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

NAME	LENGTH	BEG	END	CONTENTS

*** DMERC Claim Record (NCH)
VAR 1 18927 REC

STANDARD ALIAS : DMERC_CLM_REC
SYSTEM ALIAS : UTLDMERL

LIMITATIONS :

REFER TO :
CHOICES_DEMO_LIM
PMT_AMT_EXCEDG_CHRG_AMT_LIM

1. DMERC Claim Fixed Group
1058 1 1058 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 intermediary or carrier.

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

19. CWF Claim Accretion Number
2 57 58 PACK

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

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

LENGTH : 3 SIGNED : Y

SOURCE : CWF

20. Carrier Claim Control Number
15 59 73 CHAR

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

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

LENGTH : 15

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

SOURCE : CWF

EDIT RULES :
LEFT JUSTIFY

21. FILLER
38 74 111 CHAR

DB2 ALIAS : FILLER
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 generated number used in conjunction with the NCH daily process date to keep records/segments belonging to a specific claim together. This field was added to ensure that records/segments that come in on the same batch with the same identifying information in the link group are not mixed with each other.

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

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

LENGTH : 9 SIGNED : Y

SOURCE : NCH

24. Claim Total Segment Count
2 125 126 NUM

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

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

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

LENGTH : 2 SIGNED : N

SOURCE : CWF

25. Claim Segment Number
2 127 128 NUM

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

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

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

LENGTH : 2 SIGNED : N

SOURCE : CWF

26. Claim Total Line Count
3 129 131 NUM

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

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

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

LENGTH : 3 SIGNED : N

SOURCE : CWF

27. Claim Segment Line Count
2 132 133 NUM

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

NOTE: During the Version I conversion this
field was populated with data throughout

history (back to service year 1991).
The maximum line count per record/segment
on the revenue center trailer is 45. The
maximum number of lines on carrier and DMERC
claims are 13.

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

LENGTH : 2 SIGNED : N

SOURCE : CWF

28. Carrier/DMERC Claim Common 2 Group
911 134 1044 GRP

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

CODE TABLE : NCH_CLM_BIC_MDFY_TB

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

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

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

LENGTH : 3

SOURCE : SSA/EDB

EDIT RULES :
OPTIONAL: MAY BE BLANK

36. Carrier Claim Receipt Date
8 149 156 NUM

The date the carrier receives the non-institutional claim.

DB2 ALIAS : CLM_RCPT_DT
SAS ALIAS : RCPT_DT
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 transition from a carrier to a MAC the CARR_NUM field could contain either a Carrier number or a MAC number. See the CARR_NUM table of codes to identify the new MAC numbers and their effective dates.

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

LENGTH : 5

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

SOURCE : CWF

CODE TABLE : CARR_NUM_TB

40. FILLER
8 178 185 CHAR

DB2 ALIAS : FILLER
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 processed prior to 10/3/97 will contain spaces in this field.

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

LENGTH : 1

SOURCE : CWF

50. Beneficiary CWF Location Code
1 219 219 CHAR

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

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : BENE_CWF_LOC_TB

51. Claim Principal Diagnosis Group

8 220 227 GRP

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

STANDARD ALIAS : CLM_PRNCPAL_DGNS_GRP

52. Claim Principal Diagnosis Version Code
1 220 220 CHAR

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

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

DB2 ALIAS : UNDEFINED
SAS ALIAS : PDVRSNCD
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 :

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 required under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted.

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM_EXCPTD_NEXCPTD_TRTMT_TB

57. Claim Payment Amount
6 232 237 PACK

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

Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). After 4/1/03, the payment amount could also include a "new technology" add-on amount. 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 beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a non-institutional claim.

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

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

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

59. FILLER
1 244 244 CHAR

DB2 ALIAS : FILLER
STANDARD ALIAS : FILLER

LENGTH : 1

60. DMERC Claim Ordering Physician UPIN Number
6 245 250 CHAR

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

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

LENGTH : 6

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

SOURCE : CWF

61. DMERC Claim Ordering Physician NPI Number
10 251 260 CHAR

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

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

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

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

LENGTH : 10

SOURCE : CWF

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

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

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

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : CARR_CLM_PRVDR_ASGNMT_IND_TB

63. NCH Claim Provider Payment Amount
6 262 267 PACK

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

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

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

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

64. NCH Claim Beneficiary Payment Amount
6 268 273 PACK

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

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

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

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

65. Carrier Claim Beneficiary Paid Amount
6 274 279 PACK

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

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

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

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

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

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

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

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

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

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

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

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

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

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

TITLE ALIAS : ALOW_CHRG

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

EDIT RULES :
$$$$$$$CC

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

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

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

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

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

69. Carrier Claim HCPCS Year Code
1 298 298 NUM

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

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

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

LENGTH : 1 SIGNED : N

SOURCE : CWF

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

Effective with Version H, the code used to indicate whether or not an MCO investigation

applies to the claim (used for internal CWFMQA editing purposes).

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

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : CARR_CLM_MCO_OVRRD_IND_TB

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

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

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

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : CARR_CLM_HOSPC_OVRRD_IND_TB

72. Claim Business Segment Identifier Code
4 301 304 CHAR

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

Workload Identifier number. The business segment identifier (BSI) is intended to help sort workloads that may be redistributed with the implementation of contracting reform as required by MMA.

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

LENGTH : 4

SOURCE : CWF

73. Claim Clinical Trial Number
8 305 312 CHAR

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

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

DB2 ALIAS : CLM_CLNCL_TRIL_NUM
SAS ALIAS : 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. DMERC Claim National Mail Order (NMO) Competitive Bidding Area (CBA) Indicator Code
5 345 349 CHAR

Effective with CR#8, the field used to identify when a beneficiary does not reside in a competitive bidding area (CBA) and at least one line on the claim is subject to National Mail Order (NMO) program.

DB2 ALIAS : DMERC_NMO_CBA_CD
SAS ALIAS : NMOIND
STANDARD ALIAS : DMERC_CLM_NMO_CBA_CD

LENGTH : 5

CODE TABLE : DMERC_CLM_NMO_CBA_IND_TB

87. Claim Paper Provider Code
2 350 351 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

88. Claim Residual Payment Indicator Code
1 352 352 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

89. Claim Accountable Care Organization (ACO) Identification Number
10 353 362 CHAR

Effective with CR#12, this field identifies the unique identification 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

90. Medicare Beneficiary Identification (MBI) Number
11 363 373 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

91. Claim Beneficiary Identifier Type Code
1 374 374 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

92. FILLER
670 375 1044 CHAR

DB2 ALIAS : H_FILLER_7

LENGTH : 670

93. DMERC NCH Edit Code Count
2 1045 1046 NUM

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

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

LENGTH : 2 SIGNED : N

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

SOURCE : NCH

94. DMERC NCH Patch Code Count
2 1047 1048 NUM

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

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

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

LENGTH : 2 SIGNED : N

SOURCE : NCH

95. DMERC MCO Period Count
1 1049 1049 NUM

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

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

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

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 2

96. DMERC Claim Demonstration ID Count
1 1050 1050 NUM

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

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

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

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 5

97. DMERC Claim Diagnosis Code Count
2 1051 1052 NUM

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

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

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

LENGTH : 2 SIGNED : N

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

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 12

98. DMERC Claim Line Count
2 1053 1054 NUM

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

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

LENGTH : 2 SIGNED : N

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

SOURCE : CWFB CLAIMS

EDIT RULES :
RANGE: 1 TO 13

99. FILLER
4 1055 1058 CHAR

DB2 ALIAS : FILLER
STANDARD ALIAS : FILLER

LENGTH : 4

100. DMERC Claim Variable Group
VAR 1059 18927 GRP

101. NCH Edit Group
65 1059 1123 GRP

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

STANDARD ALIAS : NCH_EDIT_GRP

OCCURS MIN: 0 OCCURS MAX: 13

DEPENDING ON : DMERC_NCH_EDIT_CD_CNT

102. NCH Edit Trailer Indicator Code
1 1059 1059 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

103. NCH Edit Code
4 1060 1063 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

104. NCH Patch Group
330 1124 1453 GRP

STANDARD ALIAS : NCH_PATCH_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : DMERC_NCH_PATCH_CD_I_CNT

105. NCH Patch Trailer Indicator Code
1 1124 1124 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

106. NCH Patch Code
2 1125 1126 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

107. NCH Patch Applied Date
8 1127 1134 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

108. MCO Period Group
74 1454 1527 GRP

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

STANDARD ALIAS : MCO_PRD_GRP

OCCURS MIN: 0 OCCURS MAX: 2

DEPENDING ON : DMERC_MCO_PRD_CNT

109. NCH MCO Trailer Indicator Code
1 1454 1454 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

110. MCO Contract Number

5 1455 1459 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

111. MCO Option Code

1 1460 1460 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

112. MCO Period Effective Date
8 1461 1468 NUM

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

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

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

113. MCO Period Termination Date
8 1469 1476 NUM

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

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

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

114. MCO Health PLANID Number
14 1477 1490 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

115. Claim Demonstration Identification Group
90 1528 1617 GRP

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

STANDARD ALIAS : CLM_DEMO_ID_GRP

OCCURS MIN: 0 OCCURS MAX: 5

DEPENDING ON : DMERC_CLM_DEMO_ID_CNT

116. NCH Demonstration Trailer Indicator Code
1 1528 1528 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

117. Claim Demonstration Identification Number
2 1529 1530 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 tradi-
tionally noncovered physician services for
medical consultation furnished via two-way, inter-
active video systems (i.e. teleconsultation)
in 4 states. The claims contain line items
with 'QQ' HCPCS code.

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

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

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

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

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

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

NOTE2: During the Version H conversion, Demo ID

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

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

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

NOTE2: During the Version H conversion, any claims where Medicare is the primary payer that were not already identified as Demo ID '06' (stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4, Version G) were annotated based on the following criteria: Inpatient - presence of DRG '106' or '107' and a provider number=220897, 150897, 380897,450897,110082,230156 or 360085 for specified service dates; noninstitutional - presence of HCPCS modifier (initial and/or second) = 'Q2' and a carrier number =00700/31143 00630,01380,00900,01040/00511,00710,00623, or 13630 for specified service dates.

07 = Virginia Cardiac Surgery Initiative (VCSI) (formerly referred to as Medicare Quality Partnerships Demo) -- this is a voluntary consortium of the cardiac surgery physician groups and the non-Veterans Administration hospitals providing open heart surgical services in the Commonwealth of Virginia. The goal of the demo is to share data on quality and process innovations in an attempt to improve the care for all cardiac patients. The demonstration only affects those FIs that process claims from hospitals in Virginia and the carriers that process claims from physicians providing

inpatient services at those hospitals. The hospitals will be reimbursed on a global payment basis for selected cardiac surgical diagnosis related groups (DRGs). The inpatient claims will contain a DRG '104', '105', '106', '107', '109'; the related physician/supplier claims will contain the claim payment denial reason code = 'D'.

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

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

NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '08' to claim.

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

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

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

NOTE: Effective for all claim types (except DMERC) with NCH weekly process date after 2/27/98 (and service date after 10/31/97) -- the FI adds Demo ID '30' based on the presence of a condition code = EY;

the participating physician (not the carrier) adds
ID to the noninstitutional claim. DUE TO THE 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 transmitting the claims to Trailblazers for processing.

NOTE: Effective October, 2000 for carrier claims.

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

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

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 service episode of care will be set at 95% of the amount that would otherwise be paid for home health services provided entirely in the home.

NOTE: Effective July 5, 2005 for HHA claims.

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 because 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 prac-
tices. 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

118. Claim Demonstration Information Text
15 1531 1545 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

119. Carrier Claim Diagnosis Group
108 1618 1725 GRP

The number of claim diagnosis trailers is determined by

the carrier claim diagnosis code count.

STANDARD ALIAS : CARR_CLM_DGNS_GRP

OCCURS MIN: 0 OCCURS MAX: 12

DEPENDING ON : DMERC_CLM_DGNS_CD_J_CNT

120. NCH Diagnosis Trailer Indicator Code
1 1618 1618 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

121. Claim Diagnosis Version Code
1 1619 1619 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

122. Claim Diagnosis Code
7 1620 1626 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

123. DMERC Line Group
17199 1726 18924 GRP

OCCURS MIN: 0 OCCURS MAX: 13

DEPENDING ON : DMERC_CLM_LINE_CNT

124. NCH Line Item Trailer Indicator Code
1 1726 1726 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

125. DMERC Line Supplier Provider Number
10 1727 1736 CHAR

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

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

LENGTH : 10

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

SOURCE : CWF

126. DMERC Line Item Supplier NPI Number
10 1737 1746 CHAR

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

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

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

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

LENGTH : 10

SOURCE : CWF

127. DMERC Line Pricing State Code
2 1747 1748 CHAR

Prior to Version H this field was named:
CWFB_DME_PRCNG_STATE_CD.

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

LENGTH : 2

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

SOURCE : CWF/NCH

CODE TABLE : GEO_SSA_STATE_TB

128. DMERC Line Pricing Zip Code
9 1749 1757 CHAR

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

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

DB2 ALIAS : DMERC_PRCNG_ZIP_CD
SAS ALIAS : PRCNGZIP
STANDARD ALIAS : DMERC_LINE_PRCNG_ZIP_CD

LENGTH : 9

LANGUAGE : C

129. DMERC Line Beneficiary Mailing State Code
2 1758 1759 CHAR

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

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

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

DB2 ALIAS : DMERC_MLG_STATE_CD
SAS ALIAS : MLGSTATE
STANDARD ALIAS : DMERC_LINE_BENE_MLG_STATE_CD

LENGTH : 2

LANGUAGE : C

130. DMERC Line Provider State Code
2 1760 1761 CHAR

Prior to Version H this field was named:
CWFB_DME_PRVDR_STATE_CD.

DB2 ALIAS : DMERC_PRVDR_STATE
SAS ALIAS : PRVSTATE
STANDARD ALIAS : DMERC_LINE_PRVDR_STATE_CD
TITLE ALIAS : DMERC_PRVDR_STATE_CD

LENGTH : 2

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

SOURCE : CWF/NCH

CODE TABLE : GEO_SSA_STATE_TB

131. DMERC Line Supplier Type Code
1 1762 1762 CHAR

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

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

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : DMERC_LINE_SUPLR_TYPE_TB

132. Line Provider Tax Number
10 1763 1772 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

133. Line HCFA Provider Specialty Code
2 1773 1774 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

134. Line Provider Participating Indicator Code
1 1775 1775 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

135. Line Service Count
6 1776 1781 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

136. Line HCFA Type Service Code
1 1782 1782 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

137. Line Place of Service Code
2 1783 1784 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

138. Line First Expense Date
8 1785 1792 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

139. Line Last Expense Date
8 1793 1800 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

140. Line HCPCS Code
5 1801 1805 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.

141. Line HCPCS Initial Modifier Code
2 1806 1807 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

142. Line HCPCS Second Modifier Code
2 1808 1809 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

143. DMERC Line HCPCS Third Modifier Code
2 1810 1811 CHAR

Prior to Version H this field was named: HCPCS_3RD_MDFR_CD.

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

LENGTH : 2

COMMENTS :
Prior to Version H this field was named: HCPCS_3RD_MDFR_CD.

SOURCE : CWF

144. DMERC Line HCPCS Fourth Modifier Code
2 1812 1813 CHAR

Prior to Version H this field was named:
HCPCS_4TH_MDFR_CD.

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

LENGTH : 2

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

SOURCE : CWF

145. Line NCH BETOS Code
3 1814 1816 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

146. Line IDE Number
7 1817 1823 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

147. DMERC Line Not Otherwise Classified HCPCS Code Text
14 1824 1837 CHAR

Prior to Version H this field was named:
CWFB_DME_ITM_NOC_HCPCS_CD_TXT.

DB2 ALIAS : NOC_HCPCS_CD_TXT
SAS ALIAS : NOC_TXT
STANDARD ALIAS : DMERC_LINE_NOC_HCPCS_CD_TXT
TITLE ALIAS : NOC_HCPCS_TXT

LENGTH : 14

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

SOURCE : CWF

148. Line National Drug Code
11 1838 1848 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

149. Line NCH Payment Amount
6 1849 1854 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

150. Line Beneficiary Payment Amount
6 1855 1860 PACK

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

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

zeroes in this field.

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

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

151. Line Provider Payment Amount
6 1861 1866 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

152. Line Beneficiary Part B Deductible Amount
6 1867 1872 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

153. Line Beneficiary Primary Payer Code
1 1873 1873 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

154. Line Beneficiary Primary Payer Paid Amount
6 1874 1879 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

155. Line Coinsurance Amount
6 1880 1885 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

156. Line Interest Amount
6 1886 1891 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

157. Line Primary Payer Allowed Charge Amount
6 1892 1897 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

158. Line 10% Penalty Reduction Amount
6 1898 1903 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

159. Line Submitted Charge Amount
6 1904 1909 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

160. Line Allowed Charge Amount

6 1910 1915 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

161. DMERC Line Screen Savings Amount
6 1916 1921 PACK

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

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

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

162. Line DME Purchase Price Amount
6 1922 1927 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

163. Line Processing Indicator Code
2 1928 1929 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

164. Line Payment 80%/100% Code
1 1930 1930 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

165. Line Service Deductible Indicator Switch
1 1931 1931 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

166. Line Payment Indicator Code
1 1932 1932 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

167. DMERC Line Miles/Time/Units/Services Count
6 1933 1938 PACK

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

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

LENGTH : 7.3 SIGNED : Y

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

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

168. DMERC Line Miles/Time/Units/Services Indicator Code
1 1939 1939 CHAR

Prior to Version H this field was named:
CWFB_DME_MTUS_IND_CD.

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

TITLE ALIAS : MTUS_IND

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : DMERC_LINE_MTUS_IND_TB

169. Line Diagnosis Code Group
8 1940 1947 GRP

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

STANDARD ALIAS : LINE_DGNS_CD_GRP

170. Line Diagnosis Version Code
1 1940 1940 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

171. Line Diagnosis Code
7 1941 1947 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

172. Line Additional Claim Documentation Indicator Code
1 1948 1948 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

173. DMERC Line Screen Suspension Indicator Code
4 1949 1952 CHAR

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

DB2 ALIAS : SCRN_SUSPNSN_CD
SAS ALIAS : SUSP_IND
STANDARD ALIAS : DMERC_LINE_SCRN_SUSPNSN_IND_CD
TITLE ALIAS : SCRN_SUSPNSN_IND

LENGTH : 4

SOURCE : CWF

CODE TABLE : DMERC_LINE_SCRN_SUSPNSN_IND_TB

174. DMERC Line Screen Result Indicator Code
1 1953 1953 CHAR

Effective with Version G, code indicating the
outcome of the medical review (MR) unit's evaluation
of the DMERC line item.

DB2 ALIAS : SCRN_RSLT_IND_CD
SAS ALIAS : RSLT_IND
STANDARD ALIAS : DMERC_LINE_SCRN_RSLT_IND_CD
TITLE ALIAS : SCRN_RSLT_IND

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : DMERC_LINE_SCRN_RSLT_IND_TB

175. DMERC Line Waiver Of Provider Liability Switch
1 1954 1954 CHAR

Effective with Version G, the switch indicating
the beneficiary was notified that the item, reported
as a DMERC line item, may not be considered medically
necessary and has agreed in writing to pay for
the item.

DB2 ALIAS : WVR_PRVDR_LBLTY_SW
SAS ALIAS : WAIVERSW
STANDARD ALIAS : DMERC_LINE_WVR_PRVDR_LBLTY_SW
TITLE ALIAS : WAIVER_LBLTY_SW

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : YES_NO_TB

176. DMERC Line Decision Indicator Switch
1 1955 1955 CHAR

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

DB2 ALIAS : DMERC_DCSN_IND_SW
SAS ALIAS : DCSN_IND

STANDARD ALIAS : DMERC_LINE_DCSN_IND_SW
TITLE ALIAS : DCSN_IND

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : DMERC_LINE_DCSN_IND_TB

177. Line Consolidated Billing Indicator Code
1 1956 1956 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

178. Line Duplicate Claim Check Indicator Code
1 1957 1957 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

179. Line Hematocrit/Hemoglobin Test Type Code
2 1958 1959 CHAR

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

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

LENGTH : 2

CODE TABLE : LINE_HCT_HGB_TYPE_TB

180. Line Hematocrit/Hemoglobin Result Number
3 1960 1962 CHAR

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

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

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

LENGTH : 3

181. Line Hematocrit/Hemoglobin Result Number -- Redefined
3 1963 1965 NUM

Effective September 1, 2008, with the implementation of CR#3, the number used to identify the most recent

hematocrit or hemoglobin reading on the noninstitutional claim.

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

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

LENGTH : 2.1 SIGNED : N

REDEFINE : LINE_HCT_HGB_RSLT_NUM

182. Worker's Compensation Indicator Code
1 1966 1966 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

183. Line Paperwork (PWK) Code
2 1967 1968 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

184. Line Unique Tracking Number
14 1969 1982 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 authorization 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 authorization 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)

185. Line Other Applied Indicator 1 Code
2 1983 1984 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

186. Line Other Applied Indicator 2 Code
2 1985 1986 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

187. Line Other Applied Indicator 3 Code
2 1987 1988 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

188. Line Other Applied Indicator 4 Code
2 1989 1990 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

189. Line Other Applied Indicator 5 Code
2 1991 1992 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

190. Line Other Applied Indicator 6 Code
2 1993 1994 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

191. Line Other Applied Indicator 7 Code
2 1995 1996 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

192. Line Other Applied 1 Amount
6 1997 2002 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

193. Line Other Applied 2 Amount
6 2003 2008 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

194. Line Other Applied 3 Amount
6 2009 2014 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

195. Line Other Applied 4 Amount
6 2015 2020 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

196. Line Other Applied 5 Amount
6 2021 2026 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

197. Line Other Applied 6 Amount
6 2027 2032 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

198. Line Other Applied 7 Amount
6 2033 2038 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

199. Line FPS Model Number
2 2039 2040 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

200. Line FPS Reason Code
3 2041 2043 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

201. Line FPS Remark Code
5 2044 2048 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

202. Line FPS MSN 1 Code
5 2049 2053 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

203. Line FPS MSN 2 Code
5 2054 2058 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

204. DMERC Line Competitive Bidding Area (CBA) Code
5 2059 2063 CHAR

Effective with CR#8, the code used to identify the Competitive Bidding Area (CBA).

DB2 ALIAS : DMERC_LINE_CBA_CD
SAS ALIAS : CBACD
STANDARD ALIAS : DMERC_LINE_CBA_CD

LENGTH : 5

CODE TABLE : DMERC_LINE_CBA_TB

205. DMERC Line Competitive Bidding Area (CBA) Date
8 2064 2071 NUM

Effective with CR#8, the date used to identify the start date for a particular round of competitive bidding used to determine the eligibility for contract or grandfathering suppliers.

DB2 ALIAS : DMERC_LINE_CBA_DT
SAS ALIAS : CBADATE
STANDARD ALIAS : DMERC_LINE_CBA_DT

LENGTH : 8 SIGNED : N

206. Line Prior Authorization Indicator Code
4 2072 2075 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

207. Line Representative Payee (RP) Indicator Code
1 2076 2076 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

208. Line Residual Payment Indicator Code
1 2077 2077 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

209. Line Foreign Address Indicator
2 2078 2079 CHAR

Effective with CR#12, this field is used to identify claims for expatriate beneficiaries (beneificiary whose permanent address is outside the U.S.) who purchased DMEPOS items that were furnished in the United States.

DB2 ALIAS : FRGN_ADR_IND_CD
SAS ALIAS : FRGNADR
STANDARD ALIAS : DMERC_LINE_FRGN_ADR_IND_CD

LENGTH : 2

COMMENTS :
(CMS CR9468) - CWF July 2016 Release

CODE TABLE : DMERC_LINE_FRGN_ADR_IND_TB

210. DMERC Line Railroad Board Exclusion Indicator Switch
1 2080 2080 CHAR

Effective with CR#14 (April 2019 release), this field informs the Shared System Maintainer (SSM) and Common Working File (CWF) if the Railroad Board (RRB) beneficiary claim should either be included or excluded from Prior Authorization (PA) processing.

For example, if the field is valued "Y", and it is an RRB beneficiary claim, it will be excluded from PA processing.

DB2 ALIAS : UNDEFINED
SAS ALIAS : DLEXCLSN

LENGTH : 1

CODE TABLE : DMERC_LINE_RRB_EXCLSN_IND_TB

211. Line Voluntary Service Indicator Code
1 2081 2081 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

212.
970 2082 3051 CHAR

DB2 ALIAS : H_FILLER_9

LENGTH : 970

213. End of Record Code
3 18925 18927 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: DMERC_CLM_REC**********

1
TABLE OF CODES APPENDIX FOR RECORD: DMERC_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_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 Adjustment 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)
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(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)
(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)
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_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

DMERC_CLM_NMO_CBA_IND_TB Claim National Mail Order (NMO) Competitive Bidding Area (CBA) Indicator Code Table

20001 = Beneficiary does not reside in a Competitive Bidding Area
(CBA) and at least one line on the claim is subject to
the National Mail Order (NMO) program.

DMERC_LINE_CBA_TB Line Competitive Bidding Area (CBA) Code Table

16740 = Charlotte-Gastonia-Concor, NC-SC -- Non Mail-Order
16741 = Charlotte-Gastonia-Concor, NC-SC -- Mail-Order
17140 = Cincinnati-Middletown, OH-KY-IN -- Non Mail-Order
17141 = Cincinnati-Middletown, OH-KY-IN -- Mail-Order
17460 = Cleveland-Elyria-Mentor, OH -- Non Mail-Order
17461 = Cleveland-Elyria-Mentor, OH -- Mail-Order
19100 = Dallas-Fort Worth-Arlington, TX -- Non Mail-Order
19101 = Dallas-Fort Worth-Arlington, TX -- Mail-Order
28140 = Kansas City, MS-KS -- Non Mail-Order
28141 = Kansas City, MS-KS -- Mail-Order
33100 = Miami-Fort Lauderdale-Pompano Beach, FL - Non Mail-Order
33101 = Miami-Fort Lauderdale-Pompano Beach, FL - Mail-Order
36740 = Orlando-Kissimmee, FL -- Non Mail-Order
36741 = Orlando-Kissimmee, FL -- Mail-Order
38300 = Pittsburgh, PA -- Non Mail-Order
38301 = Pittsburgh, PA -- Mail-Order
40140 = Riverside-San Bernardino, CA -- Non Mail-Order
40141 = Riverside-San Bernardino, CA -- Mail-Order

DMERC_LINE_DCSN_IND_TB DMERC Line Decision Indicator Table

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

DMERC_LINE_FRGN_ADR_IND_TB DMERC Line Foreign Address Indicator Table

EX = Expatriate Beneficiary

DMERC_LINE_MTUS_IND_TB DMERC Line Miles/Time/Units Indicator Table

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

DMERC_LINE_RRB_EXCLSN_IND_TB DMERC Line RRB Exclusion Indicator Table

Y = Exclude RRB beneficiary services from the prior authorization
program

Blank = Subject RRB beneficiary services to prior authorization

DMERC_LINE_SCRN_RSLT_IND_TB DMERC Line Screen Result Indicator Table

A = Denied for lack of medical necessity; highest level of review was automated level I review
B = Reduced (partially denied) for lack of medical necessity; highest level of review was automated level I review
C = Denied as statutorily noncovered; highest level of review was automated level I review
D = Reserved for future use
E = Paid after automated level I review
F = Denied for lack of medical necessity; highest level of review was manual level I review
G = Reduced (partially denied) for lack of medical necessity; highest level of review was manual level I review
H = Denied as statutorily noncovered; highest level of review was manual level I review
I = Denied for coding/unbundling reasons; highest level of review was manual level I review
J = Paid after manual level I review
K = Denied for lack of medical necessity; highest level of review was manual level II review
L = Reduced (partially denied) for lack of medical necessity; highest level of review was manual level II review
M = Denied as statutorily noncovered; highest level of review was manual level II review
N = Denied for coding/unbundling reasons; highest level of review was manual level II review
O = Paid after manual level II review
P = Denied for lack of medical necessity; highest level of review was manual level III review
Q = Reduced (partially denied) for lack of medical necessity; highest level of review was manual level III review
R = Denied as statutorily noncovered; highest level of review was manual level III review
S = Denied for coding/unbundling reasons; highest level of review was manual

level III review
T = Paid after manual level III review

DMERC_LINE_SCRN_SUSPNSN_IND_TB DMERC Line Screen Suspension Indicator Table

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

DMERC_LINE_SUPLR_TYPE_TB DMERC Line Supplier Type Table

0 = Clinics, groups, associations, Intervention, or other entities for which the carrier's own ID number has been assigned.
1 = Physicians or suppliers billing as solo practitioners 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 than 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 EI numbers are used in coding the ID field.
6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.
7 = Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field.
8 = Other entities for whom EI numbers are used in coding the ID field.

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)

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_SRVC_DDCTBL_IND_TB Line Service Deductible Indicator Switch Code Table

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

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 derivation of this field where the claim was missing revenue center code = '0001'. In 1994, patch was applied to the OP and HHA SAFs only. (This SAF patch indicator was stored in the redefined Claim Edit Group, 4th occurrence, position 2). During the 'H' 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' conversion to claims with NCH weekly process date 10/1/93-10/30/95, where MSP values = invalid '0', '1', '2', '3' or '4' (caused by erroneous logic in HCFA program code, which was corrected on 11/1/95).

09 = Zero CWF claim accretion date replaced with NCH weekly process date (all claim types) -- applied during Version 'H' conversion to Instnl and DMERC claims; applied during Version 'G' conversion to non-institutional (non-DMERC) claims. Prior to Version 'H', patch indicator stored in redefined claim edit group, 3rd occurrence, position 1.

10 = Multiple Revenue Center 0001 (Outpatient, HHA and Hospice) -- patch applied to 1998 & 1999 Nearline and SAFs to delete any revenue codes that followed the first '0001' revenue center code. The edit was applied across all institutional claim types, including Inpatient/ SNF (the problem was only found with OP/HHA/ Hospice claims). The problem was corrected 6/25/99.

11 = Truncated claim total charge amount in the fixed portion replaced with the total charge amount in the revenue center 0001 amount field -- service years 1998 & 1999 patched during quarterly merge. The 1998 & 1999 SAFs were corrected when finalized in 7/99. The patch was done for records with NCH Daily Process Date 1/4/99 - 5/14/99.

12 = Missing claim-level HHA Total Visit Count -- service years 1998, 1999 & 2000 patch applied during Version 'I' conversion of both the Nearline and SAFs. Problem occurs in those claims recovered during the missing claims effort.

13 = Inconsistent Claim MCO Paid Switch made consistent with criteria used to identify an inpatient encounter claim -- if MCO paid switch equal to blank or '0' and ALL conditions are met to indicate an inpatient encounter claim (bene enrolled in a risk MCO during the service period), change the switch to a '1'. The patch was applied during the Version 'I' conversion, for claims back to 7/1/97 service thru date.

14 = SNF claims incorrectly identified as Inpatient
Encounter claims -- SNF claims matching the Inpatient encounter data criteria were incorrectly identified as Inpatient encounter claims (claim type code = '61' instead of '20' or '30'). NOTE: if the SNF claims were identified the MCO paid switch was set to '1'. The patch was applied to correctly identify these claims as a '20' or '30'. The MCO paid switch will be set to '0' as there is no way to recover the original value. The problem occurred in claims with an NCH Weekly Process Date ranging from 7/7/2000 - 1/26/2001. The patch applied date is 03/30/2001.

15 = HHA Part A claims with overlaid revenue center lines -
During the Version 'I' conversion, NCH made each segment of a claim contains a maximum of 45 revenue lines. During the month of June 2000 our CWFMQA had to be ready to except the new expanded format, but the NCH was not ready. CWFMQA converted these 'I' claims back to Version 'H', a typo in the code caused the additional revenue lines to overlay some of the revenue lines on the base/initial record/segment. The problem occurred in claims with NCH Weekly Process dates from 6/16/00, 6/23/00, 6/30/00 and 7/7/00 (both Version 'H' & 'I' files).

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

The patch applied date is 06/29/2001.

NCH_PATCH_TRLR_IND_TB NCH Patch Trailer Indicator Table

P = Patch code trailer present

NCH_STATE_SGMT_TB NCH State Segment Table

NCH State Segment	State Codes
B =	01;02;03;04;06;07;08;09; 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

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

YES_NO_TB Yes/No Table

Y = Yes
N = No

QUERY: RIFQQ11, RIFQQ21 ON DB2T
*******END OF TOC APPENDIX FOR RECORD: DMERC_CLM_REC********

1
LIMITATIONS APPENDIX FOR RECORD: DMERC_CLM_REC, STATUS: PROD, VERSION: 21006
PRINTED: 04/26/2021, USER: F43D, DATA SOURCE: CA REPOSITORY ON DB2T

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 implemented 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 distributed, but the new payment amounts were never sent to CWF (not in NCH). There is currently no requirement that FIs and carriers update CWF with final payment information by submitting payment only adjustments. It was noted that there is no expectation that CWF 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: DMERC_CLM_REC*******