004

N223 = Missing documentation of benefit to the
patient during initial treatment period.

N224 = Incomplete/invalid documentation of
benefit to the patient during initial
treatment period.
Start: 08/01/2004

N225 = Incomplete/invalid
documentation/orders/notes/summary/
report/chart.

Start: 08/01/2004

N226 = Incomplete/invalid American Diabetes
    Association Certificate of Recognition.
    Start: 08/01/2004

N227 = Incomplete/invalid Certificate of
    Medical Necessity.
    Start: 08/01/2004

N228 = Incomplete/invalid consent form.
    Start: 08/01/2004

N229 = Incomplete/invalid contract indicator.
    Start: 08/01/2004

N230 = Incomplete/invalid indication of
    whether the patient owns the equipment
    equipment that requires the part or
    or supply.
    Start: 08/01/2004

N231 = Incomplete/invalid invoice or statement
    certifying the actual cost of the lens,
    less discounts, and/or the type of
    intraocular lens used.
    Start: 08/01/2004

N232 = Incomplete/invalid itemized
    bill/statement.
    Start: 08/01/2004

N233 = Incomplete/invalid operative
    note/report.
    Start: 08/01/2004

N234 = Incomplete/invalid oxygen
    certification/re-certification.
    Start: 08/01/2004

N235 = Incomplete/invalid pacemaker
    registration form.
    Start: 08/01/2004

N236 = Incomplete/invalid pathology report.
    Start: 08/01/2004

N237 = Incomplete/invalid patient medical
    record for this service.
    Start: 08/01/2004

N238 = Incomplete/invalid physician certified
    plan of care
    Start: 08/01/2004

N239 = Incomplete/invalid physician financial
    relationship form.
    Start: 08/01/2004

N240 = Incomplete/invalid radiology report.
    Start: 08/01/2004

N241 = Incomplete/invalid review organization
    approval.
    Start: 08/01/2004

N242 = Incomplete/invalid radiology film(s)
    /image(s).
    Start: 08/01/2004

N243 = Incomplete/invalid/not approved
    screening document.

Start: 08/01/2004
N244 = Incomplete/invalid pre-operative
    photos/visual field results.
    Start: 08/01/2004
N245 = Incomplete/invalid plan information for
    other insurance
    Start: 08/01/2004
N246 = State regulated patient payment
    limitations apply to this service.
    Start: 12/02/2004
N247 = Missing/incomplete/invalid assistant
    surgeon taxonomy.
    Start: 12/02/2004
N248 = Missing/incomplete/invalid assistant
    surgeon name.
    Start: 12/02/2004
N249 = Missing/incomplete/invalid assistant
    surgeon primary identifier.
    Start: 12/02/2004
N250 = Missing/incomplete/invalid assistant
    surgeon secondary identifier.
    Start: 12/02/2004
N251 = Missing/incomplete/invalid attending
    provider taxonomy.
    Start: 12/02/2004
N252 = Missing/incomplete/invalid attending
    provider name.
    Start: 12/02/2004
N253 = Missing/incomplete/invalid attending
    provider primary identifier.
    Start: 12/02/2004
N254 = Missing/incomplete/invalid attending
    provider secondary identifier.
    Start: 12/02/2004
N255 = Missing/incomplete/invalid billing
    provider taxonomy.
    Start: 12/02/2004
N256 = Missing/incomplete/invalid billing
    provider/supplier name.
    Start: 12/02/2004
N257 = Missing/incomplete/invalid billing
    provider/supplier primary identifier.
    Start: 12/02/2004
N258 = Missing/incomplete/invalid billing
    provider/supplier address.
    Start: 12/02/2004
N259 = Missing/incomplete/invalid billing
    provider/supplier secondary identifier.
    Start: 12/02/2004
N260 = Missing/incomplete/invalid billing
    provider/supplier contact information.
    Start: 12/02/2004
N261 = Missing/incomplete/invalid operating
    provider name.

Start: 12/02/2004

N262 = Missing/incomplete/invalid operating provider primary identifier.
Start: 12/02/2004

N263 = Missing/incomplete/invalid operating provider secondary identifier.
Start: 12/02/2004

N264 = Missing/incomplete/invalid ordering provider name.
Start: 12/02/2004

N265 = Missing/incomplete/invalid ordering provider primary identifier.
Start: 12/02/2004

N266 = Missing/incomplete/invalid ordering provider address.
Start: 12/02/2004

N267 = Missing/incomplete/invalid ordering provider secondary identifier.
Start: 12/02/2004

N268 = Missing/incomplete/invalid ordering provider contact information.
Start: 12/02/2004

N269 = Missing/incomplete/invalid other provider name.
Start: 12/02/2004

N270 = Missing/incomplete/invalid other provider primary identifier.
Start: 12/02/2004

N271 = Missing/incomplete/invalid other provider secondary identifier.
Start: 12/02/2004

N272 = Missing/incomplete/invalid other payer attending provider identifier.
Start: 12/02/2004

N273 = Missing/incomplete/invalid other payer operating provider identifier.
Start: 12/02/2004

N274 = Missing/incomplete/invalid other payer other provider identifier.
Start: 12/02/2004

N275 = Missing/incomplete/invalid other payer purchased service provider identifier.
Start: 12/02/2004

N276 = Missing/incomplete/invalid other payer referring provider identifier.
Start: 12/02/2004

N277 = Missing/incomplete/invalid other payer rendering provider identifier.
Start: 12/02/2004

N278 = Missing/incomplete/invalid other payer service facility provider identifier.
Start: 12/02/2004

N279 = Missing/incomplete/invalid pay-to provider name.

Start: 12/02/2004

N280 = Missing/incomplete/invalid pay-to provider primary identifier.
Start: 12/02/2004

N281 = Missing/incomplete/invalid pay-to provider address.
Start: 12/02/2004

N282 = Missing/incomplete/invalid pay-to provider secondary identifier.
Start: 12/02/2004

N283 = Missing/incomplete/invalid purchased service provider identifier.
Start: 12/02/2004

N284 = Missing/incomplete/invalid referring provider taxonomy.
Start: 12/02/2004

N285 = Missing/incomplete/invalid referring provider name.
Start: 12/02/2004

N286 = Missing/incomplete/invalid referring provider primary identifier.
Start: 12/02/2004

N287 = Missing/incomplete/invalid referring provider secondary identifier.
Start: 12/02/2004

N288 = Missing/incomplete/invalid rendering provider taxonomy.
Start: 12/02/2004

N289 = Missing/incomplete/invalid rendering provider name.
Start: 12/02/2004

N290 = Missing/incomplete/invalid rendering provider primary identifier.
Start: 12/02/2004

N291 = Missing/incomplete/invalid rendering provider secondary identifier.
Start: 12/02/2004

N292 = Missing/incomplete/invalid service facility name.
Start: 12/02/2004

N293 = Missing/incomplete/invalid service facility primary identifier.
Start: 12/02/2004

N294 = Missing/incomplete/invalid service facility primary address.
Start: 12/02/2004

N295 = Missing/incomplete/invalid service facility secondary identifier.
Start: 12/02/2004

N296 = Missing/incomplete/invalid supervising provider name.
Start: 12/02/2004

N297 = Missing/incomplete/invalid supervising provider primary identifier.

Start: 12/02/2004

N298 = Missing/incomplete/invalid supervising
provider secondary identifier.
Start: 12/02/2004

N299 = Missing/incomplete/invalid occurrence
date(s).
Start: 12/02/2004

N300 = Missing/incomplete/invalid occurrence
span date(s).
Start: 12/02/2004

N301 = Missing/incomplete/invalid procedure
date(s).
Start: 12/02/2004

N302 = Missing/incomplete/invalid other
procedure date(s).
Start: 12/02/2004

N303 = Missing/incomplete/invalid principal
procedure date.
Start: 12/02/2004

N304 = Missing/incomplete/invalid dispensed
date.
Start: 12/02/2004

N305 = Missing/incomplete/invalid accident
date.
Start: 12/02/2004

N306 = Missing/incomplete/invalid acute
manifestation date.
Start: 12/02/2004

N307 = Missing/incomplete/invalid adjudication
or payment date.
Start: 12/02/2004

N308 = Missing/incomplete/invalid appliance
placement date.
Start: 12/02/2004

N309 = Missing/incomplete/invalid assessment
date.
Start: 12/02/2004

N310 = Missing/incomplete/invalid assumed or
relinquished care date.
Start: 12/02/2004

N311 = Missing/incomplete/invalid authorized
to return to work date.
Start: 12/02/2004

N312 = Missing/incomplete/invalid begin
therapy date.
Start: 12/02/2004

N313 = Missing/incomplete/invalid
certification revision date.
Start: 12/02/2004

N314 = Missing/incomplete/invalid diagnosis
date.
Start: 12/02/2004

N315 = Missing/incomplete/invalid disability
from date.

Start: 12/02/2004

N316 = Missing/incomplete/invalid disability
to date.
Start: 12/02/2004

N317 = Missing/incomplete/invalid discharge
hour.
Start: 12/02/2004

N318 = Missing/incomplete/invalid discharge or
end of care date.
Start: 12/02/2004

N319 = Missing/incomplete/invalid hearing or
vision prescription date.
Start: 12/02/2004

N320 = Missing/incomplete/invalid Home Health
Certification Period.
Start: 12/02/2004

N321 = Missing/incomplete/invalid last
admission period.
Start: 12/02/2004

N322 = Missing/incomplete/invalid last
certification date.
Start: 12/02/2004

N323 = Missing/incomplete/invalid last contact
date.
Start: 12/02/2004

N324 = Missing/incomplete/invalid last
seen/visit date.
Start: 12/02/2004

N325 = Missing/incomplete/invalid last worked
date.
Start: 12/02/2004

N326 = Missing/incomplete/invalid last x-ray
date.
Start: 12/02/2004

N327 = Missing/incomplete/invalid other insured
birth date.
Start: 12/02/2004

N328 = Missing/incomplete/invalid Oxygen
Saturation Test date.
Start: 12/02/2004

N329 = Missing/incomplete/invalid patient
birth date
Start: 12/02/2004

N330 = Missing/incomplete/invalid patient
death date.
Start: 12/02/2004

N331 = Missing/incomplete/invalid physician
order date.
Start: 12/02/2004

N332 = Missing/incomplete/invalid prior
hospital discharge date.
Start: 12/02/2004

N333 = Missing/incomplete/invalid prior
placement date.

Start: 12/02/2004

N334 = Missing/incomplete/invalid re- evaluation
date
Start: 12/02/2004

N335 = Missing/incomplete/invalid referral
date.
Start: 12/02/2004

N336 = Missing/incomplete/invalid replacement
date.
Start: 12/02/2004

N337 = Missing/incomplete/invalid secondary
diagnosis date.
Start: 12/02/2004

N338 = Missing/incomplete/invalid shipped date.
Start: 12/02/2004

N339 = Missing/incomplete/invalid similar
illness or symptom date.
Start: 12/02/2004

N340 = Missing/incomplete/invalid subscriber
birth date.
Start: 12/02/2004

N341 = Missing/incomplete/invalid surgery date.
Start: 12/02/2004

N342 = Missing/incomplete/invalid test
performed date.
Start: 12/02/2004

N343 = Missing/incomplete/invalid
Transcutaneous Electrical Nerve
Stimulator (TENS) trial start date.
Start: 12/02/2004

N344 = Missing/incomplete/invalid
Transcutaneous Electrical Nerve
Stimulator (TENS) trial end date.
Start: 12/02/2004

N345 = Date range not valid with units
submitted.
Start: 03/30/2005

N346 = Missing/incomplete/invalid oral cavity
designation code.
Start: 03/30/2005

N347 = Your claim for a referred or purchased
service cannot be paid because payment
has already been made for this same
service to another provider by a payment
contractor representing the payer.
Start: 03/30/2005

N348 = You chose that this service/supply/drug
would be rendered/supplied and billed by
a different practitioner/supplier.
Start: 08/01/2005

N349 = The administration method and drug must
be reported to adjudicate this service.
Start: 08/01/2005

N350 = Missing/incomplete/invalid description

of service for a Not Otherwise Classified
(NOC) code or for an Unlisted/By Report
procedure.
Start: 08/01/2005
N351 = Service date outside of the approved
treatment plan service dates.
Start: 08/01/2005
N352 = Alert: There are no scheduled payments
for this service. Submit a claim for
each patient visit.
Start: 08/01/2005
N353 = Alert: Benefits have been estimated,
when the actual services have been
rendered, additional payment will be
considered based on the submitted claim.
Start: 08/01/2005
N354 = Incomplete/invalid invoice
Start: 08/01/2005
"Alert: The law permits exceptions to
the refund requirement in two cases: -
If you did not know, and could not have
reasonably been expected to know, that
we would not pay for this service; or -
If you notified the patient in writing
before providing the service that you
believed that we were likely to deny the
service, and the patient signed a
statement agreeing to pay for the
service.
If you come within either exception, or
if you believe the carrier was wrong in
its determination that we do not pay for
this service, you should request appeal
of this determination within 30 days of
the date of this notice. Your request
for review should include any additional
information necessary to support your
position.
If you request an appeal within 30 days
of receiving this notice, you may delay
refunding the amount to the patient
until you receive the results of the
review. If the review decision is
favorable to you, you do not need to
make any refund. If, however, the review
is unfavorable, the law specifies that
you must make the refund within 15 days
of receiving the unfavorable review
decision.
The law also permits you to request an
appeal at any time within 120 days of
the date you receive this notice.
However, an appeal request that is
received more than 30 days after the

date of this notice, does not permit you
to delay making the refund. Regardless
of when a review is requested, the
patient will be notified that you have
requested one, and will receive a copy
of the determination.
The patient has received a separate
notice of this denial decision. The
notice advises that he/she may be
entitled to a refund of any amounts
paid, if you should have known that we
would not pay and did not tell him/her.
It also instructs the patient to contact
our office if he/she does not hear
anything about a refund within 30 days"
Start: 08/01/2005
N356 = Not covered when performed with, or
subsequent to, a non-covered service.
Start: 08/01/2005
N357 = Time frame requirements between this
service/procedure/supply and a related
service/procedure/supply have not been
met.
Start: 11/18/2005
N358 = Alert: This decision may be reviewed if
additional documentation as described in
the contract or plan benefit documents
is submitted.
Start: 11/18/2005
N359 = Missing/incomplete/invalid height.
Start: 11/18/2005
N360 = Alert: Coordination of benefits has not
been calculated when estimating benefits
for this pre-determination. Submit
payment information from the primary
payer with the secondary claim.
Start: 11/18/2005
N361 = Payment adjusted based on multiple
diagnostic imaging procedure rules
Start: 11/18/2005
Stop: 10/01/2007
Notes: (Modified 12/1/06)
Consider using Reason Code 59
N362 = The number of Days or Units of Service
exceeds our acceptable maximum.
Start: 11/18/2005
N363 = Alert: in the near future we are
implementing new policies/procedures
that would affect this determination.
Start: 11/18/2005
N364 = Alert: According to our agreement, you
must waive the deductible and/or
coinsurance amounts.
Start: 11/18/2005

N365 = This procedure code is not payable.
It is for reporting/information purposes
only.
Start: 04/01/2006

N366 = Requested information not provided. The
claim will be reopened if the
information previously requested is
submitted within one year after the date
of this denial notice.
Start: 04/01/2006

N367 = Alert: The claim information has been
forwarded to a Consumer Spending Account
processor for review; for example,
flexible spending account or health
savings account.
Start: 04/01/2006
Last Modified: 07/01/2008

N368 = You must appeal the determination of
the previously adjudicated claim.
Start: 04/01/2006

N369 = Alert: Although this claim has been
processed, it is deficient according to
state legislation/regulation.
Start: 04/01/2006

N370 = Billing exceeds the rental months
covered/approved by the payer.
Start: 08/01/2006

N371 = Alert: title of this equipment must be
transferred to the patient.
Start: 08/01/2006

N372 = Only reasonable and necessary
maintenance/service charges are covered.
Start: 08/01/2006

N373 = It has been determined that another
payer paid the services as primary when
they were not the primary payer.
Therefore, we are refunding to the payer
that paid as primary on your behalf.
Start: 12/01/2006

N374 = Primary Medicare Part A insurance has
been exhausted and a Part B Remittance
Advice is required.
Start: 12/01/2006

N375 = Missing/incomplete/invalid
questionnaire/information required to
determine dependent eligibility.
Start: 12/01/2006

N376 = Subscriber/patient is assigned to
active military duty, therefore
primary coverage may be TRICARE.
Start: 12/01/2006

N377 = Payment based on a processed
replacement claim.
Start: 12/01/2006

N378 = Missing/incomplete/invalid prescription
quantity.
Start: 12/01/2006
N379 = Claim level information does not match
line level information.
Start: 12/01/2006
N380 = The original claim has been processed,
submit a corrected claim.
Start: 04/01/2007
N381 = Consult our contractual agreement for
restrictions/billing/payment information
related to these charges.
Start: 04/01/2007
N382 = Missing/incomplete/invalid patient
identifier.
Start: 04/01/2007
N383 = Not covered when deemed cosmetic.
Start: 04/01/2007
Last Modified: 03/08/2011
Notes: (Modified 3/8/11)
N384 = Records indicate that the referenced
body part/tooth has been removed in a
previous procedure.
Start: 04/01/2007
N385 = Notification of admission was not
timely
according to published plan procedures.
Start: 04/01/2007
N386 = This decision was based on a National
Coverage Determination (NCD). An NCD
provides a coverage determination as to
whether a particular item or service is
covered. A copy of this policy is
available at www.cms.gov/mcd/search.asp.
If you do not have web access, you may
contact the contractor to request a copy
of the NCD.
Start: 04/01/2007
N387 = Alert: Submit this claim to the
patient's other insurer for potential
payment of supplemental benefits. We did
not forward the claim information.
Start: 04/01/2007
N388 = Missing/incomplete/invalid prescription
number.
Start: 08/01/2007
N389 = Duplicate prescription number
submitted.
Start: 08/01/2007
N390 = This service/report cannot be billed
separately.
Start: 08/01/2007
N391 = Missing emergency department records.
Start: 08/01/2007

N392 = Incomplete/invalid emergency department records.
Start: 08/01/2007

N393 = Missing progress notes/report.
Start: 08/01/2007

N394 = Incomplete/invalid progress notes/report.
Start: 08/01/2007

N395 = Missing laboratory report.
Start: 08/01/2007

N396 = Incomplete/invalid laboratory report.
Start: 08/01/2007

N397 = Benefits are not available for incomplete service(s)/undelivered item(s).
Start: 08/01/2007

N398 = Missing elective consent form.
Start: 08/01/2007

N399 = Incomplete/invalid elective consent form.
Start: 08/01/2007

N400 = Alert: Electronically enabled providers should submit claims electronically.
Start: 08/01/2007

N401 = Missing periodontal charting.
Start: 08/01/2007

N402 = Incomplete/invalid periodontal charting.
Start: 08/01/2007

N403 = Missing facility certification.
Start: 08/01/2007

N404 = Incomplete/invalid facility certification.
Start: 08/01/2007

N405 = This service is only covered when the donor's insurer(s) do not provide coverage for the service.
Start: 08/01/2007

N406 = This service is only covered when the recipient's insurer(s) do not provide coverage for the service.
Start: 08/01/2007

N407 = You are not an approved submitter for this transmission format.
Start: 08/01/2007

N408 = This payer does not cover deductibles assessed by a previous payer.
Start: 08/01/2007

N409 = This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident.
Start: 08/01/2007

N410 = Not covered unless the prescription

changes.
Start: 08/01/2007

N411 = This service is allowed one time in a
6-month period. (This temporary code
will be deactivated on 2/1/09. Must be
used with Reason Code 119.)
Start: 08/01/2007
Stop: 02/01/2009

N412 = This service is allowed 2 times in a
12-month period. (This temporary code
will be deactivated on 2/1/09. Must be
used with Reason Code 119.)
Start: 08/01/2007
Stop: 02/01/2009

N413 = This service is allowed 2 times in a
benefit year. (This temporary code will
be deactivated on 2/1/09. Must be used
with Reason Code 119.)
Start: 08/01/2007
Stop: 02/01/2009

N414 = This service is allowed 4 times in a
12-month period. (This temporary code
will be deactivated on 2/1/09. Must be
used with Reason Code 119.)
Start: 08/01/2007
Stop: 02/01/2009

N415 = This service is allowed 1 time in an
18-month period. (This temporary code
will be deactivated on 2/1/09. Must be
used with Reason Code 119.)
Start: 08/01/2007
Stop: 02/01/2009

N416 = This service is allowed 1 time in a
3-year period. (This temporary code will
be deactivated on 2/1/09. Must be used
with Reason Code 119.)
Start: 08/01/2007
Stop: 02/01/2009

N417 = This service is allowed 1 time in a
5-year period. (This temporary code will
be deactivated on 2/1/09. Must be used
with Reason Code 119.)
Start: 08/01/2007
Stop: 02/01/2009

N418 = Misrouted claim. See the payer's claim
submission instructions.
Start: 08/01/2007

N419 = Claim payment was the result of a
payer's retroactive adjustment due to a
retroactive rate change.
Start: 08/01/2007

N420 = Claim payment was the result of a
payer's retroactive adjustment due to a
Coordination of Benefits or Third Party

Liability Recovery.
Start: 08/01/2007

N421 = Claim payment was the result of a
payer's retroactive adjustment due to a
review organization decision.
Start: 08/01/2007

N422 = Claim payment was the result of a
payer's retroactive adjustment due to a
payer's contract incentive program.
Start: 08/01/2007

N423 = Claim payment was the result of a
payer's retroactive adjustment due to a
non standard program.
Start: 08/01/2007

N424 = Patient does not reside in the
geographic area required for this type
of payment.
Start: 08/01/2007

N425 = Statutorily excluded service(s).
Start: 08/01/2007

N426 = No coverage when self-administered.
Start: 08/01/2007

N427 = Payment for eyeglasses or contact
lenses can be made only after cataract
surgery.
Start: 08/01/2007

N428 = Not covered when performed in this
place of surgery.
Start: 08/01/2007

N429 = Not covered when considered routine.
Start: 08/01/2007

N430 = Procedure code is inconsistent with the
units billed.
Start: 11/05/2007

N431 = Not covered with this procedure.
Start: 11/05/2007

N432 = Adjustment based on a Recovery Audit.
Start: 11/05/2007

N433 = Resubmit this claim using only your
National Provider Identifier (NPI)
Start: 02/29/2008

N434 = Missing/Incomplete/Invalid Present on
Admission indicator.
Start: 07/01/2008

N435 = Exceeds number/frequency approved
/allowed within time period without
support documentation.
Start: 07/01/2008

N436 = The injury claim has not been accepted
and a mandatory medical reimbursement
has been made.
Start: 07/01/2008

N437 = Alert: If the injury claim is accepted,
these charges will be reconsidered.

Start: 07/01/2008

N438 = This jurisdiction only accepts paper
   claims
   Start: 07/01/2008

N439 = Missing anesthesia physical status
   report/indicators.
   Start: 07/01/2008

N440 = Incomplete/invalid anesthesia physical
   status report/indicators.
   Start: 07/01/2008

N441 = This missed appointment is not covered.
   Start: 07/01/2008

N442 = Payment based on an alternate fee
   schedule.
   Start: 07/01/2008

N443 = Missing/incomplete/invalid total time
   or begin/end time.
   Start: 07/01/2008

N444 = Alert: This facility has not filed the
   Election for High Cost Outlier form with
   the Division of Workers' Compensation.
   Start: 07/01/2008

N445 = Missing document for actual cost or
   paid amount.
   Start: 07/01/2008

N446 = Incomplete/invalid document for actual
   cost or paid amount.
   Start: 07/01/2008

N447 = Payment is based on a generic
   equivalent
   as required documentation was not
   provided.
   Start: 07/01/2008

N448 = This drug/service/supply is not
   included
   in the fee schedule or
   contracted/legislated fee arrangement
   Start: 07/01/2008

N449 = Payment based on a comparable
   drug/service/supply.
   Start: 07/01/2008

N450 = Covered only when performed by the
   primary treating physician or the
   designee.
   Start: 07/01/2008

N451 = Missing Admission Summary Report.
   Start: 07/01/2008

N452 = Incomplete/invalid Admission Summary
   Report.
   Start: 07/01/2008

N453 = Missing Consultation Report.
   Start: 07/01/2008

N454 = Incomplete/invalid Consultation Report.
   Start: 07/01/2008

N455 = Missing Physician Order.
  Start: 07/01/2008
N456 = Incomplete/invalid Physician Order.
  Start: 07/01/2008
N457 = Missing Diagnostic Report.
  Start: 07/01/2008
N458 = Incomplete/invalid Diagnostic Report.
  Start: 07/01/2008
N459 = Missing Discharge Summary.
  Start: 07/01/2008
N460 = Incomplete/invalid Discharge Summary.
  Start: 07/01/2008
N461 = Missing Nursing Notes.
  Start: 07/01/2008
N462 = Incomplete/invalid Nursing Notes.
  Start: 07/01/2008
N463 = Missing support data for claim.
  Start: 07/01/2008
N464 = Incomplete/invalid support data for
  claim.
  Start: 07/01/2008
N465 = Missing Physical Therapy Notes/Report.
  Start: 07/01/2008
N466 = Incomplete/invalid Physical Therapy
  Notes/Report.
  Start: 07/01/2008
N467 = Missing Report of Tests and Analysis
  Report.
  Start: 07/01/2008
N468 = Incomplete/invalid Report of Tests and
  Analysis Report.
  Start: 07/01/2008
N469 = Alert: Claim/Service(s) subject to
  appeal process, see section 935 of
  Medicare Prescription Drug, Improvement,
  and Modernization Act of 2003 (MMA).
  Start: 07/01/2008
N470 = This payment will complete the
  mandatory
  medical reimbursement limit.
  Start: 07/01/2008
N471 = Missing/incomplete/invalid HIPPS Rate
  Code.
  Start: 07/01/2008
N472 = Payment for this service has been
  issued
  to another provider.
  Start: 07/01/2008
N473 = Missing certification.
  Start: 07/01/2008
N474 = Incomplete/invalid certification
  Start: 07/01/2008
N475 = Missing completed referral form.
  Start: 07/01/2008

N476 = Incomplete/invalid completed referral form
Start: 07/01/2008
N477 = Missing Dental Models.
Start: 07/01/2008
N478 = Incomplete/invalid Dental Models
Start: 07/01/2008
N479 = Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
Start: 07/01/2008
N480 = Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
Start: 07/01/2008
N481 = Missing Models.
Start: 07/01/2008
N482 = Incomplete/invalid Models
Start: 07/01/2008
N483 = Missing Periodontal Charts.
Start: 07/01/2008
N484 = Incomplete/invalid Periodontal Charts
Start: 07/01/2008
N485 = Missing Physical Therapy Certification.
Start: 07/01/2008
N486 = Incomplete/invalid Physical Therapy Certification.
Start: 07/01/2008
N487 = Missing Prosthetics or Orthotics Certification.
Start: 07/01/2008
N488 = Incomplete/invalid Prosthetics or Orthotics Certification
Start: 07/01/2008
N489 = Missing referral form.
Start: 07/01/2008
N490 = Incomplete/invalid referral form
Start: 07/01/2008
N491 = Missing/Incomplete/Invalid Exclusionary Rider Condition.
Start: 07/01/2008
N492 = Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge.
Start: 07/01/2008
N493 = Missing Doctor First Report of Injury.
Start: 07/01/2008
N494 = Incomplete/invalid Doctor First Report of Injury.
Start: 07/01/2008
N495 = Missing Supplemental Medical Report.

Start: 07/01/2008

N496 = Incomplete/invalid Supplemental Medical
Report.
Start: 07/01/2008

N497 = Missing Medical Permanent Impairment or
Disability Report.
Start: 07/01/2008

N498 = Incomplete/invalid Medical Permanent
Impairment or Disability Report.
Start: 07/01/2008

N499 = Missing Medical Legal Report.
Start: 07/01/2008

N500 = Incomplete/invalid Medical Legal
Report.
Start: 07/01/2008

N501 = Missing Vocational Report.
Start: 07/01/2008

N502 = Incomplete/invalid Vocational Report.
Start: 07/01/2008

N503 = Missing Work Status Report.
Start: 07/01/2008

N504 = Incomplete/invalid Work Status Report.
Start: 07/01/2008

N505 = Alert: This response includes only
services that could be estimated in real
time. No estimate will be provided for
the services that could not be estimated
in real time.
Start: 11/01/2008

N506 = Alert: This is an estimate of the
member's liability based on the
information available at the time the
estimate was processed. Actual coverage
and member liability amounts will be
determined when the claim is processed.
This is not a pre-authorization or a
guarantee of payment.
Start: 11/01/2008

N507 = Plan distance requirements have not
been met.
Start: 11/01/2008

N508 = Alert: This real time claim
adjudication response represents the
the member responsibility to the
provider for services reported. The
member will receive an Explanation of
Benefits electronically or in the mail.
Contact the insurer if there are any
questions.
Start: 11/01/2008

N509 = Alert: A current inquiry shows the
member's Consumer Spending Account
contains sufficient funds to cover the
member liability for this claim/service.

Actual payment from the Consumer
Spending Account will depend on the
availability of funds and determination
of eligible services at the time of
payment processing.
Start: 11/01/2008

N510 = Alert: A current inquiry shows the
members Consumer Spending Account does
not contain sufficient funds to cover
the member's liability for this
claim/service. Actual payment from the
Consumer Spending Account will depend on
the availability of funds and
determination of eligible services at
the time of payment processing.
Start: 11/01/2008

N511 = Alert: Information on the availability
of Consumer Spending Account funds to
cover the member liability on this
claim/service is not available at this
time.
Start: 11/01/2008

N512 = Alert: This is the initial remit of a
non-NCPDP claim originally submitted
real-time without change to the
adjudication.
Start: 11/01/2008

N513 = Alert: This is the initial remit of a
non-NCPDP claim originally submitted
real-time with a change to the
adjudication.
Start: 11/01/2008

N514 = Consult plan benefit
documents/guidelines for information
about restrictions for this service.
Start: 11/01/2008
Stop: 01/01/2011
Notes: Consider using N130

N515 = Alert: Submit this claim to the
patient's other insurer for potential
payment of supplemental benefits. We did
not forward the claim information. (use
N387 instead)
Start: 11/01/2008
Stop: 10/1/2009

N516 = Records indicate a mismatch between the
submitted NPI and EIN.
Start: 03/01/2009

N517 = Resubmit a new claim with the requested
information.
Start: 03/01/2009

N518 = No separate payment for accessories
when furnished for use with oxygen
equipment.

Start: 03/01/2009
N519 = Invalid combination of HCPCS modifiers.
Start: 07/01/2009
N520 = Alert: Payment made from a Consumer
Spending Account.
Start: 07/01/2009
N521 = Mismatch between the submitted provider
information and the provider information
stored in our system.
Start: 11/01/2009
N522 = Duplicate of a claim processed, or to
be processed, as a crossover claim.
Start: 11/01/2009
N523 = The limitation on outlier payments
defined by this payer for this service
period has been met. The outlier payment
otherwise applicable to this claim has
not been paid.
Start: 03/01/2010
N524 = Based on policy this payment
constitutes payment in full.
Start: 03/01/2010
N525 = These services are not covered when
performed within the global period of
another service.
Start: 03/01/2010
N526 = Not qualified for recovery based on
employer size.
Start: 03/01/2010
N527 = We processed this claim as the primary
payer prior to receiving the recovery
demand.
Start: 03/01/2010
N528 = Patient is entitled to benefits for
Institutional Services only.
Start: 03/01/2010
N529 = Patient is entitled to benefits for
Professional Services only.
Start: 03/01/2010
N530 = Not Qualified for Recovery based on
enrollment information.
Start: 03/01/2010 |
N531 = Not qualified for recovery based on
direct payment of premium.
Start: 03/01/2010
N532 = Not qualified for recovery based on
disability and working status.
Start: 03/01/2010
N533 = Services performed in an Indian Health
Services facility under a self-insured
tribal Group Health Plan.
Start: 07/01/2010
N534 = This is an individual policy, the
employer does not participate in plan

sponsorship.
Start: 07/01/2010

N535 = Payment is adjusted when procedure is
performed in this place of service based
on the submitted procedure code and
place of service.
Start: 07/01/2010

N536 = We are not changing the prior payer's
determination of patient responsibility,
which you may collect, as this service
is not covered by us.
Start: 07/01/2010

N537 = We have examined claims history and no
records of the services have been found.
Start: 07/01/2010

N538 = A facility is responsible for payment
to outside providers who furnish these
services/supplies/drugs to its
patients/residents.
Start: 07/01/2010

N539 = Alert: We processed appeals/waiver
requests on your behalf and that request
has been denied.
Start: 07/01/2010

N540 = Payment adjusted based on the
interrupted stay policy.
Start: 11/01/2010

N541 = Mismatch between the submitted
insurance type code and the information
stored in our system.
Start: 11/01/2010

N542 = Missing income verification.
Start: 03/08/2011

N543 = Incomplete/invalid income verification
Start: 03/08/2011

N544 = Alert: Although this was paid, you have
billed with a referring/ordering
provider that does not match our system
record. Unless, corrected, this will not
be paid in the future.
Start: 07/01/2011

N545 = Payment reduced based on status as an
unsuccessful eprescriber per the
Electronic Prescribing (eRx) Incentive
Program.
Start: 07/01/2011

N546 = Payment represents a previous reduction
based on the Electronic Prescribing
(eRx) Incentive Program.
Start: 07/01/2011

N547 = A refund request (Frequency Type Code
8) was processed previously.
Start: 03/06/2012

N548 = Alert: Patient's calendar year

deductible has been met.
Start: 03/06/2012

N549 = Alert: Patient's calendar year out-of-
pocket maximum has been met.
Start: 03/06/2012

N550 = Alert: You have not responded to
requests to revalidate your
provider/supplier enrollment
information. Your failure to revalidate
your enrollment information will result
in a payment hold in the near future.
Start: 03/06/2012

N551 = Payment adjusted based on the
Ambulatory
Surgical Center (ASC) Quality Reporting
Program.
Start: 03/06/2012

N552 = Payment adjusted to reverse a previous
withhold/bonus amount.
Start: 03/06/2012

N553 = Payment adjusted based on a Low Income
Subsidy (LIS) retroactive coverage or
status change.
Start: 03/06/2012
Stop: 11/1/2012

N554 = Missing/Incomplete/Invalid Family
Planning Indicator
Start: 07/01/2012

N555 = Missing medication list.
Start: 07/01/2012

N556 = Incomplete/invalid medication list.
Start: 07/01/2012

N557 = This claim/service is not payable under
our service area. The claim must be
filed to the Payer/Plan in whose service
area the specimen was collected.
Start: 07/01/2012

N558 = This claim/service is not payable under
our service area. The claim must be
filed to the Payer/Plan in whose service
area the equipment was received.
Start: 07/01/2012

N559 = This claim/service is not payable under
our service area. The claim must be
filed to the Payer/Plan in whose service
area the Ordering Physician is located.
Start: 07/01/2012

N560 = The pilot program requires an interim or
final claim within 60 days of the Notice
of Admission. A claim was not received.
Start: 11/01/2012

N561 = The bundled claim originally submitted
for this episode of care includes
related readmissions. You may resubmit

the original claim to receive a
corrected payment based on this
readmission.
Start: 11/01/2012

N562 = The provider number of your incoming
claim does not match the provider number
on the processed Notice of Admission
(NOA) for this bundled payment.
Start: 11/01/2012

N563 = Missing required provider/supplier
issuance of advance patient notice of
non-coverage. The patient is not liable
for payment for this service.
Start: 11/01/2012
Notes: Related to M39

N564 = Patient did not meet the inclusion
criteria for the demonstration project
or pilot program.
Start: 11/01/2012

N565 = Alert: This procedure code requires a
modifier. Future claims containing this
procedure code must include an
appropriate modifier for the claim to be
processed.
Start: 11/01/2012

N566 = Alert: This procedure code requires
functional reporting. Future claims
containing this procedure code must
include an applicable non-payable code
and appropriate modifiers for the claim
to be processed.
Start: 11/01/2012

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 = Speech Language Pathologists
15 = Obstetrics (osteopaths only)
   (discontinued 5/92 use code 16)
16 = Obstetrics/gynecology
17 = Hospice and Palliative Care
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 = Cardiac Electrophysiology
21 = Pathologic anatomy, clinical
   pathology (osteopaths only)
   (discontinued 5/92 use code 22)
22 = Pathology
23 = Sports medicine
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 = Geriatric Psychiatry Colorectal Surgery
27 = Psychiatry, neurology (osteopaths
   only) (discontinued 5/92 use code 86)
28 = Colorectal surgery (formerly
   proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Intensive Cardiac Rehabilitation
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 Facilites
     (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)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized Flu
C4 = Non-Provider Convener Participants in the BPCI Advanced
   Model (eff. 7/2019)
C5 = Dentist (eff. 7/2016)
D5 = Opiod Treatment Progrm (eff. 1/2020)

CMS_TYPE_SRVC_TB   CMS Type of Service Table

1 = Medical care
2 = Surgery
3 = Consultation
4 = Diagnostic radiology
5 = Diagnostic laboratory
6 = Therapeutic radiology
7 = Anesthesia
8 = Assistant at surgery
9 = Other medical items or services
0 = Whole blood only eff 01/96,
   whole blood or packed red cells before 01/96
A = Used durable medical equipment (DME)
B = High risk screening mammography
   (obsolete 1/1/98)
C = Low risk screening mammography
   (obsolete 1/1/98)
D = Ambulance (eff 04/95)
E = Enteral/parenteral nutrients/supplies
   (eff 04/95)
F = Ambulatory surgical center (facility

usage for surgical services)
G = Immunosuppressive drugs
H = Hospice services (discontinued 01/95)
I = Purchase of DME (installment basis)
    (discontinued 04/95)
J = Diabetic shoes (eff 04/95)
K = Hearing items and services (eff 04/95)
L = ESRD supplies (eff 04/95)
    (renal supplier in the home before 04/95)
M = Monthly capitation payment for dialysis
N = Kidney donor
P = Lump sum purchase of DME, prosthetics,
    orthotics
Q = Vision items or services
R = Rental of DME
S = Surgical dressings or other medical supplies
    (eff 04/95)
T = Psychological therapy (term. 12/31/97)
    outpatient mental health limitation (eff. 1/1/98)
U = Occupational therapy
V = Pneumococcal/flu vaccine (eff 01/96),
    Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),
    Pneumococcal only before 04/95
W = Physical therapy
Y = Second opinion on elective surgery
    (obsoleted 1/97)
Z = Third opinion on elective surgery
    (obsoleted 1/97)

CTGRY_EQTBL_BENE_IDENT_TB   Category Equatable Beneficiary Identification Code (BIC) Table

  NCH BIC   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

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)
75 - California
76 - Iowa
77 - Minnesota
78 - Illinois
79 - Missouri
80 = Maryland (eff. 8/2000)
96 = New Mexico
97 = Texas
98 = Hawaii
99 = With 000 county code is AS (American Samoa);
       otherwise - unknown
A0 = California (eff. 4/2019)
A1 = California (eff. 4/2019)
A2 = Florida (eff. 4/2019)
A3 = Louisianna (eff. 4/2019)
A4 = Michigan (eff. 4/2019)
A5 = Mississippi (eff. 4/2019)
A6 = Ohio (eff. 4/2019)
A7 = Pennsylvania (eff. 4/2019)
A8 = Tennessee (eff. 4/2019)
A9 = Texas (eff. 4/2019)
B0 = Kentucky (eff. 4/2020)
B1 = West Virginia (eff. 4/2020)
B2 = California (eff. 4/2020)

GEO_STATE_TB   Geographic 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 = Asia
56 = Canada
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 = Northern Marianas
70 = U.S. Possession

```
71 = Foreign (Not U.S.)
97 = Northern Marianas
99 = Unknown
```

LINE_ADDTNL_CLM_DCMTN_IND_TB   Line Additional Claim Documentation Indicator Table

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

LINE_CNSLDTD_BLG_TB   Line Consolidated Billing Indicator Table

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

LINE_DGNS_VRSN_TB   Line Diagnosis Version Code Table

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

LINE_DUP_CLM_CHK_IND_TB   Line Duplicate Claim Check Indicator Table

```
1= Suspect duplicate review performed
```

LINE_HCT_HGB_TYPE_TB   Line Hematocrit/Hemoglobin Test Type Code

```
R1 = Hemoglobin Test
R2 = Hematocrit Test
```

LINE_PLC_SRVC_TB   Line Place Of Service Table

01 = Pharmacy (eff. 10/1/05)
03 = School (eff. 1/1/03
04 = Homeless Shelter (eff. 1/1/03)
09 = Prison/correctional facility setting
   (eff. 10/2006)
11 = Office
12 = Home
13 = Assisted Living Facility (eff. 10/1/2003)
14 = Group Home (eff. 10/1/2003)
15 = Mobile Unit (eff. 1/1/03)
18 = Place of Employment/Worksite
20 = Urgent Care Facility (eff. 1/1/03)
21 = Inpatient hospital
22 = Outpatient hospital
23 = Emergency room - hospital
24 = Ambulatory surgical center
25 = Birthing center
26 = Military treatment facility
31 = Skilled nursing facility
32 = Nursing facility
33 = Custodial care facility
34 = Hospice
35 = Adult living care facilities (ALCF)
   (eff. NYD - added 12/3/97)
41 = Ambulance - land
42 = Ambulance - air or water
49 = Independent Care (eff. 10/1/2003)
50 = Federally qualified health centers
   (eff. 10/1/93)
51 = Inpatient psychiatric facility
52 = Psychiatric facility partial hospitalization
53 = Community mental health center
54 = Intermediate care facility/mentally
   retarded
55 = Residential substance abuse treatment
   facility
56 = Psychiatric residential treatment
   center
57 = Non-residential substance abuse treatment
   facility (eff. 10/1/2003)
58 = Non-residential OPIOD treatment facility
   (eff. 1/2020)
60 = Mass immunizations center (eff. 9/1/97)
61 = Comprehensive inpatient rehabilitation
   facility
62 = Comprehensive outpatient rehabilitation
   facility
65 = End stage renal disease treatment facility
71 = State or local public health clinic
72 = Rural health clinic
81 = Independent laboratory
99 = Other unlisted facility

LINE_PMT_80_100_TB   Line Payment 80%/100% Table

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

LINE_PRCSG_IND_TB   Line Processing Indicator Table

   A = Allowed
   B = Benefits exhausted
   C = Noncovered care
   D = Denied (existed prior to 1991; from
      BMAD)
   E = MSP Cost Avoided - First Claim Development
   F = MSP Cost Avoided - Trauma Code Development
   G = MSP Cost Avoided - Secondary Claims Investigation
   H = MSP Cost Avoided - Self Reports
   I = Invalid data
   J = MSP Cost Avoided - 411.25
   K = MSP Cost Avoided - Insurer Voluntary Reporting
   L = CLIA (eff 9/92)
   M = Multiple submittal--duplicate line item
   N = Medically unnecessary
   O = Other
   P = Physician ownership denial (eff 3/92)
   Q = MSP cost avoided (contractor #88888) -
      voluntary agreement (eff. 1/98)
   R = Reprocessed--adjustments based on
      subsequent reprocessing of claim
   S = Secondary payer
   T = MSP cost avoided - IEQ contractor
      (eff. 7/76)
   U = MSP cost avoided - HMO rate cell
      adjustment (eff. 7/96)
   V = MSP cost avoided - litigation
      settlement (eff. 7/96)
   X = MSP cost avoided - generic
   Y = MSP cost avoided - IRS/SSA data
      match project
   Z = Bundled test, no payment
      (eff. 1/1/98)
   00 = MSP cost avoided - COB Contractor
   12 = MSP cost avoided - BC/BS Voluntary Agreements
   13 = MSP cost avoided - Office of Personnel Management
   14 = MSP cost avoided - Workman's Compensation (WC) Datamatch
   15 = MSP cost avoided - Workman's Compensation Insurer Voluntary
      Data Sharing Agreements (WC VDSA) (eff. 4/2006)
   16 = MSP cost avoided - Liability Insurer VDSA (eff.4/2006)
   17 = MSP cost avoided - No-Fault Insurer VDSA (eff.4/2006)
   18 = MSP cost avoided - Pharmacy Benefit Manager Data Sharing

Agreement (eff.4/2006)
19 = MSP cost avoided - Worker's Compensation Set Aside
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)
39 = MSP cost avoided - Group Health Plan Recovery
41 = MSP cost avoided - Next Generation Desktop
42 = MSP cost avoided - Non Group Health Plan ORM
43 = MSP cost avoided - COBC Medicare Part C/Medicare Advantage

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

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

LINE_PRIOR_AUTHRZTN_TB   Line Prior Authorization Indicator Table

A = Part A
B = Part B
D = DME
H = Home Health and Hospice

+ 3 digit number

LINE_PRVDR_PRTCPTG_IND_TB   Line Provider Participating Indicator Table

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

LINE_PWK_TB   Line 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

LINE_RNDRNG_BLG_NPI_ASCTN_TB   Line Rendering Billing NPI Association Code Table

   Y = The rendering provider NPI is a member of the group prac-
         tice billing NPI on the claim.

   N = The rendering provider NPI is not associated with the
         billing provider NPI.

   Blank = For historical claims where there is no billing provider
             NPI available.

LINE_SRVC_DDCTBL_IND_TB   Line Service Deductible Indicator Switch Code Table

   0 = SERVICE SUBJECT TO DEDUCTIBLE

1 = SERVICE NOT SUBJECT TO DEDUCTIBLE

LINE_THRPY_CAP_IND_CD_TB   Line Therapy CAP Indicator Code Table

A = Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator will be used on institutional claims only).

B = Critical Access Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator will be used on institutional claims only). Note: Currently, Critical Access Hospital claims are not subject to any therapy cap policies. Indicator B is created here to prepare for possible future legislation to include these claims.

C = The therapy cap exceptions process, as indicated by the submission of the KX modifier, no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

D = The $3700 threshold for review therapy services no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

LINE_VLNTRY_SRVC_IND_TB   Line Voluntary Service Indicator Table

V = A voluntary procedure code
Blank = A required procedure code

LINE_WC_IND_TB   Workers' Compensation Indicator Code

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

Spaces

MCO_OPTN_TB   MCO Option Table

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

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

NCH_CLM_BIC_MDFY_TB   NCH Claim BIC Modify H Code Table

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

NCH_CLM_TYPE_TB   NCH Claim Type Table

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

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

NCH_DEMO_TRLR_IND_TB   NCH Demonstration Trailer Indicator Table

   D = Demo trailer present

NCH_DGNS_TRLR_IND_TB   NCH Diagnosis Trailer Indicator Table

   Y = Diagnosis code trailer present

NCH_EDIT_DISP_TB   NCH Edit Disposition Table

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

NCH_EDIT_TB   NCH EDIT TABLE

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

D5X8 = (C) TWO ANTI-EMETIC DRUGS PRESENT ON SAME CLAIM
        WITH IDENTICAL DATES OF SERVICE.
D6X1 = (C) DME SUPPLIER NUMBER MISSING
D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1
D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6
D922 = (C) THERAPEUTIC SHOE CODES 'A5505-A5501'
        W/MODIFIER 'LT' OR 'RT' MUST HAVE
        UNITS = '001'
XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1
Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
Y003 = (C) HCPCS R0075/UNITS=SERVICES
Y010 = (C) TOB=13X/14X AND T.C.>$7,500
Y011 = (C) INP CLAIM/REIM > $350,000
Z001 = (C) RVNU 820-859 REQ COND CODE 71-76
Z002 = (C) CC M2 PRESENT/REIMB > $150,000
Z003 = (C) CC M2 PRESENT/UNITS > 150
Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX
Z005 = (C) REIMB>99999 AND REIMB<150000
Z006 = (C) UNITS>99 AND UNITS<150
Z007 = (C) TOB VS TOTAL CHARGE
Z008 = (C) TOB VS TOTAL CHARGE W/O 20/21
        CONDITION CODE
Z237 = (E) HOSPICE OVERLAP - DATE ZERO
0011 = (C) ACTION CODE INVALID
0012 = (C) IME/GME CLAIM -- '04' OR '69'
        CONDITION CODE
0013 = (C) CABG/PCOE/MPPD AND INVALID ADMIT DATE
0014 = (C) DEMO NUM INVALID
0015 = (C) ESRD PLAN VS DEMO NUM
0016 = (C) INVALID VA CLAIM
0017 = (C) DEMO=38 W/O CONTRACTOR #80881/80882
0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
0019 = (C) DEMO 07/08 WITH CONDITION CODE B1
0020 = (C) CANCEL ONLY CODE INVALID
0021 = (C) DEMO COUNT > 1
0022 = (C) TOB '32X' OR '33X' W/DATES OF SERVICE >9/30/00
        AND HAS CANCEL ONLY CODE OTHER THAN A,B,E,F
0023 = (C) DEMO '46' AND HCPCS INCONSISTENT
0301 = (C) INVALID HI CLAIM NUMBER
0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK
04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)
04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
0401 = (C) BILL TYPE/PROVIDER INVALID
0402 = (C) BILL TYPE/REV CODE/PROVR RANGE
0403 = (C) TOB '41X'/PRVDR # 1990-1999) OR TOB '51X'/
        PRVDR #6990-6999, TRANS CODE SHOULD BE
        '0' OR '3'
0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092 OR SEX NOT F
0407 = (C) RESPITE CARE BILL TYPE NOT 34X,NO REV 66
0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974
041A = (C) TOB '11A' OR '11D' AND DEMO #'07' OR '08'
        NOT PRESENT

0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636
0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES
0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS
0414 = (C) VALU CD 61,MSA AMOUNT MISSING
0415 = (C) HOME HEALTH INCORRECT ALPHA RIC
0416 = (C) REVENUE CENTER '0022', TOB MUST BE
       '18X' OR '21X'
0417 = (C) REVENUE CENTER '0023', TOB MUST BE '32X'
       OR '33X'
0418 = (C) HHA--TOB '3X5' AND DATES OF SERVICE
       >9/30/00
0419 = (C) HHA--RIC 'W' MUST HAVE VALUE CODE '63'/
       RIC 'V' MUST HAVE VALUE CODE '62' AND
       RIC 'U' MUST HAVE VALUE CODES '62' AND
       '63' PRESENT FOR DATES OF SERVICE >
       9/30/00.
0420 = (C) HHA W/O REVENUE CODE '0023'
0421 = (C) START DATE MISSING
0422 = (C) COB VS. OVERRIDE CODE
05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE
05X5 = (C) UPIN REQUIRED FOR DME
0501 = (C) REFFERING UPIN REQUIRED FOR CLINICAL LAB
0502 = (C) REFERRING UPIN INVALID
0601 = (C) GENDER INVALID
0701 = (C) CONTRACTOR/POS 1-2 PROVIDER NUM INVALID
0702 = (C) PROVIDER NUMBER VS. TOB
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
0704 = (C) INVALID CONT FOR CABG DEMO
0705 = (C) INVALID CONT FOR PCOE DEMO
0706 = (C) REVENUE CENTER CODE MAMMOGRAPHY AND
       BENEFICIARY <35
0901 = (C) INVALID DISP CODE OF 02
0902 = (C) INVALID DISP CODE OF SPACES
0903 = (C) INVALID DISP CODE
1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE
13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
1301 = (C) LINE COUNT NOT NUMERIC OR > 13
1302 = (C) RECORD LENGTH INVALID
1401 = (C) INVALID MEDICARE STATUS CODE
1501 = (C) ADMIT DATE/START DATE/ENTRY CODE INVALID
1502 = (C) ADMIT DATE/START CARE DATE > STAY FROM DATE
1503 = (C) ADMIT DATE INVALID WITH THRU DATE
1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
1505 = (C) HCPCS W SERVICE DATES > 09-30-94
1601 = (C) INVESTIGATION IND INVALID
1701 = (C) SPLIT IND INVALID
1801 = (C) PAY-DENY CODE INVALID
1802 = (C) HEADER AMT/LINE ITEMS DENIED
1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME
1901 = (C) AB CROSSOVER IND INVALID
2001 = (C) HOSPICE OVERRIDE INVALID
2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
2102 = (C) PATIENT STATUS VS. TOB
2103 = (C) HIPPS RATE/CMG CODE VS. PATIENT STATUS

2201 = (C) FROM DATE/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) MULITIPLE PET SCANS W/O MODIFIER 26
        OR TC
3401 = (C) DEMO ID = 04 AND RIC NOT = 1 OR 2
34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN
34#3 = (C) CONDITION CODE = W0 AND DEMO NOT = 04
35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS
35X2 = (C) COND = 60 OR 61 AND NO VALU 17
35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0
35#3 = (C) (SECOND CONDITION) CONDITION CODE = C3
        REQUIRES SPAN CODE 76 OR 77
35#4 = (C) CONDITION CODE = 69 AND TOB NOT 11X
36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU
36#1 = (C) SURGICAL DATE = ZEROES OR < FROM OR >
        THRU DATES
3701 = (C) ASSIGN CODE INVALID
3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA
3706 = (C) INVALID IDE NUMBER-NOT IN FILE
3710 = (C) NUM OF IDE# > REV 0624
3715 = (C) NUM OF IDE# < REV 0624
3720 = (C) IDE AND LINE ITEM NUMBER > 2
3801 = (C) AMT BENE PD INVALID
3XA/ = (C) COLORECTAL/PROSTATE SCREENING BILLED
        MULTIPLE TIMES
4001 = (C) BLOOD PINTS FURNISHED INVALID
4002 = (C) BLOOD FURNISHED/REPLACED INVALID
4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
4201 = (C) BLOOD PINTS UNREPLACED INVALID
4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED
4203 = (C) INVALID CPO PROVIDER NUMBER
4301 = (C) BLOOD DEDUCTABLE INVALID
4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
4304 = (C) BLOOD DEDUCT > 3 - REPLACED

4501 = (C) PRIMARY DIAGNOSIS INVALID
4502 = (C) SERVICE DATES > CURRENT DATE
46#A = (C) MSP VET AND VET AT MEDICARE
46#B = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
46#C = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
46#G = (C) VALU CODE 20 INVALID
46#L = (C) BLOOD FURNISHED < BLOOD REPLACED
46#N = (C) VALUE CODE 37,38,39 INVALID
46#O = (C) VALUE CDE 37,38,39 AMOUNT NOT > 00
46#P = (C) BLD UNREP VS REV CDS AND/OR UNITS
46#Q = (C) VALUE CDE 37=39 AND 38 IS PRESENT
46#R = (C) BLD FIELDS VS REV CDE 380,381,382
46#S = (C) VALU CODE 39, AND 37 IS NOT PRESENT
46#T = (C) CABG/PCOE/MPPD,VC<>Y1,Y2,Y3,Y4,VA NOT>0
46#U = (C) MSP VALUES ON CABG/PCOE/MPPD (INP)
        TOB '32X'/'33X' MUST HAVE VALUE 62/64
        OR 63/65 (HHA)
46#V = (C) TOB '32X'/'33X' VISITS IN 62/63 NOT =
        REVENUE CODE 42X-44X, 55X-57X
46#W = (C) CONDITION CODE =30/78 AND WITH VALUE
        CODE = A1, B1, C1
46#1 = (C) VALUE AMOUNT INVALID
46#2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
46#3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
46#4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
46#5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
46#6 = (C) VALU 17 AND NO COND CODE 60 OR 61
46#7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
46#8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
4601 = (C) CABG/PCOE, MSP CODE PRESENT
4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
4604 = (C) DEMO = 03 WITH DATES OF SERVICE
        > 09/31/01
4901 = (C) PCOE/CABG,DEN CD NOT D
4902 = (C) PCOE/CABG BUT DME
50#1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
50#2 = (C) REV CD=054X,MOD NOT = QM,QN
5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
51#A = (C) HCPCS EYEWARE & REV CODE NOT 274
51#C = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51#D = (C) HCPCS REQUIRES UNITS > ZERO
51#E = (C) HCPCS REQUIRES REVENUE CODE 636/294
51#F = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51#G = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
51#H = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044
51#I = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045
51#J = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
51#K = (C) TOB 21X/P82=2/3/4,REV CD = NNX
51#L = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83
51#M = (C) 21X,RC>9041/<9045,RC<>4/234

51#N = (C) 21X,RC>9032/<9042,RC<>4/234
51#O = (C) TWO ANTI-EMETIC/ANTI-CANCER DRUGS
     ON SAME CLAIM
51#P = (C) HHA/OUTPATIENT RC DATE OF SRVC MISSING
51#Q = (C) NO RC 0636 OR DTE INVALID
51#R = (C) DEMO ID=01,RIC NOT=2
51#S = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21
51#V = (C) TOB 72X W HCPCS 'J1955' MISSING REVENUE
     CENTER 636
51#W = (C) TOB 12X, 13X, 22X, 23X, 34X, 74X, 75X,
     83X, HCPCS '97504', '97116', PRESENT
     ON SAME DAY
51#X = (C) TOB '32X-34X' REQUIRE HCPCS FOR REVENUE
     CODE '29X', '60X', '636'
51X0 = (C) REV CENTER CODE INVALID
51X1 = (C) REV CODE CHECK
51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
51X3 = (C) UNITS MUST BE > 0
51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR
51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
51X9 = (C) HCPCS/REV CODE/BILL TYPE
5100 = (U) TRANSITION SPELL / SNF
5160 = (U) LATE CHG HSP BILL STAY DAYS > 0
5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT
5168 = (E) CLAIM IN HOSPICE WITH 2ND START DATE
     PRESENT
5169 = (U) PROVIDER NE TO WORK PROVIDER
5170 = (E) OCCURRENCE CODE = 42 AND < DOLBA
5177 = (U) PROVIDER NE TO WORK PROVIDER
5178 = (U) HOSPICE BILL THRU < DOLBA
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
5200 = (E) ENTITLEMENT EFFECTIVE DATE
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
5202 = (U) HOSPICE TRAILER ERROR
5203 = (E) ENTITLEMENT HOSPICE PERIODS
5203 = (U) HOSPICE START DATE ERROR
5204 = (U) HOSPICE DATE DIFFERENCE NE 90
5205 = (U) HOSPICE DATE DISCREPANCY
5206 = (U) HOSPICE DATE DISCREPANCY
5207 = (U) HOSPICE THRU > TERM DATE 2ND
5208 = (U) HOSPICE PERIOD NUMBER BLANK
5209 = (U) HOSPICE DATE DISCREPANCY
5210 = (E) ENTITLEMENT FRM/TRU/END DATES
5211 = (E) ENTITLEMENT DATE DEATH/THRU
5212 = (E) ENTITLEMENT DATE DEATH/THRU
5213 = (E) ENTITLEMENT DATE DEATH MBR
5220 = (E) ENTITLEMENT FROM/EFF DATES
5225 = (E) ENT INP PPS SPAN 70 DATES
5232 = (E) ENTL HMO NO HMO OVERRIDE CDE

5233 = (E) ENTITLEMENT HMO PERIODS
5234 = (E) ENTITLEMENT HMO NUMBER NEEDED
5235 = (E) ENTITLEMENT HMO HOSP+NO CC07
5236 = (E) ENTITLEMENT HMO HOSP + CC07
5237 = (E) ENTITLEMENT HOSP OVERLAP
5238 = (U) HOSPICE CLAIM OVERLAP > 90
5239 = (U) HOSPICE CLAIM OVERLAP > 60
524Z = (E) HOSP OVERLAP NO OVD NO DEMO
5240 = (U) HOSPICE DAYS STAY+USED > 90
5241 = (U) HOSPICE DAYS STAY+USED > 60
5242 = (C) INVALID CARRIER FOR RRB
5243 = (C) HMO=90091,INVALID SERVICE DTE
5244 = (E) DEMO CABG/PCOE MISSING ENTL
5245 = (C) INVALID CARRIER FOR NON RRB
525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO
5250 = (U) HOSPICE DOEBA/DOLBA
5255 = (U) HOSPICE DAYS USED
5256 = (U) HOSPICE DAYS USED > 999
526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0
526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0
5270 = (C) CONDITION CODE = 30 AND HMO REQUIRES
        MODIFIER = 'QV' OR 'KZ'/DED IND
5271 = (C) RISK HMO NOT PRESENT AND MOD 'KZ'/
        OR CONDITION CODE 78 PRESENT
527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0
527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
5299 = (U) HOSPICE PERIOD NUMBER ERROR
52#K = (C) HCPCS VS DIAGNOSIS
52#L = (C) HCPCS VS MODIFIER
52#M = (C) HCPCS VS DATES OF SERVICE
52#N = (C) TOB '71X' OR '73X' WITH REVENUE
        CENTER CODE 0403 MISSING REVENUE
        CENTER CODE 0521
52#O = (C) REVENUE CENTER CODE 0022/0024 WITH
        CHARGES >0
52#P = (C) REVENUE CENTER CODE 010X-021X MINUS
        18X <> 0022
52#Q = (C) REVENUE CENTER CODE 0022 AND HIPPS
        MISSING
52#R = (C) REVENUE CENTER CODE 0022 MISSING DATE
        OF SERVICE
52#T = (C) REVENUE CENTER CODE 0022 MISSING REVENUE
        CENTER CODE 042X-044X
5320 = (U) BILL > DOEBA AND IND-1 = 2
5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
5355 = (U) HOSPICE DAYS USED SECONDARY
5362 = (C) MAMMOGRAPHY AND BENE <35
5378 = (C) SERVICE DATE < AGE 50
5379 = (C) HCPCS 'G0160' PRESENT MORE THAN
        ONCE
5381 = (C) HCPCS 'G0161' PRESENT MORE THAN
        ONCE
5382 = (C) HCPCS 'G0102-03' AND BENE <50
538Q = (C) SERVICE DATES WITHIN ALIEN RECORD

5397 = (C) DEMO '37' AND NOT CAT 74
5398 = (C) HCPCS 'G9001-G9005 & G9009-G9011 >1
        OR 2 ARE PRESENT
5399 = (U) HOSPICE PERIOD NUM MATCH
539A = (C) HCPCS 'G9008' PRESENT MORE THAN ONCE
539C = (C) HCPCS 'G9013-G9015' PRESENT MORE THAN
        ONCE OR 2 PRESENT
5410 = (U) INPAT DEDUCTABLE
5425 = (U) PART B DEDUCTABLE CHECK
5430 = (U) PART B DEDUCTABLE CHECK
5450 = (U) PART B COMPARE MED EXPENSE
5460 = (U) PART B COMPARE MED EXPENSE
5499 = (U) MED EXPENSE TRAILER MISSING
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS
5510 = (U) COIN DAYS/SNF COIN DAYS
5515 = (U) FULL DAYS/COIN DAYS
5516 = (U) SNF FULL DAYS/SNF COIN DAYS
5520 = (U) LIFE RESERVE DAYS
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS
5540 = (U) HH VISITS NE AFT PT B TRLR
5550 = (E) SNF LESS THAN PT A EFF DATE
5600 = (D) LOGICAL DUPE, COVERED
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123
5602 = (D) LOGICAL DUPE, PANDE C, E OR I
5603 = (D) LOGICAL DUPE, COVERED
5604 = (D) LOGICAL DUPE, DATES
5605 = (D) POSS DUPE, OUTPAT REIMB
5606 = (D) POSS DUPE, HOME HEALTH COVERED U
5623 = (U) NON-PAY CODE IS P
57X1 = (C) PROVIDER SPECIALITY CODE INVALID
57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL
57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND
57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID
57X5 = (C) HCPCS 98940-2 MODIFIER NOT = 'AT'
5700 = (U) LINKED TO THREE SPELLS
5701 = (C) DEMO ID=02,RIC NOT = 5
5702 = (C) DEMO ID=02,INVALID PROVIDER NUM
58X1 = (C) PROVIDER TYPE INVALID
58X9 = (C) TYPE OF SERVICE INVALID
5802 = (C) REIMB > $150,000
5803 = (C) UNITS/VISITS > 150
5804 = (C) UNITS/VISITS > 99
5805 = (C) OUTPATIENT CHARGE > $150,000
5806 = (C) REVENUE CENTER CODE '042X-044X'
        WITHOUT MODIFIER 'GN-GP'
58#4 = (C) REVENUE CENTER CODE MISSING REQUIRED
        HCPCS OR MODIFIER
59XA = (C) PROST ORTH HCPCS/FROM DATE
59XB = (C) HCPCS/FROM DATE/TYPE P OR I
59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE
59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE
59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS
59XG = (C) INVALID TOS FOR DME
59XH = (C) HCPCS E0620/TYPE/DATE

59XI = (C) HCPCS E0627-9/ DATE < 1991
59XJ = (C) GLOBAL HCPCS TOS MUST = 2
59XK = (C) HCPCS PEN PUMP AND TOS <>9
59XL = (C) HCPCS 00104 - TOS/POS
59X1 = (C) INVALID HCPCS/TOS COMBINATION
59X2 = (C) ASC IND/TYPE OF SERVICE INVALID
59X3 = (C) TOS INVALID TO MODIFIER
59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB
59X5 = (C) MAMMOGRAPHY FOR MALE
59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS
59X7 = (C) CAPPED-HCPCS/FROM DATE
59X8 = (C) FREQUENTLY MAINTAINED HCPCS
59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R
5901 = (U) ERROR CODE OF Q
5A#1 = (C) DEMO=37, UNITS >1 FOR 'G9001-05'
        'G9007-11', G9013-G9015'
60X1 = (C) ASSIGN IND INVALID
6000 = (U) ADJUSTMENT BILL SPELL DATA
6020 = (U) CURRENT SPELL DOEBA < 1990
6030 = (U) ADJUSTMENT BILL SPELL DATA
6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA
61X1 = (C) PAY PROCESS IND INVALID
61X2 = (C) DENIED CLAIM/NO DENIED LINE
61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
61X4 = (C) RATE MISSING OR NON-NUMERIC
61#E = (C) PROVIDER PAYMENT INCONSISTENCIES
61#F = (C) BENEFICIARY PAYMENT INCONSISTENCIES
61#G = (C) PATIENT RESPONSIBILITY INCONSISTENCIES
61#H = (C) MEDICARE PAYMENT INCONSISTENCIES
61#I = (C) LINE DATE OF SERVICE < FROM DATE
        > THRU DATE
61#J = (C) DUPLICATE HCPCS CODE '55873'
61#K = (C) HCPCS 'G0117-8' >2 OR BOTH PRESENT
61#L = (C) REVENUE CENTER CODE 0024 > 2
61#M = (C) REVENUE CENTER CODE 0024 VS PROVIDER
        NUMBER
61#N = (C) REVENUE CENTER CODE 0024 REQUIRES
        VALID HIPPS RATE CMG CODE
61#R = (C) HCPCS/TOB/REVENUE CENTER CODE
61#S = (C) HCPCS 'G0247' REQUIRES 'G0245-6' TO
        BE COVERED
61#T = (C) HCPCS CODE '0245-0246' PRESENT MULTIPLE
        TIMES
61#0 = (C) REVENUE CENTER CODE VS SPAN CODE '74'
61#6 = (C) PAYMENT METHOD INVALID
61#7 = (C) ANSI CODE MISSING
61#8 = (C) BLOOD CASH DEDUCTIBLE INCONSISTENCIES
61#9 = (C) CASH DEDUCTIBLE INCONSISTENCIES
6100 = (C) REV 0001 NOT PRESENT ON CLAIM
6101 = (C) REV COMPUTED CHARGES NOT=TOTAL
6102 = (C) REV COMPUTED NON-COVERED/NON-COV
6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER
6105 = (C) REVE CODE 0001 > 1
6106 = TOB 3X2 REVENUE CENTER CODE 0023 NOT =

TOTAL CHARGE
6109 = (C) REIMBURSEMENT > 4 OR 6 TIMES
62XA = (C) PSYC OT PT/REIM/TYPE
62XC = (C) DEMO 37 WITH REIMBURSEMENT/DED IND
   <>1
62X1 = (C) DME/DATE/100% OR INVAL REIMB IND
62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED
62X8 = (C) KIDNEY DONO/TYPE/100%
62X9 = (C) PNEUM VACCINE/TYPE/100%
6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV
6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE
6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA
6260 = (U) HOSPICE ADJUSTMENT STAY DAYS
6261 = (U) HOSPICE ADJUSTMENT DAYS USED
6265 = (U) HOSPICE ADJUSTMENT DAYS USED
6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)
63X1 = (C) DEDUCT IND INVALID
63X2 = (C) DED/HCFA COINS IN PCOE/CABG
6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS
6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)
64X1 = (C) PROVIDER IND INVALID
6430 = (U) PART B DEDUCTABLE CHECK
65X1 = (C) PAYSCREEN IND INVALID
66?? = (D) POSS DUPE, CR/DB, DOC-ID
66XX = (D) POSS DUPE, CR/DB, DOC-ID
66X1 = (C) UNITS AMOUNT INVALID
66X2 = (C) UNITS IND > 0; AMT NOT VALID
66X3 = (C) UNITS IND = 0; AMT > 0
66X4 = (C) MT INDICATOR/AMOUNT
66X7 = (C) DEMO 37/HCPCS/UNITS
6600 = (U) ADJUSTMENT BILL FULL DAYS
6610 = (U) ADJUSTMENT BILL COIN DAYS
6620 = (U) ADJUSTMENT BILL LIFE RESERVE
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
67X1 = (C) UNITS INDICATOR INVALID
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0
67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS
68XA = (C) HCPCS G0117-8 >1 OR BOTH PRESENT
68XB = (C) HCPCS CODE G0245-46 > 1
68X1 = (C) INVALID HCPCS CODE
68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092
68X3 = (C) TYPE OF SERVICE = G /PROC CODE
68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE
68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC
68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC
68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.
68X8 = (C) ANTI-EMETIC WITHOUT ANTI-CANCER DRUG
6812 = (C) DEMO 37 WITH PRIMARY PAYER CODE

69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
69XB = (C) HCPCS CODE 97504/97116 PRESENT ON
        SAME DAY
69XC = (C) HCPCS CODE VS PAY PROCESS INDICATOR
69X3 = (C) PROC CODE MOD = LL / TYPE = R
69X6 = (C) PROC CODE MOD/NOT CAPPED
69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL
69X9 = (C) NURSE PRACTITIONER, MOD INVALID
6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO
6902 = (C) KRON IND AND NO-PAY CODE B OR N
6903 = (C) KRON IND AND INPATIENT DEDUCT = 0
6904 = (C) KRON IND AND TRANS CODE IS 4
6910 = (C) REV CODES ON HOME HEALTH
6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY
6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO
6913 = (C) REV CODE INVAL FOR OXYGEN
6914 = (C) REV CODE INVAL FOR DME
6915 = (C) PURCHASE OF RENT DME INVAL ON DATES
6916 = (C) PURCHASE OF RENT DME INVAL ON DATES
6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000
6918 = (C) HCPCS INVALID ON DATE RANGES
6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89
6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33
6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X
6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274
6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291
6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL
6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X
6929 = (U) ADJUSTMENT BILL LIFE RESERVE
6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
7000 = (U) INVALID DOEBA/DOLBA
7002 = (U) LESS THAN 60/61 BETWEEN SPELLS
7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD
71X1 = (C) SUBMITTED CHARGES INVALID
71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG
71X3 = (C) HCPCS 76092 PAY INDICATOR <> A,R,S
        & 76085 PAY INDICATOR A,R,S
72X1 = (C) ALLOWED CHGS INVALID
72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
72X3 = (C) DENIED LINE/ALLOWED CHARGES
7230 = (C) FRAMES >1, LENSES >2
73X1 = (C) SS NUMBER INVALID
73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING
74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT
76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL
77X1 = (C) PLACE OF SERVICE INVALID
77X2 = (C) PHYS THERAPY/PLACE
77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE
77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND
77X6 = (C) TOS=F, PL OF SER NOT = 24
7701 = (C) INCORRECT MODIFIER
7777 = (D) POSS DUPE, PART B DOC-ID
78XA = (C) MAMMOGRAPHY BEFORE 1991
78XB = (C) ANTI-CANCER BEFORE 01/01/1998

78X1 = (C) FROM DATE IMPOSSIBLE
78X2 = (C) FROM DATE > CURRENT DATE OR
     < 07/01/1966
78X3 = (C) FROM DATE GREATER THAN THRU DATE
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY
78X5 = (C) FROM DATE > PAID DATE/TYPE/100%
78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE
79X1 = (C) THRU DATE IMPOSSIBLE
79X2 = (C) THRU DATE > CURRENT DATE
79X3 = (C) THRU DATE>RECD DATE/NOT DENIED
79X4 = (C) THRU DATE>PAID DATE/NOT DENIED
8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90
8028 = (E) NO ENTITLEMENT
8029 = (U) HH BEFORE PERIOD NOT PRESENT
8030 = (U) HH BILL VISITS > PT A REMAINING
8031 = (U) HH PT A REMAINING > 0
8032 = (U) HH DOLBA+59 NOT GT FROM-DATE
8050 = (U) HH QUALIFYING INDICATOR = 1
8051 = (U) HH # VISITS NE AFT PT B APPLIED
8052 = (U) HH # VISITS NE AFT TRAILER
8053 = (U) HH BENEFIT PERIOD NOT PRESENT
8054 = (U) HH DOEBA/DOLBA NOT > 0
8060 = (U) HH QUALIFYING INDICATOR NE 1
8061 = (U) HH DATE NE DOLBA IN AFT TRLR
8062 = (U) HH NE PT-A VISITS REMAINING
81X1 = (C) NUM OF SERVICES INVALID
83X1 = (C) DIAGNOSIS INVALID
8301 = (C) HCPCS/GENDER DIAGNOSIS
8302 = (C) HCPCS G0101 V-CODE/SEX CODE
8303 = (C) HCPCS/GENDER
8304 = (C) BILL TYPE INVALID FOR G0123/4
8305 = (C) HCPCS/SERVICE DATES/GENDER
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
84X2 = (C) INVALID DME START DATE
84X3 = (C) INVALID DME START DATE W/HCPCS
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
84X5 = (C) HCPCS CODE WITH INV DIAG CODE
84X6 = (C) HCPCS/GENDER
84X7 = (C) HCPCS/SERVICE DATES/GENDER
84X8 = (C) DUPLICATE HCPCS
86X1 = (C) CLINICAL LAB HCPCS W/O CLINICAL
     LAB ID
86X2 = (C) NON-WAIVER HCPCS/PAY DENIAL CODE/
     MODIFIER
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD
9000 = (U) DOEBA/DOLBA CALC
9005 = (U) FULL/COINS HOSP DAYS CALC
9010 = (U) FULL/COINS SNF DAYS CALC
9015 = (U) LIFE RESERVE DAYS CALC
9020 = (U) LIFE PSYCH DAYS CALC
9030 = (U) INPAT DEDUCTABLE CALC
9040 = (U) DATA INDICATOR 1 SET
9050 = (U) DATA INDICATOR 2 SET

91X1 = (C) PATIENT REIMB/PAY-DENY CODE
92X1 = (C) PATIENT REIMB INVALID
92X2 = (C) PROVIDER REIMB INVALID
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
92X7 = (C) REIMB/PAY-DENY INCONSISTANT
9201 = (C) UPIN REF NAME OR INITIAL MISSING
9202 = (C) UPIN REF FIRST 3 CHAR INVALID
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
93X1 = (C) CASH DEDUCTABLE INVALID
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
93X4 = (C) FROM DATE/CASH DEDUCTIBLE
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
9300 = (C) UPIN OTHER, NOT PRESENT
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
9351 = (C) OTHER UPIN PRESENT/MISSING OTHER FIELDS
9352 = (C) OTHER UPIN INVALID
9353 = (C) OTHER UPIN INVALID
94A1 = (C) NON-COVERED FROM DATE INVALID
94A2 = (C) NON-COVERED FROM > THRU DATE
94A3 = (C) NON-COVERED THRU DATE INVALID
94A4 = (C) NON-COVERED THRU DATE > ADMIT
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
94C1 = (C) PR-PSYCH DAYS INVALID
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
94F1 = (C) REIMBURSEMENT AMOUNT INVALID
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
94G1 = (C) NO-PAY CODE INVALID
94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
94G4 = (C) NO PAY CODE = R & REIMB PRESENT
94X1 = (C) BLOOD LIMIT INVALID
94X2 = (C) TYPE/BLOOD DEDUCTIBLE
94X3 = (C) TYPE/DATE/LIMIT AMOUNT
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
9401 = (C) BLOOD DEDUCTIBLE AMT > 3
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
9404 = (C) INVALID GENDER CODE ON PRO-PAY
9407 = (C) INVALID DIAGNOSIS
9408 = (C) INVALID DRG NUMBER (GLOBAL)
9409 = (C) HCFA DRG<>DRG ON BILL
940X = (C) INVALID DRG
9410 = (C) CABG/PCOE,INVALID DRG
95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
95X2 = (C) MSP AMOUNT APPLIED INVALID
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
95X5 = (C) MSP CODE = G/DATE BEFORE 1987

95X6 = (C) MSP CODE = X AND NOT AVOIDED
95X7 = (C) MSP CODE VALID, CABG/PCOE
96X1 = (C) OTHER AMOUNTS INVALID
96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB
97X1 = (C) OTHER AMOUNTS INDICATOR INVALID
97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0
98X1 = (C) COINSURANCE INVALID
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
9801 = (C) REV CENTER CODE 0910 WITH SERVICE
        DATE > 10/15/2004
99XX = (D) POSS DUPE, PART B DOC-ID
9901 = (C) REV CODE INVALID OR TRAILER CNT=0
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
9903 = (C) NO CLINIC VISITS FOR RHC
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE
991X = (C) NO DATE OF SERVICE
9910 = (C) BLOOD DEDUCTIBLE NON NUMERIC
9911 = (C) BLOOD DEDUCTIBLE PRESENT WITHOUT
        BLOOD FURNISHED
9920 = (C) CASH DEDUCTIBLE INVALID
9930 = (C) COINSURANCE INVALID
9931 = (C) OUTPAT COINSURANCE VALUES
9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT
9934 = (C) HCPCS 76092 NON COVERED/76085 COVERED
9940 = (C) PROVIDER PAYMENT INVALID
9941 = (C) REIMBURSEMENT AMOUNT/COND/NON-PAYMENT/
        PRIMARY PAYER
9942 = (C) PATIENT DISTRIBUTION INVALID
9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
9945 = (C) HCPCS INVALID FOR SERVICE DATES
9946 = (C) TOB INVALID FOR HCPCS
9947 = (C) INVALID DATE FOR HCPCS
9948 = (C) STAY FROM>96365,DIAG=V725
9960 = (C) MED CHOICE BUT HMO DATA MISSING
9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER
9999 = (U) MAIN SPELL TRAILER NUMBER DOES NOT MATCH SPELL

NCH_EDIT_TRLR_IND_TB   NCH Edit Trailer Indicator Table

    E = Edit code trailer present

NCH_LINE_TRLR_IND_TB   NCH Line Item Trailer Indicator Table

    L = Line Item trailer present
    Blank = No trailer present

NCH_MCO_TRLR_IND_TB   NCH Managed Care Organization (MCO) Trailer Indicator Table

   M = MCO trailer present

NCH_MQA_RIC_TB   NCH MQA Record Identification Code Table

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

NCH_NEAR_LINE_REC_VRSN_TB   NCH Near Line Record Version Table

   A = Record format as of January 1991
   B = Record format as of April 1991
   C = Record format as of May 1991
   D = Record format as of January 1992
   E = Record format as of March 1992
   F = Record format as of May 1992
   G = Record format as of October 1993
   H = Record format as of September 1998
   I = Record format as of July 2000
   J = Record format as of January 2011
   K = Record format as of April 2013
   L = Record format as of January 2021

NCH_NEAR_LINE_RIC_TB   NCH Near-Line Record Identification Code Table

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

NCH_PATCH_TB   NCH Patch Table

01 = RRB Category Equatable BIC - changed (all
     claim types) -- applied during the Nearline
     'G' conversion to claims with NCH weekly
     process date before 3/91.   Prior to Version
     'H', patch indicator stored in redefined Claim
     Edit Group, 3rd occurrence, position 2.
02 = Claim Transaction Code made consistent with
     NCH payment/edit RIC code (OP and HHA) --
     effective 3/94, CWFMQA began patch. During
     'H' conversion, patch applied to claims with
     NCH weekly process date prior to 3/94. Prior
     to version 'H', patch indicator stored in
     redefined Claim Edit Group, 4th occurrence,
     position 1.
03 = Garbage/nonnumeric Claim Total Charge Amount
     set to zeroes (Instnl) -- during the Version
     'G' conversion, error occurred in the deriva-
     tion 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' ocnversion, 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' con-
version to claims with NCH weekly process
date 10/1/93-10/30/95, where MSP values =
invalid '0', '1', '2', '3' or '4' (caused
by erroneous logic in HCFA program code,
which was corrected on 11/1/95).

09 = Zero CWF claim accretion date replaced with
NCH weekly process date (all claim types)
-- applied during Version 'H' conversion to
Instnl and DMERC claims; applied during
Version 'G' conversion to non-institutional
(non-DMERC) claims. Prior to Version 'H',
patch indicator stored in redefined claim
edit group, 3rd occurrence, position 1.

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

11 = Truncated claim total charge amount in the
fixed portion replaced with the total charge
amount in the revenue center 0001 amount field
-- service years 1998 & 1999 patched during
quarterly merge. The 1998 & 1999 SAFs were
corrected when finalized in 7/99. The patch
was done for records with NCH Daily Process
Date 1/4/99 - 5/14/99.

12 = Missing claim-level HHA Total Visit Count --
service years 1998, 1999 & 2000 patch applied
during Version 'I' conversion of both the
Nearline and SAFs.   Problem occurs in those
claims recovered during the missing claims
effort.

13 = Inconsistent Claim MCO Paid Switch made consistent
with criteria used to identify an inpatient
encounter claim -- if MCO paid switch equal to blank
or '0' and ALL conditions are met to indicate an
inpatient encounter claim (bene enrolled in a risk
MCO during the service period), change the switch to
a '1'. The patch was applied during the Version 'I'
conversion, for claims back to 7/1/97 service thru date.

14 = SNF claims incorrectly identified as Inpatient
Encounter claims -- SNF claims matching the Inpatient
encounter data criteria were incorrectly identified

as Inpatient encounter claims (claim type code = '61'
instead of '20' or '30').   NOTE: if the SNF claims
were identified the MCO paid switch was set to '1'.
The patch was applied to correctly identify these
claims as a '20' or '30'. The MCO paid switch will
be set to '0' as there is no way to recover the original
value. The problem occurred in claims with an NCH
Weekly Process Date ranging from 7/7/2000 - 1/26/2001.
The patch applied date is 03/30/2001.

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

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

The patch applied date is 06/29/2001.

NCH_PATCH_TRLR_IND_TB   NCH Patch Trailer Indicator Table

  P = Patch code trailer present

NCH_STATE_SGMT_TB   NCH State Segment Table

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

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

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

E =   22;23;31;34;36;45

F =   10;22;23;31;34;36;45

G =   10;22;23;36;39

H =   05;10;22;23;39

I =   05;10;39

J =   05;10;33;39

K =   05;33;39

L =   05;33;39

M =   05;33

N =   05;33

O =   33

P =   33

Q =   33

R =   33

NG_ACO_IND_TB   Next Generation (NG) Accountable Care Organization (ACO) Indicator Code Table

0 = Base record (no enhancements)
1 = Population Based Payments (PBP)
2 = Telehealth
3 = Post Discharge Home Health Visits
4 = 3-Day SNF Waiver
5 = Capitation
6 = CEC Telehealth
7 = Care Management Home Visits
8 = Primary Care Capitation (PCC)
9 = Home Health Benefit Enhancement - eff. 4/2021
B = Concurrent Care for Beneficiaries that Elect the Medicare
    Hospice Benefit - eff. 4/2021
C = Kidney Disease Education (KDE) eff. 4/2021
D = Seriously Ill Population (SIP)
E = Flat Visit Fee (FVF)
F = Quarterly Capitation Payment (QCP) eff. 4/2021

RP_IND_TB   Claim Representative Payee (RP) Indicator Code Table

R = bypass representative payee
Space

RSDL_PMT_IND_TB   Claim Residual Payment Indicator Code Table

X = Residual Payment
Space

<div align="center">

QUERY: RIFQQ11, RIFQQ21 ON DB2T
*******END OF TOC APPENDIX FOR RECORD: CARR_CLM_REC*******

</div>

1
LIMITATIONS APPENDIX FOR RECORD: CARR_CLM_REC, STATUS: PROD, VERSION: 21006
PRINTED: 04/26/2021, USER: F43D, DATA SOURCE: CA REPOSITORY ON DB2T

CARR_LINE_DME_CVRG_STRT_LIM
            FULL NAME: Carrier Line DME Coverage Period Start Date Limitation
            DESCRIPTION :
              When the revised DME processing was implemented
              (phased in between 10/93-6/94), this field was not
              included on the new DMERC claim; it is being
              reported on the certificate of medical necessity
              (CMN) transaction. HCFA does not receivee CMN
              transaction from CWF.
            SOURCE:
CARR_LINE_DME_NCSTY_LIM
            FULL NAME: Carrier Line DME Medical Necessity Month Count Limitation
            DESCRIPTION :
              When the revised DME processing was implemented
              (phased in between 10/93-6/94), this field was not
              included on the new DMERC claim; it is being
              reported on the certificate of medical necessity
              (CMN) transaction. HCFA does not receive CMN
              transaction from CWF.
            SOURCE:
CARR_LINE_MTUS_CNT_LIM
            FULL NAME: Carrier Line Miles/Time/Units/Services Count Limitation
            DESCRIPTION :
              Inaccurate data reflected in the MTUS field for anesthesia claims.
            BACKGROUND   :
              A problem was found with the CARR-LINE-MTUS-CNT field on the NCH carrier
              claims when an anesthesia claim (CARR-LINE-MTUS-IND-CD = '2') is
              submitted with minutes. The problem is happening now because as of July
              6,2009, the shared system maintainers (SSM) and CWF maintainers began
              using the 5010 claim format (will be NCH Version 'J' format) which has
              expanded this field from S999 to S9(7)V999.

              When anesthesia claims are being received with minutes, MCS (SSM)

converts them to units, which is causing the field to the right
of the decimal to be utilized when the claims are transmitted to CWF.

For example,14 minutes converted to units (15 minutes = 1 unit) converts
to 0.9 units. CWF maps 0.900 to the MTUS field and sends that on to the
NCH. Since the NCH has not implemented Version 'J', the data in the NCH
will reflect '0'.

The NCH and other downstream systems are still using the Version 'I'
format (4010 data) and will be until January 3, 2011.   It was our
understanding since the implementation of the HIPAA 5010 project
that no 5010 data would be coming in to NCH until January 3, 2011.
CORRECTIVE ACTION :
  The problem has been forwarded to the CWF BAMG staff for further
  investigation.
SOURCE:
ADMINISTRATIVE DATA:
  START DATE   : 07/05/2009
  END DATE   : UNKNOWN
  CONTACT   : OIS/DG/DIDPM

CARR_LINE_PRFRMG_UPIN_LIM
              FULL NAME: Carrier Line Performing UPIN Limitation
              DESCRIPTION :
              Missing performing provider UPINS on denied carrier
              claims.
              BACKGROUND   :
              In 1996 it was discovered that the performing provider
              UPINs were missing on denied carrier claims.
              CORRECTIVE ACTION :
              A change release was added in CWF in 7/00. A remedy
              had been worked out prior to 7/00 but other activities
              precluded its resolution.
              SOURCE:
              ADMINISTRATIVE DATA:
              START DATE   : 1996
              END DATE   : 07/00
              CONTACT   : OIS/EDG/DMUDD

CARR_LINE_RX_NUM_LIM
              FULL NAME: Carrier Line Prescription (RX) Number
              DESCRIPTION :
              Invalid data found in the prescription number (RX)
              field on the carrier claim.
              BACKGROUND   :
              MMA required the implementation of a Competitive
              Aquisition Program (CAP) for Part B drugs and
              biologicals not paid on a cost or prospective
              payment system basis. Under this program, physi-
              cians are given the choice between buying and
              billing these drugs under the average sales price
              (ASP) system, or obtaining these drugs from the
              CAP if competitive pricing will not result in
              significant savings or have an adverse impact on
              access to these drugs.

During an analysis of carrier claims to review CAP
physician and vendor claims it was discovered that
these claims contained invalid data.

In both the NCH and NMUD claims from 7/1/2006 -
12/12/2006 will contain invalid data in the
CARR_LINE_RX_NUM field. The problem was caused
by a coding error in the CWFMQA front-end process.
Due to the coding error the prescription (RX)
number was never passed to the NCH or NMUD.
CORRECTIVE ACTION :
A fix was put into the CWFMQA code to move the
RX number on the host files into the appropriate
field on the CWFMQA file that is used in the NCH
process. The fix was implemented 12/12/2006.
SOURCE:
ADMINISTRATIVE DATA:
START DATE   : 07/01/06
END DATE   : 12/12/06
CONTACT   : OIS/EDG/DIDPM

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_ACNT_NUM_LIM
FULL NAME: Beneficiary Claim Account Number Limitation
DESCRIPTION :
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.
SOURCE:

NCH_CLM_TYPE_CD_LIM
FULL NAME: NCH Claim Type Code Limitation
DESCRIPTION :
As of the implementation of Version 'J', the NCH claim
type codes '62' and '64' were not correctly being set.
BACKGROUND   :

With the implementation of Version 'J', we added three
new claim type codes ('62', '63' and '64') to identify
Medicare Advantage claims.

It appears that the conversion code we used to convert
all of our history files (claims prior to start of Version
'J') set the 62 and 64 correctly but that same code was not
used in our normal monthly claims processing (claims
received January 1, 2011 and after). The error was with
the MCO-PD-SW logic used to derive the claim type code.
CORRECTIVE ACTION :
This anamoly was handled in two phases:

Phase 1 -- a fix was put into the NCH code to use
the correct MCO-PD-SW logic. The fix was imple-
mented prior to our October 2012 NCH monthly
load. This fix corrected the claims received
October 1st and forward.

Phase 2 -- History files (January 1, 2011 thru
September 28, 2012) were corrected during our
NCH Version 'K' conversion, which was implemented
April 2013.
SOURCE:
ADMINISTRATIVE DATA:
 START DATE   : 01/01/2011
 END DATE   : 10/01/2012

NCH_DAILY_PROC_DT_LIM
FULL NAME: NCH Daily Process Date Limitation
DESCRIPTION :
The NCH Daily Process Date was mistakenly changed on
all Version 'J' claims during the history conversion
process.
BACKGROUND   :
It was discovered during the process of modifying the
conversion code used during Version 'J' processing that
the NCH Daily Process Date was mistakenly changed in the
Version 'J' conversion code. When preparing the specs for
the Version 'J' conversion code, we were told to change the
NCH Daily Process Date to reflect the date the history files
were converted.

This change impacts the linkage of Part A claims that have
multiple segments (claims with more than 45 revenue center
lines) on the Version 'J' claim files. The NCH Daily
Process Date is used in conjuction with the NCH Segment
Link Number to keep records/segments belonging to a
specific claim together.

There is the possibility that two different claims could
now have the same NCH Daily Process Date and NCH Segment
Link Number. This could cause users of the data to
match claim records/segments together that should not
be paired.   We believe the chances of this occurring to

be minimal.

CORRECTIVE ACTION :
 Because the Version 'I' files were converted and the
 date changed, we have no way of going back and retrieving
 the original NCH Daily Process Date so no fix/patch
 will be applied.

SOURCE:
 CONTACT   : OIS/EDG/DDOM

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.

 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.

SQL_INFO: NUMBER(11,2)

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 dis-
 tributed, 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 wll 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

QUERY: RIFQQ41 ON DB2T
*******END OF LIMITATION APPENDIX FOR RECORD: CARR_CLM_REC*******