

NAME	LENGTH	BEG	END	CONTENTS
*** FI Inpatient/SNF Claim Record (NCH)				
	VAR	1	31656	REC
				STANDARD ALIAS : FI_IP_SNF_CLM_REC SYSTEM ALIAS : UTLIPSNL
				LIMITATIONS :
				REFER TO :
				CHOICES_DEMO_LIM
				CLM_POA_IND_CD_LIM
				CLM_SNF_VRSN_I_REC_LIM
				CLM_TRANS_CD_LIM
				CNCL_CLM_LIM
				HHA_HCPCS_LIM
				IP_IME_GME_LIM
				MCO_PD_SW_LIM
				MLTPL_REV_CNTR_0001_CD_LIM
				PMT_AMT_EXCEDG_CHRG_AMT_LIM
				PPS_CPTL_DRG_WT_NUM_LIM
				PPS_CPTL_DSCHRG_FRCTN_PCT_LIM
				REV_CNTR_IDE_NDC_UPC_LIM
				REV_CNTR_TOT_CHRG_AMT_LIM
				REV_RNDRNG_PHYSN_NPI_NUM_LIM
				TOT_CHRG_AMT_LIM
1. FI Inpatient/SNF Claim Fixed Group				
	2058	1	2058	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. Fiscal Intermediary Claim Link Group

125 9 133 GRP

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

STANDARD ALIAS : FI\_CLM\_LINK\_GRP

9. Claim Locator Number Group

11 9 19 GRP

This number uniquely identifies the beneficiary in the NCH Nearline.

COMMON ALIAS : HIC

STANDARD ALIAS : CLM\_LCTR\_NUM\_GRP

TITLE ALIAS : HICAN

10. Beneficiary Claim Account Number

9 9 17 CHAR

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

COMMON ALIAS : CAN

DB2 ALIAS : BENE\_CLM\_ACNT\_NUM

SAS ALIAS : CAN

STANDARD ALIAS : BENE\_CLM\_ACNT\_NUM

TITLE ALIAS : CAN

LENGTH : 9

SOURCE : SSA,RRB

LIMITATIONS :

REFER TO :

CLM\_ACNT\_NUM\_LIM

11. NCH Category Equatable Beneficiary Identification Code

2 18 19 CHAR

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

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

COMMON ALIAS : NCH\_BASE\_CATEGORY\_BIC  
DB2 ALIAS : CTGRY\_EQTBL\_BIC  
SAS ALIAS : EQ\_BIC  
STANDARD ALIAS : NCH\_CTGRY\_EQTBL\_BIC\_CD  
TITLE ALIAS : EQUATED\_BIC

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CTGRY\_EQTBL\_BENE\_IDENT\_CD.

SOURCE : BIC EQUATE MODULE

CODE TABLE : CTGRY\_EQTBL\_BENE\_IDENT\_TB

## 12. Beneficiary Identification Code

2 20 21 CHAR

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

COMMON ALIAS : BIC  
DB2 ALIAS : BENE\_IDENT\_CD  
SAS ALIAS : BIC  
STANDARD ALIAS : BENE\_IDENT\_CD  
TITLE ALIAS : BIC

LENGTH : 2

SOURCE : SSA/RRB

EDIT RULES :  
EDB REQUIRED FIELD

CODE TABLE : BENE\_IDENT\_TB

## 13. NCH State Segment Code

1 22 22 CHAR

The code identifying the segment of the NCH Nearline file containing the beneficiary's record for a specific service



year. Effective 12/96, segmentation is by CLM\_LCTR\_NUM, then final action sequence within residence state. (Prior to 12/96, segmentation was by ranges of county codes within the residence state.)

DB2 ALIAS : NCH\_STATE\_SGMT\_CD  
SAS ALIAS : ST\_SGMT  
STANDARD ALIAS : NCH\_STATE\_SGMT\_CD  
TITLE ALIAS : NEAR\_LINE\_SEGMENT

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
BENE\_STATE\_SGMT\_NEAR\_LINE\_CD.

SOURCE : NCH

CODE TABLE : NCH\_STATE\_SGMT\_TB

#### 14. Beneficiary Residence SSA Standard State Code

2 23 24 CHAR

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

DB2 ALIAS : BENE\_SSA\_STATE\_CD  
SAS ALIAS : STATE\_CD  
STANDARD ALIAS : BENE\_RSDNC\_SSA\_STD\_STATE\_CD  
TITLE ALIAS : BENE\_STATE\_CD

LENGTH : 2

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

SOURCE : SSA/EDB

EDIT RULES :  
OPTIONAL: MAY BE BLANK

CODE TABLE : GEO\_SSA\_STATE\_TB

#### 15. Claim From Date

8 25 32 NUM

The first day on the billing statement covering services rendered to the bene-

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

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

DB2 ALIAS : CLM\_FROM\_DT  
SAS ALIAS : FROM\_DT  
STANDARD ALIAS : CLM\_FROM\_DT  
TITLE ALIAS : FROM\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

#### 16. Claim Through Date

8 33 40 NUM

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

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

DB2 ALIAS : CLM\_THRU\_DT  
SAS ALIAS : THRU\_DT  
STANDARD ALIAS : CLM\_THRU\_DT  
TITLE ALIAS : THRU\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

#### 17. NCH Weekly Claim Processing Date

8 41 48 NUM

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

DB2 ALIAS : NCH\_WKLY\_PROC\_DT  
SAS ALIAS : WKLY\_DT  
STANDARD ALIAS : NCH\_WKLY\_PROC\_DT

TITLE ALIAS : NCH\_PROCESS\_DT

LENGTH : 8 SIGNED : N

COMMENTS :

Prior to Version H this field was named:  
HCFA\_CLM\_PROC\_DT.

SOURCE : NCH

EDIT RULES :

YYYYMMDD

#### 18. CWF Claim Accretion Date

8 49 56 NUM

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

DB2 ALIAS : CWF\_CLM\_ACRTN\_DT

SAS ALIAS : ACRTN\_DT

STANDARD ALIAS : CWF\_CLM\_ACRTN\_DT

TITLE ALIAS : ACCRETION\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :

YYYYMMDD

#### 19. CWF Claim Accretion Number

2 57 58 PACK

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

DB2 ALIAS : CWF\_CLM\_ACRTN\_NUM

SAS ALIAS : ACRTN\_NM

STANDARD ALIAS : CWF\_CLM\_ACRTN\_NUM

TITLE ALIAS : ACCRETION\_NUMBER

LENGTH : 3 SIGNED : Y

SOURCE : CWF

20. FI Document Claim Control Number

23 59 81 CHAR

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

COMMON ALIAS : ICN  
DB2 ALIAS : DOC\_CLM\_CNTL\_NUM  
SAS ALIAS : CLM\_CNTL  
STANDARD ALIAS : FI\_DOC\_CLM\_CNTL\_NUM  
TITLE ALIAS : ICN

LENGTH : 23

SOURCE : CWF

21. FI Original Claim Control Number

23 82 104 CHAR

Effective with Version G, the original intermediary control number (ICN) which is present on adjustment claims, representing the ICN of the original transaction now being adjusted.

COMMON ALIAS : ORIGINAL\_ICN  
DB2 ALIAS : ORIG\_CLM\_CNTL\_NUM  
SAS ALIAS : ORIGCNTL  
STANDARD ALIAS : FI\_ORIG\_CLM\_CNTL\_NUM  
TITLE ALIAS : ORIGINAL\_ICN

LENGTH : 23

SOURCE : CWF

22. Claim Query Code

1 105 105 CHAR

Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator).

DB2 ALIAS : CLM\_QUERY\_CD  
SAS ALIAS : QUERY\_CD  
STANDARD ALIAS : CLM\_QUERY\_CD  
TITLE ALIAS : QUERY\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_QUERY\_TB

23. Provider Number

6 106 111 CHAR

The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.

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

DB2 ALIAS : PRVDR\_NUM  
SAS ALIAS : PROVIDER  
STANDARD ALIAS : PRVDR\_NUM  
TITLE ALIAS : PROVIDER\_NUMBER

LENGTH : 6

CODE TABLE : PRVDR\_NUM\_TB

24. NCH Daily Process Date

8 112 119 NUM

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

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

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

DB2 ALIAS : NCH\_DAILY\_PROC\_DT  
SAS ALIAS : DAILY\_DT  
STANDARD ALIAS : NCH\_DAILY\_PROC\_DT  
TITLE ALIAS : DAILY\_PROCESS\_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH

LIMITATIONS :

REFER TO :  
NCH\_DAILY\_PROC\_DT\_LIM

EDIT RULES :  
YYYYMMDD

25. 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

26. Claim Total Segment Count  
2 125 126 NUM

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

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

DB2 ALIAS : TOT\_SGMT\_CNT  
SAS ALIAS : SGMT\_CNT  
STANDARD ALIAS : CLM\_TOT\_SGMT\_CNT  
TITLE ALIAS : SEGMENT\_COUNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

27. Claim Segment Number

2 127 128 NUM

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

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

DB2 ALIAS : CLM\_SGMT\_NUM  
SAS ALIAS : SGMT\_NUM  
STANDARD ALIAS : CLM\_SGMT\_NUM  
TITLE ALIAS : SEGMENT\_NUMBER

LENGTH : 2 SIGNED : N

SOURCE : CWF

28. Claim Total Line Count

3 129 131 NUM

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

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

DB2 ALIAS : TOT\_LINE\_CNT  
SAS ALIAS : LINECNT  
STANDARD ALIAS : CLM\_TOT\_LINE\_CNT  
TITLE ALIAS : TOTAL\_LINE\_COUNT

LENGTH : 3 SIGNED : N

SOURCE : CWF

29. Claim Segment Line Count

2 132 133 NUM

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

segment.

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

DB2 ALIAS : SGMT\_LINE\_CNT  
SAS ALIAS : SGMTLINE  
STANDARD ALIAS : CLM\_SGMT\_LINE\_CNT  
TITLE ALIAS : SEGMENT\_LINE\_COUNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

30. FI CLAIM COMMON GROUP

1091 134 1224 GRP  
ALPHANUM

31. NCH Payment and Edit Record Identification Code

1 134 134 CHAR

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

DB2 ALIAS : PMT\_EDIT\_RIC\_CD  
SAS ALIAS : PE\_RIC  
STANDARD ALIAS : NCH\_PMT\_EDIT\_RIC\_CD  
TITLE ALIAS : NCH\_PAYMENT\_EDIT\_RIC

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : PMT\_EDIT\_RIC\_TB

32. Claim Transaction Code

1 135 135 CHAR

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

DB2 ALIAS : CLM\_TRANS\_CD  
SAS ALIAS : TRANS\_CD  
STANDARD ALIAS : CLM\_TRANS\_CD  
TITLE ALIAS : TRANSACTION\_CODE

LENGTH : 1



SOURCE : CWF

LIMITATIONS :

REFER TO :  
CLM\_TRANS\_CD\_LIM

CODE TABLE : CLM\_TRANS\_TB

### 33. Claim Bill Type Group

2 136 137 GRP

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

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

STANDARD ALIAS : CLM\_BILL\_TYPE\_CD\_GRP

CODE TABLE : CLM\_BILL\_TYPE\_TB

### 34. Claim Facility Type Code

1 136 136 CHAR

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

COMMON ALIAS : TOB1  
DB2 ALIAS : CLM\_FAC\_TYPE\_CD  
SAS ALIAS : FAC\_TYPE  
STANDARD ALIAS : CLM\_FAC\_TYPE\_CD  
TITLE ALIAS : TOB1

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_FAC\_TYPE\_TB

### 35. Claim Service Classification Type Code

1 137 137 CHAR

The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification of the type of service provided to the beneficiary.

COMMON ALIAS : TOB2

DB2 ALIAS : SRVC\_CLSFCTN\_CD  
SAS ALIAS : TYPESRVC  
STANDARD ALIAS : CLM\_SRVC\_CLSFCTN\_TYPE\_CD  
TITLE ALIAS : TOB2

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_SRVC\_CLSFCTN\_TYPE\_TB

36. Claim Frequency Code

1 138 138 CHAR

The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care.

COMMON ALIAS : TOB3  
DB2 ALIAS : CLM\_FREQ\_CD  
SAS ALIAS : FREQ\_CD  
STANDARD ALIAS : CLM\_FREQ\_CD  
TITLE ALIAS : FREQUENCY\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_FREQ\_TB

37. FILLER

1 139 139 CHAR

DB2 ALIAS : FILLER  
STANDARD ALIAS : FILLER

LENGTH : 1

38. NCH MQA Query Patch Code

1 140 140 CHAR

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

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

DB2 ALIAS : MQA\_QUERY\_PATCH\_CD  
SAS ALIAS : MQAQUERY  
STANDARD ALIAS : NCH\_MQA\_QUERY\_PATCH\_CD  
TITLE ALIAS : MQA\_QUERY\_PATCH\_IND

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH\_MQA\_QUERY\_PATCH\_TB

39. Claim Disposition Code

2 141 142 CHAR

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

DB2 ALIAS : CLM\_DISP\_CD

SAS ALIAS : DISP\_CD

STANDARD ALIAS : CLM\_DISP\_CD

TITLE ALIAS : DISPOSITION\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_DISP\_TB

40. NCH Edit Disposition Code

2 143 144 CHAR

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

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

DB2 ALIAS : NCH\_EDIT\_DISP\_CD

SAS ALIAS : EDITDISP

STANDARD ALIAS : NCH\_EDIT\_DISP\_CD

TITLE ALIAS : NCH\_EDIT\_DISP

LENGTH : 2

SOURCE : NCH QA Process

CODE TABLE : NCH\_EDIT\_DISP\_TB

41. NCH Claim BIC Modify H Code

1 145 145 CHAR

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

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

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

DB2 ALIAS : NCH\_BIC\_MDFY\_CD  
SAS ALIAS : BIC\_MDFY  
STANDARD ALIAS : NCH\_CLM\_BIC\_MDFY\_CD  
TITLE ALIAS : BIC\_MODIFY\_CD

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH\_CLM\_BIC\_MDFY\_TB

42. Beneficiary Residence SSA Standard County Code

3 146 148 CHAR

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

DB2 ALIAS : BENE\_SSA\_CNTY\_CD  
SAS ALIAS : CNTY\_CD  
STANDARD ALIAS : BENE\_RSDNC\_SSA\_STD\_CNTY\_CD  
TITLE ALIAS : BENE\_COUNTY\_CD

LENGTH : 3

SOURCE : SSA/EDB

EDIT RULES :  
OPTIONAL: MAY BE BLANK

43. FI Claim Receipt Date

8 149 156 NUM

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

DB2 ALIAS : FI\_CLM\_RCPT\_DT  
SAS ALIAS : RCPT\_DT  
STANDARD ALIAS : FI\_CLM\_RCPT\_DT  
TITLE ALIAS : RECEIPT\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_CLM\_RCPT\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

44. FI Claim Scheduled Payment Date

8 157 164 NUM

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

DB2 ALIAS : FI\_SCHLD\_PMT\_DT  
SAS ALIAS : SCHLD\_DT  
STANDARD ALIAS : FI\_CLM\_SCHLD\_PMT\_DT  
TITLE ALIAS : SCHEDULED\_PMT\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_CLM\_PMT\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

45. CWF Forwarded Date

8 165 172 NUM

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

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

DB2 ALIAS : CWF\_FRWRD\_DT  
SAS ALIAS : FRWRD\_DT  
STANDARD ALIAS : CWF\_FRWRD\_DT  
TITLE ALIAS : FORWARD\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

46. FI Number

5 173 177 CHAR

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

Effective October 2006, the Medicare Administrative

Contractors (MACs) began replacing the existing fiscal intermediaries and started processing institutional claim records for states assigned to its jurisdiction.

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

DB2 ALIAS : FI\_NUM  
SAS ALIAS : FI\_NUM  
STANDARD ALIAS : FI\_NUM  
TITLE ALIAS : INTERMEDIARY

LENGTH : 5

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_IDENT\_NUM.

SOURCE : CWF

CODE TABLE : FI\_NUM\_TB

#### 47. CWF Claim Assigned Number

8 178 185 CHAR

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

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

DB2 ALIAS : CWF\_CLM\_ASGN\_NUM  
SAS ALIAS : ASGN\_NUM  
STANDARD ALIAS : CWF\_CLM\_ASGN\_NUM  
TITLE ALIAS : ASSIGNED\_NUM

LENGTH : 8

SOURCE : CWF

#### 48. CWF Transmission Batch Number

4 186 189 CHAR

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

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

DB2 ALIAS : TRNSMSN\_BATCH\_NUM  
SAS ALIAS : FIBATCH  
STANDARD ALIAS : CWF\_TRNSMSN\_BATCH\_NUM  
TITLE ALIAS : BATCH\_NUM

LENGTH : 4

SOURCE : CWF

#### 49. Beneficiary Mailing Contact ZIP Code

9 190 198 CHAR

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

DB2 ALIAS : BENE\_MLG\_ZIP\_CD  
SAS ALIAS : BENE\_ZIP  
STANDARD ALIAS : BENE\_MLG\_CNTCT\_ZIP\_CD  
TITLE ALIAS : BENE\_ZIP

LENGTH : 9

SOURCE : EDB

#### 50. Beneficiary Sex Identification Code

1 199 199 CHAR

The sex of a beneficiary.

COMMON ALIAS : SEX\_CD  
DB2 ALIAS : BENE\_SEX\_IDENT\_CD  
SAS ALIAS : SEX  
STANDARD ALIAS : BENE\_SEX\_IDENT\_CD  
TITLE ALIAS : SEX\_CD

LENGTH : 1

SOURCE : SSA,RRB,EDB

EDIT RULES :  
REQUIRED FIELD

CODE TABLE : BENE\_SEX\_IDENT\_TB

#### 51. Beneficiary Race Code

1 200 200 CHAR

The race of a beneficiary.

DB2 ALIAS : BENE\_RACE\_CD  
SAS ALIAS : RACE  
STANDARD ALIAS : BENE\_RACE\_CD  
TITLE ALIAS : RACE\_CD

LENGTH : 1

SOURCE : SSA

CODE TABLE : BENE\_RACE\_TB

## 52. Beneficiary Birth Date

8 201 208 NUM

The beneficiary's date of birth.

COMMON ALIAS : DOB  
DB2 ALIAS : BENE\_BIRTH\_DT  
SAS ALIAS : BENE\_DOB  
STANDARD ALIAS : BENE\_BIRTH\_DT  
TITLE ALIAS : BENE\_BIRTH\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

## 53. CWF Beneficiary Medicare Status Code

2 209 210 CHAR

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

COMMON ALIAS : MSC  
DB2 ALIAS : BENE\_MDCR\_STUS\_CD  
SAS ALIAS : MS\_CD  
STANDARD ALIAS : CWF\_BENE\_MDCR\_STUS\_CD  
TITLE ALIAS : MSC

LENGTH : 2

DERIVATIONS :

CWF derives MSC from the following:

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

Items 1,3,4,5 come from the CWF Beneficiary Master Record; item 2 comes from the FI/Carrier



claim record. MSC is assigned as follows:

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

COMMENTS :

Prior to Version H this field was named:  
BENE\_MDCR\_STUS\_CD. The name has been changed  
to distinguish this CWF-derived field from the  
EDB-derived MSC (BENE\_MDCR\_STUS\_CD).

SOURCE : CWF

CODE TABLE : BENE\_MDCR\_STUS\_TB

54. Claim Patient 6 Position Surname

6 211 216 CHAR

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

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

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

COMMON ALIAS : PATIENT\_SURNAME  
DB2 ALIAS : PTNT\_6\_PSTN\_SRNM  
SAS ALIAS : SURNAME  
STANDARD ALIAS : CLM\_PTNT\_6\_PSTN\_SRNM\_NAME  
TITLE ALIAS : PATIENT\_SURNAME

LENGTH : 6

SOURCE : CWF

55. Claim Patient 1st Initial Given Name

1 217 217 CHAR

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

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

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

COMMON ALIAS : PATIENT\_GIVEN\_NAME  
DB2 ALIAS : 1ST\_INITL\_GVN\_NAME  
SAS ALIAS : FRSTINIT  
STANDARD ALIAS : CLM\_PTNT\_1ST\_INITL\_GVN\_NAME  
TITLE ALIAS : PATIENT\_FIRST\_INITIAL

LENGTH : 1

SOURCE : CWF

#### 56. Claim Patient First Initial Middle Name

1 218 218 CHAR

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

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

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

#### 57. Beneficiary CWF Location Code

1 219 219 CHAR

The code that identifies the Common Working File

(CWF) location (the host site) where a beneficiary's Medicare utilization records are maintained.

COMMON ALIAS : CWF\_HOST  
DB2 ALIAS : BENE\_CWF\_LOC\_CD  
SAS ALIAS : CWFLOCCD  
STANDARD ALIAS : BENE\_CWF\_LOC\_CD  
TITLE ALIAS : CWF\_HOST

LENGTH : 1

SOURCE : CWF

CODE TABLE : BENE\_CWF\_LOC\_TB

#### 58. Claim Principal Diagnosis Group

8 220 227 GRP

Effective with Version 'J', the group used to identify the principal diagnosis code.

This group contains the principal diagnosis code and the principal diagnosis version code.

STANDARD ALIAS : CLM\_PRNCPAL\_DGNS\_GRP

#### 59. Claim Principal Diagnosis Version Code

1 220 220 CHAR

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

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

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PDVRSNCD  
STANDARD ALIAS : CLM\_PRNCPAL\_DGNS\_VRSN\_CD

LENGTH : 1

CODE TABLE : CLM\_DGNS\_VRSN\_TB

#### 60. Claim Principal Diagnosis Code

7 221 227 CHAR

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

NOTE: Effective with Version H, this data is also

redundantly stored as the first occurrence of the diagnosis trailer.

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

DB2 ALIAS : PRNCPAL\_DGNS\_CD  
SAS ALIAS : PDGNS\_CD  
STANDARD ALIAS : CLM\_PRNCPAL\_DGNS\_CD

LENGTH : 7

SOURCE : CWF

EDIT RULES :  
ICD-9-CM

#### 61. FILLER

1 228 228 CHAR

DB2 ALIAS : FILLER  
STANDARD ALIAS : FILLER

LENGTH : 1

#### 62. Claim Medicare Non Payment Reason Code

2 229 230 CHAR

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

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

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

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

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

DB2 ALIAS : MDCR\_NPMT\_RSN\_CD

SAS ALIAS : NOPAY\_CD  
STANDARD ALIAS : CLM\_MDCR\_NPMT\_RSN\_CD

LENGTH : 2

CODE TABLE : CLM\_MDCR\_NPMT\_RSN\_TB

63. Claim Excepted/Nonexcepted Medical Treatment Code

1 231 231 CHAR

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

DB2 ALIAS : EXCPTD\_NEXCPTD\_CD  
SAS ALIAS : TRTMT\_CD  
STANDARD ALIAS : CLM\_EXCPTD\_NEXCPTD\_TRTMT\_CD  
TITLE ALIAS : EXCPTD\_NEXCPTD\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_EXCPTD\_NEXCPTD\_TRTMT\_TB

64. Claim Payment Amount

6 232 237 PACK

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

Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). After 4/1/03, the payment

amount could also include a "new technology" add-on amount. 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 other payer reimbursement.

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

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

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

Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total claim payment.

The payment amount also includes the outlier payment and interest.

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

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

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

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

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

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

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

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

COMMON ALIAS : REIMBURSEMENT  
DB2 ALIAS : CLM\_PMT\_AMT  
SAS ALIAS : PMT\_AMT  
STANDARD ALIAS : CLM\_PMT\_AMT  
TITLE ALIAS : REIMBURSEMENT

LENGTH : 9.2 SIGNED : Y

COMMENTS :

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

SOURCE : CWF

LIMITATIONS :

REFER TO :

PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM

EDIT RULES :

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

65. NCH Primary Payer Claim Paid Amount

6 238 243 PACK

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

DB2 ALIAS : PRMRY\_PYR\_PD\_AMT

STANDARD ALIAS : NCH\_PRMRY\_PYR\_CLM\_PD\_AMT

TITLE ALIAS : PRIMARY\_PAYER\_AMOUNT

LENGTH : 9.2 SIGNED : Y

COMMENTS :

Prior to Version H this field was named: BENE\_PRMRY\_PYR\_CLM\_PMT\_AMT and the field size was S9(7)V99.

SOURCE : NCH

EDIT RULES :

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

66. NCH Primary Payer Code

1 244 244 CHAR

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

DB2 ALIAS : NCH\_PRMRY\_PYR\_CD

SAS ALIAS : PRPAY\_CD

STANDARD ALIAS : NCH\_PRMRY\_PYR\_CD



TITLE ALIAS : PRIMARY\_PAYER\_CD

LENGTH : 1

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES

SET NCH\_PRMRY\_PYR\_CD TO 'A' WHERE THE  
CLM\_VAL\_CD = '12'

SET NCH\_PRMRY\_PYR\_CD TO 'B' WHERE THE  
CLM\_VAL\_CD = '13'

SET NCH\_PRMRY\_PYR\_CD TO 'C' WHERE THE  
CLM\_VAL\_CD = '16' and CLM\_VAL\_AMT is zeroes

SET NCH\_PRMRY\_PYR\_CD TO 'D' WHERE THE  
CLM\_VAL\_CD = '14'

SET NCH\_PRMRY\_PYR\_CD TO 'E' WHERE THE  
CLM\_VAL\_CD = '15'

SET NCH\_PRMRY\_PYR\_CD TO 'F' WHERE THE  
CLM\_VAL\_CD = '16' (CLM\_VAL\_AMT not  
equal to zeroes)

SET NCH\_PRMRY\_PYR\_CD TO 'G' WHERE THE  
CLM\_VAL\_CD = '43'

SET NCH\_PRMRY\_PYR\_CD TO 'H' WHERE THE  
CLM\_VAL\_CD = '41'

SET NCH\_PRMRY\_PYR\_CD TO 'I' WHERE THE  
CLM\_VAL\_CD = '42'

SET NCH\_PRMRY\_PYR\_CD TO 'L' (or prior to 4/97  
set code to 'J') WHERE THE CLM\_VAL\_CD = '47'

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PRMRY\_PYR\_CD.

SOURCE : NCH

CODE TABLE : BENE\_PRMRY\_PYR\_TB

67. FI Requested Claim Cancel Reason Code  
1 245 245 CHAR

The reason that an intermediary requested cancelling

a previously submitted institutional claim.

DB2 ALIAS : RQST\_CNCL\_RSN\_CD  
SAS ALIAS : CANCELCD  
STANDARD ALIAS : FI\_RQST\_CLM\_CNCL\_RSN\_CD  
TITLE ALIAS : CANCEL\_CD

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
INTRMDRY\_RQST\_CLM\_CNCL\_RSN\_CD.

SOURCE : CWF

CODE TABLE : FI\_RQST\_CLM\_CNCL\_RSN\_TB

68. FI Claim Action Code

1 246 246 CHAR

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

DB2 ALIAS : FI\_CLM\_ACTN\_CD  
SAS ALIAS : ACTIONCD  
STANDARD ALIAS : FI\_CLM\_ACTN\_CD  
TITLE ALIAS : ACTION\_CD

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
INTRMDRY\_CLM\_ACTN\_CD.

SOURCE : CWF

CODE TABLE : FI\_CLM\_ACTN\_TB

69. FI Claim Process Date

8 247 254 NUM

The date the fiscal intermediary completes  
processing and releases the institutional  
claim to the CWF host.

DB2 ALIAS : FI\_CLM\_PROC\_DT  
SAS ALIAS : APRVL\_DT  
STANDARD ALIAS : FI\_CLM\_PROC\_DT  
TITLE ALIAS : FI\_PROCESS\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

70. NCH Provider State Code

2 255 256 CHAR

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

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

DB2 ALIAS : NCH\_PRVDR\_STATE\_CD  
SAS ALIAS : PRSTATE  
STANDARD ALIAS : NCH\_PRVDR\_STATE\_CD  
TITLE ALIAS : PROVIDER\_STATE\_CD

LENGTH : 2

DERIVATIONS :  
DERIVED FROM:  
NCH PRVDR\_NUM

DERIVATION RULES:

SET NCH\_PRVDR\_STATE\_CD TO  
PRVDR\_NUM POS1-2.  
FOR PRVDR\_NUM POS1-2 EQUAL '55' OR '75'  
OR '92' OR 'A0'  
OR 'A1' OR 'B2'  
SET NCH\_PRVDR\_STATE\_CD TO '05'.

FOR PRVDR\_NUM POS1-2 EQUAL '67' OR '74'  
OR '97' OR 'A9'  
SET NCH\_PRVDR\_STATE\_CD TO '45'.

FOR PRVDR\_NUM POS1-2 EQUAL '68' OR '69'  
OR 'A2'  
SET NCH\_PRVDR\_STATE\_CD TO '10'.

FOR PRVDR\_NUM POS1-2 EQUAL '78'  
SET NCH\_PRVDR\_STATE\_CD TO '14'

FOR PRVDR\_NUM POS1-2 EQUAL TO '76'  
SET NCH\_PRVDR\_STATE\_CD TO '16'

FOR PRVDR\_NUM POS1-2 EQUAL '70'  
SET NCH\_PRVDR\_STATE\_CD TO '17'

FOR PRVDR\_NUM POS1-2 EQUAL '71' OR '95'  
OR 'A3'  
SET NCH\_PRVDR\_STATE\_CD TO '19'

FOR PRVDR\_NUM POS1-2 EQUAL '77'  
SET NCH\_PRVDR\_STATE\_CD TO '24'

FOR PRVDR\_NUM POS1-2 EQUAL TO '72' OR 'A6'  
SET NCH\_PRVDR\_STATE\_CD TO '36'

FOR PRVDR\_NUM POS1-2 EQUAL TO '73' OR 'A7'  
SET NCH\_PRVDR\_STATE\_CD TO '39'

FOR PRVDR\_NUM POS1-2 EQUAL TO '81'  
SET NCH\_PRVDR\_STATE\_CD TO '07'

FOR PRVDR\_NUM POS1-2 EQUAL TO '82'  
SET NCH\_PRVDR\_STATE\_CD TO '22'

FOR PRVDR\_NUM POS1-2 EQUAL TO '83'  
SET NCH\_PRVDR\_STATE\_CD TO '31'

FOR PRVDR\_NUM POS1-2 EQUAL TO '84'  
SET NCH\_PRVDR\_STATE\_CD TO '40'

FOR PRVDR\_NUM POS1-2 EQUAL TO '85'  
SET NCH\_PRVDR\_STATE\_CD TO '11'

FOR PRVDR\_NUM POS1-2 EQUAL TO '86'  
SET NCH\_PRVDR\_STATE\_CD TO '34'

FOR PRVDR\_NUM POS1-2 EQUAL TO '87'  
SET NCH\_PRVDR\_STATE\_CD TO '42'

FOR PRVDR\_NUM POS1-2 EQUAL TO '88' OR 'A8'  
SET NCH\_PRVDR\_STATE\_CD TO '44'

FOR PRVDR\_NUM POS1-2 EQUAL TO '89'  
SET NCH\_PRVDR\_STATE\_CD TO '04'

FOR PRVDR\_NUM POS1-2 EQUAL TO '90'  
SET NCH\_PRVDR\_STATE\_CD TO '37'

FOR PRVDR\_NUM POS1-2 EQUAL TO '91'  
SET NCH\_PRVDR\_STATE\_CD TO '06'

FOR PRVDR\_NUM POS1-2 EQUAL TO '93'  
SET NCH\_PRVDR\_STATE\_CD TO '38'

FOR PRVDR\_NUM POS1-2 EQUAL TO '94'  
SET NCH\_PRVDR\_STATE\_CD TO '50'

FOR PRVDR\_NUM POS1-2 EQUAL TO '96'  
SET NCH\_PRVDR\_STATE\_CD TO '32'

FOR PRVDR\_NUM POS1-2 EQUAL TO '00'  
SET NCH\_PRVDR\_STATE\_CD TO '03'

FOR PRVDR\_NUM POS1-2 EQUAL TO '54'  
SET NCH\_PRVDR\_STATE\_CD TO '13'

FOR PRVDR\_NUM POS1-2 EQUAL TO '57'  
SET NCH\_PRVDR\_STATE\_CD TO '33'

FOR PRVDR\_NUM POS1-2 EQUAL TO '58' OR 'B1'  
SET NCH\_PRVDR\_STATE\_CD TO '51'

FOR PRVDR\_NUM POS1-2 EQUAL TO '79'  
SET NCH\_PRVDR\_STATE\_CD TO '26'

FOR PRVDR\_NUM POS1-2 EQUAL TO '80'  
SET NCH\_PRVDR\_STATE\_CD TO '21'

FOR PRVDR\_NUM POS1-2 EQUAL TO 'A4'  
SET NCH\_PRVDR\_STATE\_CD TO '23'

FOR PRVDR\_NUM POS1-2 EQUAL TO 'A5'  
SET NCH\_PRVDR\_STATE\_CD TO '25'

FOR PRVDR\_NUM POS1-2 EQUAL TO 'B0'  
SET NCH\_PRVDR\_STATE\_CD TO '18'

SOURCE : NCH

CODE TABLE : GEO\_SSA\_STATE\_TB

#### 71. Organization NPI Number

10 257 266 CHAR

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

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

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim

when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : ORG\_NPI\_NUM  
SAS ALIAS : ORGNPINM  
STANDARD ALIAS : ORG\_NPI\_NUM  
TITLE ALIAS : ORG\_NPI

LENGTH : 10

SOURCE : CWF

#### 72. Attending Physician ID Group

24 267 290 GRP

Name and identification numbers associated with the primary care physician.

STANDARD ALIAS : ATNDG\_PHYSN\_ID\_GRP

#### 73. Claim Attending Physician UPIN Number

6 267 272 CHAR

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

COMMON ALIAS : ATTENDING\_PHYSICIAN\_UPIN  
DB2 ALIAS : ATNDG\_UPIN\_NUM  
SAS ALIAS : AT\_UPIN  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_UPIN\_NUM  
TITLE ALIAS : ATTENDING\_PHYSICIAN

LENGTH : 6

COMMENTS :

Prior to Version H this field was named: CLM\_PRMRY\_CARE\_PHYSN\_IDENT\_NUM and contained 10 positions (6-position UPIN and 4-position physician surname).

SOURCE : CWF

#### 74. Claim Attending Physician NPI Number

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

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

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

COMMON ALIAS : ATTENDING\_PHYSICIAN\_NPI  
 DB2 ALIAS : ATNDG\_NPI\_NUM  
 SAS ALIAS : AT\_NPI  
 STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_NPI\_NUM  
 TITLE ALIAS : ATNDG\_NPI

LENGTH : 10

SOURCE : CWF

75. Claim Attending Physician Surname  
 6 283 288 CHAR

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

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

DB2 ALIAS : ATNDG\_SRNM  
SAS ALIAS : AT\_SRNM  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : ANDG\_PHYSN\_SURNAME

LENGTH : 6

SOURCE : CWF

76. Claim Attending Physician Given Name  
1 289 289 CHAR

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

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

DB2 ALIAS : ATNDG\_GVN\_NAME  
SAS ALIAS : AT\_GVNNM  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_GVN\_NAME  
TITLE ALIAS : ATNDG\_PHYSN\_FIRSTNAME

LENGTH : 1

SOURCE : CWF

77. Claim Attending Physician Middle Initial Name  
1 290 290 CHAR

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

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

DB2 ALIAS : ATNDG\_MI\_NAME  
SAS ALIAS : AT\_MDL  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_MDL\_INITL\_NAME  
TITLE ALIAS : ATNDG\_PHYSN\_MI

LENGTH : 1

SOURCE : CWF

78. Operating Physician ID Group  
24 291 314 GRP



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

STANDARD ALIAS : OPRTG\_PHYSN\_ID\_GRP

79. Claim Operating Physician UPIN Number

6 291 296 CHAR

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

DB2 ALIAS : OPRTG\_UPIN

SAS ALIAS : OP\_UPIN

STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_UPIN\_NUM

TITLE ALIAS : OPRTG\_UPIN

LENGTH : 6

COMMENTS :

Prior to Version H this field was named: CLM\_PRNCPAL\_PRCDR\_PHYSN\_NUM and contained 10 positions (6-position UPIN and 4-position physician surname).

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

SOURCE : CWF

80. Claim Operating Physician NPI Number

10 297 306 CHAR

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

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase

(4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

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

DB2 ALIAS : OPRTG\_NPI  
SAS ALIAS : OP\_NPI  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_NPI\_NUM  
TITLE ALIAS : OPRTG\_NPI

LENGTH : 10

SOURCE : CWF

81. Claim Operating Physician Surname  
6 307 312 CHAR

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

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

DB2 ALIAS : OPRTG\_SRNM  
SAS ALIAS : OP\_SRNM  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_SURNAME

LENGTH : 6

SOURCE : CWF

82. Claim Operating Physician Given Name  
1 313 313 CHAR

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

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

DB2 ALIAS : OPRTG\_GVN\_NAME  
SAS ALIAS : OP\_GVN  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_GVN\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_FIRSTNAME

LENGTH : 1

SOURCE : CWF

83. Claim Operating Physician Middle Initial Name

1 314 314 CHAR

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

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

DB2 ALIAS : OPRTG\_MI\_NAME  
SAS ALIAS : OP\_MDL  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_MDL\_INITL\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_MI

LENGTH : 1

SOURCE : CWF

84. Other Operating Physician ID Group

24 315 338 GRP

Name and identification numbers associated with the other physician.

STANDARD ALIAS : OTHR\_OPRTG\_PHYSN\_ID\_GRP

COMMENTS :

This field was renamed from OTHR\_PHYSN\_ID\_GRP to OTHR\_OPRTG\_PHYSN\_ID\_GRP as part of the CR#7 updates.

85. Claim Other Physician UPIN Number

6 315 320 CHAR

On an institutional claim, the unique physician identification number (UPIN) of the other

physician associated with the institutional claim.

DB2 ALIAS : OTHR\_UPIN  
SAS ALIAS : OT\_UPIN  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_UPIN\_NUM  
TITLE ALIAS : OTH\_PHYSN\_UPIN

LENGTH : 6

COMMENTS :

Prior to Version H this field was named: CLM\_OTHR\_PHYSN\_IDENT\_NUM and contained 10 positions (6-position UPIN and 4-position other physician surname).

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

SOURCE : CWF

86. Claim Other Physician NPI Number  
10 321 330 CHAR

On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the other physician associated with the institutional claim.

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

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

for those physicians.

DB2 ALIAS : OTHR\_NPI  
SAS ALIAS : OT\_NPI  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_NPI\_NUM

LENGTH : 10

SOURCE : CWF

87. Claim Other Physician Surname

6 331 336 CHAR

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

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

DB2 ALIAS : OTHR\_SRNM  
SAS ALIAS : OT\_SRNM  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : OTH\_PHYSN\_SURNAME

LENGTH : 6

SOURCE : CWF

88. Claim Other Physician Given Name

1 337 337 CHAR

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

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

DB2 ALIAS : OTHR\_GVN\_NAME  
SAS ALIAS : OT\_GVN  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_GVN\_NAME  
TITLE ALIAS : OTH\_PHYSN\_FIRSTNAME

LENGTH : 1

SOURCE : CWF

89. Claim Other Physician Middle Initial Name

1 338 338 CHAR

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

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

DB2 ALIAS : OTHR\_MI\_NAME  
SAS ALIAS : OT\_MDL  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_MDL\_INITL\_NAME  
TITLE ALIAS : OTH\_PHYSN\_MI

LENGTH : 1

SOURCE : CWF

#### 90. Medicaid Provider Identification Number

13 339 351 CHAR

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

DB2 ALIAS : MDCD\_PRVDR\_NUM  
SAS ALIAS : MDCD\_PRV  
STANDARD ALIAS : MDCD\_PRVDR\_IDENT\_NUM  
TITLE ALIAS : MEDICAID\_PROVIDER

LENGTH : 13

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

SOURCE : CWF

#### 91. Claim Medicaid Information Code

4 352 355 CHAR

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

DB2 ALIAS : CLM\_MDCD\_INFO\_CD  
SAS ALIAS : MDCDINFO  
STANDARD ALIAS : CLM\_MDCD\_INFO\_CD  
TITLE ALIAS : MEDICAID\_INFO

LENGTH : 4

SOURCE : CWF

CODE TABLE : CLM\_MDCD\_INFO\_TB

92. Claim MCO Paid Switch

1 356 356 CHAR

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

DB2 ALIAS : CLM\_MCO\_PD\_SW  
SAS ALIAS : MCOPDSW  
STANDARD ALIAS : CLM\_MCO\_PD\_SW  
TITLE ALIAS : MCO\_PAID\_SW

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CLM\_GHO\_PD\_SW.

SOURCE : CWF

LIMITATIONS :

REFER TO :  
MCO\_PD\_SW\_LIM

CODE TABLE : CLM\_MCO\_PD\_TB

93. Claim Treatment Authorization Number

18 357 374 CHAR

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

NOTE1: Under HH PPS this field will be used to link claims to the OASIS assessment used as the basis of payment. This eighteen character string consists of the start of care date, the OASIS assessment date and the two digit reason for assessment code.

NOTE2: Treatment authorization codes should be missing for any HH claim with a From Date after 1/1/2020. This is a change to billing instructions that is part of the HH Patient-Driving

Groupings Model. The Admission Date will also be missing because it was derived from information that was encoded from the Treatment Authorization Code.

COMMON ALIAS : TAN  
DB2 ALIAS : TRTMT\_AUTHRZTN\_NUM  
SAS ALIAS : AUTHRZTN  
STANDARD ALIAS : CLM\_TRTMT\_AUTHRZTN\_NUM  
TITLE ALIAS : TREATMENT\_AUTHORIZATION

LENGTH : 18

SOURCE : CWF

94. Patient Control Number

20 375 394 CHAR

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

DB2 ALIAS : PTNT\_CNTL\_NUM  
SAS ALIAS : PTNTCNTL  
STANDARD ALIAS : PTNT\_CNTL\_NUM  
TITLE ALIAS : PATIENT\_CONTROL\_NUM

LENGTH : 20

SOURCE : CWF

95. Claim Medical Record Number

17 395 411 CHAR

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

DB2 ALIAS : CLM\_MDCL\_REC\_NUM  
SAS ALIAS : MDCL\_REC  
STANDARD ALIAS : CLM\_MDCL\_REC\_NUM  
TITLE ALIAS : MEDICAL\_RECORD\_NUM

LENGTH : 17

SOURCE : CWF

96. Claim PRO Control Number

12 412 423 CHAR

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



DB2 ALIAS : CLM\_PRO\_CNTL\_NUM  
SAS ALIAS : PRO\_CNTL  
STANDARD ALIAS : CLM\_PRO\_CNTL\_NUM  
TITLE ALIAS : PRO\_CONTROL\_NUM

LENGTH : 12

SOURCE : CWF

97. Claim PRO Process Date

8 424 431 NUM

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

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

DB2 ALIAS : CLM\_PRO\_PROC\_DT  
SAS ALIAS : PRO\_DT  
STANDARD ALIAS : CLM\_PRO\_PROC\_DT  
TITLE ALIAS : PRO\_PROC\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

98. Patient Discharge Status Code

2 432 433 CHAR

The code used to identify the status of the patient as of the CLM\_THRU\_DT.

DB2 ALIAS : PTNT\_DSCHRG\_STUS  
SAS ALIAS : STUS\_CD  
STANDARD ALIAS : PTNT\_DSCHRG\_STUS\_CD  
TITLE ALIAS : PTNT\_DSCHRG\_STUS\_CD

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CLM\_STUS\_CD.

SOURCE : CWF

CODE TABLE : PTNT\_DSCHRG\_STUS\_TB

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

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

STANDARD ALIAS : CLM\_1ST\_DGNS\_E\_CD\_GRP

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

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

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

DB2 ALIAS : UNDEFINED  
SAS ALIAS : E1VRSNCD  
STANDARD ALIAS : CLM\_1ST\_DGNS\_E\_VRSN\_CD

LENGTH : 1

CODE TABLE : CLM\_DGNS\_VRSN\_TB

101. Claim 1st Diagnosis E Code  
7 435 441 CHAR

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

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

DB2 ALIAS : CLM\_1ST\_DGNS\_E\_CD  
SAS ALIAS : DGNS\_E  
STANDARD ALIAS : CLM\_1ST\_DGNS\_E\_CD

LENGTH : 7

COMMENTS :  
Prior to version 'J', this field was named:  
CLM\_DGNS\_E\_CD.

SOURCE : CWF

EDIT RULES :

ICD-9-CM

102. Claim PPS Indicator Code

1 442 442 CHAR

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

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

DB2 ALIAS : CLM\_PPS\_IND\_CD  
SAS ALIAS : PPS\_IND  
STANDARD ALIAS : CLM\_PPS\_IND\_CD  
TITLE ALIAS : PPS\_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_PPS\_IND\_TB

103. Claim Total Charge Amount

6 443 448 PACK

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

DB2 ALIAS : CLM\_TOT\_CHRG\_AMT  
SAS ALIAS : TOT\_CHRG  
STANDARD ALIAS : CLM\_TOT\_CHRG\_AMT  
TITLE ALIAS : CLAIM\_TOTAL\_CHARGES

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

LIMITATIONS :

REFER TO :  
TOT\_CHRG\_AMT\_LIM

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

104. Claim Pricer Return Code

2 449 450 CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, the code used to identify various PPS payment adjustment types. This code identifies the payment return code or the error return code for every claim type calculated by a PRICER (Inpatient, Outpatient, SNF, Inpatient Rehab Facility (IRF), Home Health and Hospice).

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

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

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

DB2 ALIAS : CLM\_PRCR\_RTRN\_CD  
SAS ALIAS : PRCRRTRN  
STANDARD ALIAS : CLM\_PRCR\_RTRN\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_PRCR\_RTRN\_TB

105. Claim Business Segment Identifier Code

4 451 454 CHAR

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

DB2 ALIAS : BUSNS\_SGMT\_ID\_CD  
SAS ALIAS : SGMT\_ID

STANDARD ALIAS : CLM\_BUSNS\_SGMT\_ID\_CD

LENGTH : 4

SOURCE : CWF

106. Recovery Audit Contractor (RAC) Adjustment Indicator Code

1 455 455 CHAR

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

DB2 ALIAS : RAC\_ADJSTMT\_CD

SAS ALIAS : RACINDCD

STANDARD ALIAS : CLM\_RAC\_ADJSTMT\_IND\_CD

LENGTH : 1

CODE TABLE : CLM\_RAC\_ADJSTMT\_TB

107. Worker's Compensation Indicator Code

1 456 456 CHAR

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

DB2 ALIAS : CLM\_WC\_IND\_CD

SAS ALIAS : WCINDCD

STANDARD ALIAS : CLM\_WC\_IND\_CD

LENGTH : 1

CODE TABLE : CLM\_WC\_IND\_TB

108. Claim Service Facility Zip Code

9 457 465 CHAR

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

DB2 ALIAS : SRVC\_FAC\_ZIP\_CD

SAS ALIAS : SRVCFAC

STANDARD ALIAS : CLM\_SRVC\_FAC\_ZIP\_CD

LENGTH : 9

109. Claim Paperwork (PWK) Code

2 466 467 CHAR

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

DB2 ALIAS : CLM\_PWK\_CD  
STANDARD ALIAS : CLM\_PWK\_CD

LENGTH : 2

CODE TABLE : CLM\_PWK\_TB

#### 110. Claim Care Improvement Model 1 Code

2 468 469 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

#### 111. Claim Care Improvement Model 2 Code

2 470 471 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

#### 112. Claim Care Improvement Model 3 Code

2 472 473 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

113. Claim Care Improvement Model 4 Code

2 474 475 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

114. Rendering Physician ID Group

26 476 501 GRP

CR 7115 titled, Primary Care Incentive payment Program (PCIP), Section 5501(a) of the Patient Protection and Affordable Care Act (ACA), Payment to a Critical Access Hospital (CAH) paid under the Optional Method, instructed CAH providers to submit their NPI using the "Other Provider" field. With the implementation of 5010, the "Other Physician Group" was redefined to "Other Operating Physician" and thus, not appropriate for usage for PCIP reporting. With the implementation of CR7686, CAH providers must use the rendering provider fields to populate the eligible primary care practitioner NPI in order for the primary care services to qualify for the incentive bonus.

STANDARD ALIAS : RNDRNG\_PHYSN\_ID\_GRP

115. Claim Rendering Physician UPIN Number

6 476 481 CHAR

Effective with CR#7, the unique physician identification number (UPIN) of the rendering physician whose services qualify for an incentive bonus under the Primary Care Incentive Payment Program (PCIP).

NOTE: CR7115 titled, Primary Care Incentive Payment Program (PCIP), Section 5501(a) of the Patient

Protection and Affordable Care Act (ACA), payment to Critical Access Hospitals (CAH) paid under the Optional Method, instructed CAH providers to submit their NPI using the "Other Provider" field. With the implementation of 5010, the "Other Physician Group" as redefined to "Other Operating Physician" and thus, not appropriate for usage for PCIP reporting. With the implementation of CR7686, CAH providers must use the rendering provider fields to populate the eligible primary care practitioner NPI in order for primary care services to qualify for the incentive bonus.

DB2 ALIAS : RNRNG-UPIN  
SAS ALIAS : R-UPIN  
STANDARD ALIAS : CLM\_RNRNG\_PHYSN\_UPIN\_NUM

LENGTH : 6

#### 116. Claim Rendering Physician NPI Number

10 482 491 CHAR

Effective with CR#7, the national provider identifier (NPI) number assigned to uniquely identify the rendering physician whose services qualify for an incentive bonus under the Primary Care Incentive Payment Program (PCIP).

NOTE: CR7115 titled, Primary Care Incentive Payment Program (PCIP), Section 5501(a) of the Patient Protection and Affordable Care Act (ACA), payment to Critical Access Hospitals (CAH) paid under the Optional Method, instructed CAH providers to submit their NPI using the "Other Provider" field. With the implementation of 5010, the "Other Physician Group" as redefined to "Other Operating Physician" and thus, not appropriate for usage for PCIP reporting. With the implementation of CR7686, CAH providers must use the rendering provider fields to populate the eligible primary care practitioner NPI in order for primary care services to qualify for the incentive bonus.

DB2 ALIAS : RNRNG-NPI  
SAS ALIAS : R-NPI  
STANDARD ALIAS : CLM\_RNRNG\_PHYSN\_NPI\_NUM

LENGTH : 10

#### 117. Claim Rendering Physician Surname Name

6 492 497 CHAR

Effective with CR#7, the last name of the rendering physician whose services qualify for an incentive bonus under the Primary Care Incentive Payment Program.



NOTE: CR7115 titled, Primary Care Incentive Payment Program (PCIP), Section 5501(a) of the Patient Protection and Affordable Care Act (ACA), payment to Critical Access Hospitals (CAH) paid under the Optional Method, instructed CAH providers to submit their NPI using the "Other Provider" field. With the implementation of 5010, the "Other Physician Group" as redefined to "Other Operating Physician" and thus, not appropriate for usage for PCIP reporting. With the implementation of CR7686, CAH providers must use the rendering provider fields to populate the eligible primary care practitioner NPI in order for primary care services to qualify for the incentive bonus.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : R-SRNM  
STANDARD ALIAS : CLM\_RNDRNG\_PHYSN\_SRNM\_NAME

LENGTH : 6

#### 118. Claim Rendering Physician Given Name

1 498 498 CHAR

Effective with CR#7, the first name of the rendering physician whose services qualify for an incentive bonus under the Primary Care Incentive Payment Program.

NOTE: CR7115 titled, Primary Care Incentive Payment Program (PCIP), Section 5501(a) of the Patient Protection and Affordable Care Act (ACA), payment to Critical Access Hospitals (CAH) paid under the Optional Method, instructed CAH providers to submit their NPI using the "Other Provider" field. With the implementation of 5010, the "Other Physician Group" as redefined to "Other Operating Physician" and thus, not appropriate for usage for PCIP reporting. With the implementation of CR7686, CAH providers must use the rendering provider fields to populate the eligible primary care practitioner NPI in order for primary care services to qualify for the incentive bonus.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : R-GVN  
STANDARD ALIAS : CLM\_RNDRNG\_PHYSN\_GVN\_NAME

LENGTH : 1

#### 119. Claim Rendering Physician Middle Name

1 499 499 CHAR

Effective with CR#7, the middle initial name of the rendering physician whose services qualify for an

incentive bonus under the Primary Care Incentive Payment Program.

NOTE: CR7115 titled, Primary Care Incentive Payment Program (PCIP), Section 5501(a) of the Patient Protection and Affordable Care Act (ACA), payment to Critical Access Hospitals (CAH) paid under the Optional Method, instructed CAH providers to submit their NPI using the "Other Provider" field. With the implementation of 5010, the "Other Physician Group" as redefined to "Other Operating Physician" and thus, not appropriate for usage for PCIP reporting. With the implementation of CR7686, CAH providers must use the rendering provider fields to populate the eligible primary care practitioner NPI in order for primary care services to qualify for the incentive bonus.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : R-MDL  
STANDARD ALIAS : CLM\_RNDRNG\_PHYSN\_MDL\_NAME

LENGTH : 1

#### 120. Claim Rendering Physician Specialty Code

2 500 501 CHAR

Effective with CR#7, the code used to identify the CMS specialty code of the rendering physician/practitioner.

NOTE: A 10 percent initiative payment will be provided to primary care practitioners, identified as: (1) in the case of physicians, enrolled in Medicare with a primary specialty code designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics; or (2) in the case of non-physician practitioners, enrolled in Medicare with a primary care speciality code designation of 50-nurse practitioner, 89-certified clinical nurse specialist, or 97-physician assistant; and (3) for whom the primary care services displayed in the above table accounted for at least 60 percent of the allowed charged under the PFS (excluding hospital inpatient care and emergency department visits)for such practitioners.

DB2 ALIAS : RNDRNG\_SPCLTY\_CD  
SAS ALIAS : RSPCLTY  
STANDARD ALIAS : CLM\_RNDRNG\_PHYSN\_SPCLTY\_CD

LENGTH : 2

CODE TABLE : CMS\_PRVDR\_SPCLTY\_TB

#### 121. Claim Patient Relationship Code

2 502 503 CHAR

Effective with CR#7, the code used to identify the patient relationship to the beneficiary.

DB2 ALIAS : CLM\_PTNT\_RLTNSHP\_C  
SAS ALIAS : PRLTNSHP  
STANDARD ALIAS : CLM\_PTNT\_RLTNSHP\_CD

LENGTH : 2

COMMENTS :  
CMS CR7523

CODE TABLE : CLM\_PTNT\_RLTNSHP\_TB

#### 122. Claim Fraud Prevention System (FPS) Model Number

2 504 505 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

#### 123. Claim FPS Reason Code

3 506 508 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

#### 124. Claim FPS Remarks Code

5 509 513 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

125. Claim FPS MSN 1 Code

5 514 518 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

126. Claim FPS MSN 2 Code

5 519 523 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

127. Claim Mass Adjustment Indicator Code

1 524 524 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

128. Claim Next Generation (NG) Affordable Care Organization (ACO) Indicator 1 Code

1 525 525 CHAR

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

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

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

DB2 ALIAS : CLM\_NG\_ACO\_1\_CD  
SAS ALIAS : CNGACO1  
STANDARD ALIAS : CLM\_NG\_ACO\_IND\_1\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : NG\_ACO\_IND\_TB

129. Claim Next Generation (NG) Affordable Care Organization (ACO) Indicator 2 Code

1 526 526 CHAR

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

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

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

DB2 ALIAS : CLM\_NG\_ACO\_2\_CD  
SAS ALIAS : CNGACO2  
STANDARD ALIAS : CLM\_NG\_ACO\_IND\_2\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : NG\_ACO\_IND\_TB

130. Claim Next Generation (NG) Affordable Care Organization (ACO) Indicator 3 Code

1 527 527 CHAR

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

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

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

DB2 ALIAS : CLM\_NG\_ACO\_3\_CD  
SAS ALIAS : CNGACO3  
STANDARD ALIAS : CLM\_NG\_ACO\_IND\_3\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : NG\_ACO\_IND\_TB

131. Claim Next Generation (NG) Affordable Care Organization (ACO) Indicator 4 Code  
1 528 528 CHAR

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

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

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

DB2 ALIAS : CLM\_NG\_ACO\_4\_CD  
SAS ALIAS : CNGACO4  
STANDARD ALIAS : CLM\_NG\_ACO\_IND\_4\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : NG\_ACO\_IND\_TB

132. Claim Next Generation (NG) Affordable Care Organization (ACO) Indicator 5 Code  
1 529 529 CHAR

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

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

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

DB2 ALIAS : CLM\_NG\_ACO\_5\_CD  
SAS ALIAS : CNGACO5  
STANDARD ALIAS : CLM\_NG\_ACO\_IND\_5\_CD  
  
LENGTH : 1  
  
SOURCE : CWF  
  
CODE TABLE : NG\_ACO\_IND\_TB

133. Claim Residual Payment Indicator Code  
1 530 530 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

134. Claim Accountable Care Organization (ACO) Identification Number  
10 531 540 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

135. Medicare Beneficiary Identification (MBI) Number  
11 541 551 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

### 136. Claim Beneficiary Identifier Type Code

1 552 552 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

### 137. Claim Provider Validation Code

2 553 554 CHAR

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

DB2 ALIAS : UNDEFINED  
SAS ALIAS : CVLDTNCD

LENGTH : 2

CODE TABLE : CLM\_PRVDR\_VLDTN\_TB

### 138. Claim Railroad Board (RRB) Exclusion Indicator Switch

1 555 555 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 : CEXCLSN

LENGTH : 1

CODE TABLE : CLM\_RRB\_EXCLSN\_IND\_TB

139. Claim Model Reimbursement Amount  
6 556 561 PACK

Effective with CR#16, this Claim Level Field will be used to identify the "Net Reimbursement Amount" of what Medicare would have paid for Global Budget Services from a hospital participating in the particular model. If the claim only includes global services, the reimbursement amount (CLM\_PMT\_AMT) will reflect \$0 (zero). If the claim includes global services and non-global services, the reimbursement amount will reflect the amount Medicare actually paid for the non-global services.

Note: This field will be used with future models and not just the Pennsylvania Rural Health Model (PARHM) (CR11355). A demo code (CLM\_DEMO\_ID\_NUM) will be assigned for future models. CLM\_RLT\_COND\_CD = M6 and CLM\_VAL\_CD = Q4 have been created to identify the PARH model.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : CMODELAM  
STANDARD ALIAS : CLM\_MODEL\_REIMBRSMT\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

140.  
663 562 1224 CHAR

DB2 ALIAS : H\_FILLER\_3

LENGTH : 663

141. Inpatient/SNF NCH Edit Code Count

2 1225 1226 NUM

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

DB2 ALIAS : IP\_NCH\_EDIT\_CD\_CNT  
SAS ALIAS : IPEDCNT  
STANDARD ALIAS : IP\_NCH\_EDIT\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :

Prior to Version H this field was named:  
CLM\_EDIT\_CD\_CNT.

SOURCE : NCH

#### 142. Inpatient/SNF NCH Patch Code Count

2 1227 1228 NUM

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

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

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

DB2 ALIAS : IP\_PATCH\_CD\_CNT  
SAS ALIAS : IPPATCNT  
STANDARD ALIAS : IP\_NCH\_PATCH\_CD\_I\_CNT

LENGTH : 2 SIGNED : N

SOURCE : NCH

#### 143. Inpatient/SNF MCO Period Count

1 1229 1229 NUM

Effective with Version H, the count of the number of Managed Care Organization (MCO) periods reported on an inpatient/SNF 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 : IP\_MCO\_PRD\_CNT  
SAS ALIAS : IPMCOCNT  
STANDARD ALIAS : IP\_MCO\_PRD\_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 2

#### 144. Inpatient/SNF Claim Dem

1 1230 1230 NUM

Effective with Version H, the count of the number of claim demonstration IDs reported on an inpatient/SNF 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 : IP\_CLM\_DEMO\_ID  
SAS ALIAS : IPDEMCNT  
STANDARD ALIAS : IP\_CLM\_DEMO\_ID\_CNT

LENGTH : 1 SIGNED : N

#### 145. Inpatient Claim POA Diagnosis Code Count

2 1231 1232 NUM

Effective with Version 'J', the count of the number of Present on Admission (POA) codes reported on the Inpatient/SNF claim.  
The purpose of this count is to indicate how many claim POA diagnosis trailers are present.

DB2 ALIAS : CLM\_POA\_TRLR\_CNT  
SAS ALIAS : IPPOACNT  
STANDARD ALIAS : IP\_CLM\_POA\_DGNS\_CD\_CNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

EDIT RULES :  
Range: 0 to 25

#### 146. Inpatient Claim POA Diagnosis E Code Count

2 1233 1234 NUM

Effective with Version 'J', the count of the number of Present on Admission (POA) codes associated with the diagnosis E codes reported on the Inpatient/SNF claim. The purpose of this count is to indicate how many claim POA diagnosis E trailers are present.

DB2 ALIAS : CLM\_POA\_E\_TRLR\_CNT  
SAS ALIAS : IPPECNT  
STANDARD ALIAS : IP\_CLM\_POA\_DGNS\_E\_CD\_CNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

EDIT RULES :  
Range: 0 to 12

#### 147. Inpatient/SNF Claim Diagnosis Code J Count

2 1235 1236 NUM

The count of the number of diagnosis codes (both principal and secondary) reported on an Inpatient/SNF claim. The purpose of this count is to indicate how many claim diagnosis code trailers are present. Prior to Version 'J', this field was named: IP\_CLM\_DGNS\_CD\_CNT.

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

DB2 ALIAS : IP\_CLM\_DGNS\_CD\_CNT  
SAS ALIAS : IPDGNCNT  
STANDARD ALIAS : IP\_CLM\_DGNS\_CD\_J\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_OTHR\_DGNS\_CD\_CNT and the principal was not included in the count.

SOURCE : CWF

EDIT RULES :  
Range: 0 to 25

#### 148. Inpatient Claim Diagnosis E Code Count

2 1237 1238 NUM

Effective with Version 'J', the count of the number of diagnosis E codes reported on the Inpatient/SNF

claim. The purpose of this count is to indicate how many diagnosis E trailers are present.

DB2 ALIAS : DGNS\_E\_TRLR\_CNT  
SAS ALIAS : IPDECNT  
STANDARD ALIAS : IP\_CLM\_DGNS\_E\_CD\_CNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

EDIT RULES :  
Range: 0 to 12

#### 149. Inpatient/SNF Claim Procedure Code Count

2 1239 1240 NUM

The count of the number of procedure codes (both principal and secondary) reported on an Inpatient/SNF claim. The purpose of this count is to indicate how many claim procedure trailers are present. Prior to Version 'J', this field was named: IP\_CLM\_PRCDR\_CD\_CNT.

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

DB2 ALIAS : IP\_PRCDR\_CD\_CNT  
SAS ALIAS : IPPRCNT  
STANDARD ALIAS : IP\_CLM\_PRCDR\_CD\_J\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_PRCDR\_CD\_CNT.

SOURCE : CWF

EDIT RULES :  
RANGE: 0 TO 25

#### 150. Inpatient/SNF Claim Related Condition Code Count

2 1241 1242 NUM

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

DB2 ALIAS : IP\_RLT\_COND\_CD\_CNT  
SAS ALIAS : IPCONCNT  
STANDARD ALIAS : IP\_CLM\_RLT\_COND\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :

Prior to Version H this field was named:  
CLM\_RLT\_COND\_CD\_CNT.

SOURCE : CWF

EDIT RULES :

RANGE: 0 TO 30

151. Inpatient/SNF Claim Related Occurrence Code Count

2 1243 1244 NUM

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

DB2 ALIAS : IP\_OCRNC\_CD\_CNT

SAS ALIAS : IPOCRCNT

STANDARD ALIAS : IP\_CLM\_RLT\_OCRNC\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :

Prior to Version H this field was named:  
CLM\_RLT\_OCRNC\_CD\_CNT.

SOURCE : CWF

EDIT RULES :

RANGE: 0 TO 30

152. Inpatient/SNF Claim Occurrence Span Code Count

2 1245 1246 NUM

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

DB2 ALIAS : IP\_OCRNC\_SPAN\_CNT

SAS ALIAS : IPSPNCNT

STANDARD ALIAS : IP\_CLM\_OCRNC\_SPAN\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :

Prior to Version H this field was named:  
CLM\_OCRNC\_SPAN\_CD\_CNT.

SOURCE : CWF

153. Inpatient/SNF Claim Value Code Count

2 1247 1248 NUM

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

DB2 ALIAS : IP\_VAL\_CD\_CNT  
SAS ALIAS : IPVALCNT  
STANDARD ALIAS : IP\_CLM\_VAL\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_VAL\_CD\_CNT.

SOURCE : CWF

EDIT RULES :  
RANGE: 0 TO 36

#### 154. Inpatient/SNF Revenue Center Code Count

2 1249 1250 NUM

The count of the number of revenue codes reported on an inpatient/SNF claim. The purpose of the count is to indicate how many revenue center trailers are present.

DB2 ALIAS : IP\_REV\_CNTR\_CD\_CNT  
SAS ALIAS : IPREVCNT  
STANDARD ALIAS : IP\_REV\_CNTR\_CD\_I\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_REV\_CNTR\_CD\_CNT.

NOTE: During the Version 'I' conversion the number of occurrences changed to 45 (per segment - 450 total for claim). For claims prior to Version 'I' the number of occurrences was 58, but in the conversion we made all claims back to service year 1991 contain only 45 revenue center lines. It is possible that claims prior to 1991 will have 2 segments if they contained more than 45 revenue lines.

SOURCE : CWF

EDIT RULES :  
RANGE: 0 TO 45

155. FILLER

4 1251 1254 CHAR

DB2 ALIAS : FILLER  
STANDARD ALIAS : FILLER

LENGTH : 4

156. FI Inpatient SNF Claim Specific Group

804 1255 2058 GRP  
ALPHANUM

157. Claim Admission Date

8 1255 1262 NUM

On an institutional claim, the date the beneficiary was admitted to the hospital, skilled nursing facility, or christian science sanitorium.

NOTE1: The admission date is a required field on inpatient and HHA claims. The Medicare rule is the admission date and from date must be the same.

DB2 ALIAS : CLM\_ADMSN\_DT  
SAS ALIAS : ADMSN\_DT  
STANDARD ALIAS : CLM\_ADMSN\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

158. Claim Inpatient Admission Type Code

1 1263 1263 CHAR

The code indicating the type and priority of an inpatient admission associated with the service on an intermediary submitted claim.

DB2 ALIAS : IP\_ADMSN\_TYPE\_CD  
SAS ALIAS : TYPE\_ADM  
STANDARD ALIAS : CLM\_IP\_ADMSN\_TYPE\_CD  
TITLE ALIAS : IP\_ADMISSION\_TYPE

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_IP\_ADMSN\_TYPE\_TB

159. Claim Source Inpatient Admission Code

1 1264 1264 CHAR



The code indicating the source of the referral for the admission or visit.

DB2 ALIAS : SRC\_IP\_ADMSN\_CD  
SAS ALIAS : SRC\_ADMS  
STANDARD ALIAS : CLM\_SRC\_IP\_ADMSN\_CD  
TITLE ALIAS : IP\_ADMISSION\_SOURCE

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_SRC\_IP\_ADMSN\_TB

160. Claim Admitting Diagnosis Group  
8 1265 1272 GRP

Effective with Version 'J', the group used to identify the admitting diagnosis code on an Inpatient/SNF claim. This group contains the admitting diagnosis code and the admitting diagnosis version code.

STANDARD ALIAS : CLM\_ADMTG\_DGNS\_GRP

161. Claim Admitting Diagnosis Version Code  
1 1265 1265 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 : UNDEFINED  
SAS ALIAS : ADVRSNCD  
STANDARD ALIAS : CLM\_ADMTG\_DGNS\_VRSN\_CD

LENGTH : 1

CODE TABLE : CLM\_ADMTG\_DGNS\_VRSN\_TB

162. Claim Admitting Diagnosis Code  
7 1266 1272 CHAR

A diagnosis code on the institutional claim indicating the beneficiary's initial diagnosis at admission.

NOTE1: Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, the admitting diagnosis (also known as reason for patient visit) was added to the

Outpatient claim. This data was stored in positions 572-576 (FILLER) until the implementation of NCH/NMUD CR#2. Prior to 1/1/2004, this field was only present on inpatient claims.

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

NOTE1: Effective with Version 'J' this field expanded from 5 bytes to 7 bytes.

DB2 ALIAS : CLM\_ADMTG\_DGNS\_CD  
SAS ALIAS : AD\_DGNS  
STANDARD ALIAS : CLM\_ADMTG\_DGNS\_CD

LENGTH : 7

### 163. NCH Patient Status Indicator Code

1 1273 1273 CHAR

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

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

DB2 ALIAS : NCH\_PTNT\_STUS\_IND  
SAS ALIAS : PTNTSTUS  
STANDARD ALIAS : NCH\_PTNT\_STUS\_IND\_CD  
TITLE ALIAS : NCH\_PATIENT\_STUS

LENGTH : 1

DERIVATIONS :  
DERIVED FROM:  
NCH\_PTNT\_DSCHRG\_STUS\_CD

DERIVATION RULES:

SET NCH\_PTNT\_STUS\_IND\_CD TO 'A' WHERE THE PTNT\_DSCHRG\_STUS\_CD NOT EQUAL TO '20' - '30' OR '40' - '42'.

SET NCH\_PTNT\_STUS\_IND\_CD TO 'B' WHERE THE PTNT\_DSCHRG\_STUS\_CD EQUAL TO '20' - '29' OR '40' - '42'.

SET NCH\_PTNT\_STUS\_IND\_CD TO 'C' WHERE THE PTNT\_DSCHRG\_STUS\_CD EQUAL TO '30'

SOURCE : NCH QA Process

CODE TABLE : NCH\_PTNT\_STUS\_IND\_TB

164. NCH Inpatient Pro Approval Type Code

1 1274 1274 CHAR

The Peer Review Organization (PRO) determination on the type of approval or denial of an inpatient claim.

DB2 ALIAS : IP\_PRO\_APRVL\_CD  
SAS ALIAS : APRVL\_CD  
STANDARD ALIAS : NCH\_IP\_PRO\_APRVL\_TYPE\_CD  
TITLE ALIAS : PRO\_IP\_APPROVAL\_CODE

LENGTH : 1

DERIVATIONS :  
Set based upon presence of condition code equal TO C1, C3, C4, C5, C6 OR C7.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_IP\_PRO\_APRVL\_TYPE\_CD.

SOURCE : NCH

CODE TABLE : NCH\_IP\_PRO\_APRVL\_TYPE\_TB

165. NCH Inpatient PRO Approval Service From Date

8 1275 1282 NUM

On an institutional claim, the start date of service that has been approved by the Peer Review Organization (PRO).

DB2 ALIAS : IP\_PRO\_FROM\_DT  
SAS ALIAS : PRO\_FROM  
STANDARD ALIAS : NCH\_IP\_PRO\_SRVC\_FROM\_DT  
TITLE ALIAS : PRO\_FROM\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_OCRNC\_SPAN\_CD  
CLM\_OCRNC\_SPAN\_FROM\_DT

DERIVATION RULES:  
Based on the presence of occurrence span code equal to 'MO' move the corresponding occurrence span from date to the NCH\_IP\_PRO\_SRVC\_FROM\_DT.

COMMENTS :

Prior to Version H this field was named:  
CLM\_PRO\_APRVL\_SRVC\_FROM\_DT.

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

166. NCH Inpatient PRO Approval Service Thru Date  
8 1283 1290 NUM

On an institutional claim, the last day of  
service that has been approved by the Peer  
Review Organization (PRO).

DB2 ALIAS : IP\_PRO\_THRU\_DT  
SAS ALIAS : PRO\_THRU  
STANDARD ALIAS : NCH\_IP\_PRO\_SRVC\_THRU\_DT  
TITLE ALIAS : PRO\_THRU

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_OCRNC\_SPAN\_CD  
CLM\_OCRNC\_SPAN\_THRU\_DT

DERIVATION RULES:  
Based on the presence of occurrence span code  
equal to 'MO' move the corresponding occurrence  
span thru date to the NCH\_IP\_PRO\_SRVC\_THRU\_DT.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_PRO\_APRVL\_SRVC\_THRU\_DT.

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

167. NCH Inpatient PRO Approval Grace Day Count  
1 1291 1291 NUM

On an institutional claim, the number of days  
determined by a Peer Review Organization (PRO)  
to be necessary to arrange post-discharge care.

DB2 ALIAS : IP\_PRO\_GRC\_CNT  
SAS ALIAS : GRC\_DAY  
STANDARD ALIAS : NCH\_IP\_PRO\_GRC\_DAY\_CNT  
TITLE ALIAS : GRACE\_DAYS

LENGTH : 1 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to '46'  
move the corresponding value amount to the  
NCH\_IP\_PRO\_GRC\_DAY\_CNT.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_PRO\_APRVL\_GRC\_DAY\_CNT.

SOURCE : NCH

#### 168. Claim Pass Thru Per Diem Amount

6 1292 1297 PACK

The amount of the established reimbursable costs for the current year divided by the estimated Medicare days for the current year (all PPS claims), as calculated by the FI and reimbursement staff. Items reimbursed as a pass through include capital-related costs; direct medical education costs; kidney acquisition costs for hospitals approved as RTCs; and bad debts (per Provider Reimbursement Manual, Part 1, Section 2405.2). \*\*Note: Pass throughs are not included in the Claim Payment Amount.

DB2 ALIAS : PASS\_THRU\_PER\_DIEM  
SAS ALIAS : PER\_DIEM  
STANDARD ALIAS : CLM\_PASS\_THRU\_PER\_DIEM\_AMT  
TITLE ALIAS : PER\_DIEM

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

#### 169. NCH Beneficiary Inpatient Deductible Amount

6 1298 1303 PACK

The amount of the deductible the beneficiary paid for inpatient services, as originally submitted on the institutional claim.

DB2 ALIAS : BENE\_IP\_DDCTBL\_AMT  
SAS ALIAS : DED\_AMT

STANDARD ALIAS : NCH\_BENE\_IP\_DDCTBL\_AMT  
TITLE ALIAS : BENE\_DED\_AMT

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to  
A1, B1, or C1 move the corresponding value  
amount to the NCH\_BENE\_IP\_DDCTBL\_AMT.

COMMENTS :  
Prior to Version H this field was named:  
BENE\_IP\_DDCTBL\_AMT and the field size was  
S9(5)V99).

SOURCE : NCH

170. NCH Beneficiary Part A Coinsurance Liability Amount  
6 1304 1309 PACK

The amount of money for which the intermediary has  
determined that the beneficiary is liable for  
Part A coinsurance on the institutional claim.

DB2 ALIAS : PTA\_COINSRNC\_AMT  
SAS ALIAS : COIN\_AMT  
STANDARD ALIAS : NCH\_BENE\_PTA\_COINSRNC\_AMT  
TITLE ALIAS : BENE\_PTA\_COINSURANCE

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to  
8, 9, 10 or 11 move the corresponding value  
amount to the NCH\_BENE\_IP\_PTA\_COINSRNC\_AMT.

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PTA\_COINSRNC\_LBLTY\_AMT and the field size  
was S9(5)V99.

SOURCE : NCH

171. NCH Beneficiary Blood Deductible Liability Amount

6 1310 1315 PACK

The amount of money for which the intermediary determined the beneficiary is liable for the blood deductible.

DB2 ALIAS : BLOOD\_DDCTBL\_AMT  
SAS ALIAS : BLDDEDAM  
STANDARD ALIAS : NCH\_BENE\_BLOOD\_DDCTBL\_AMT  
TITLE ALIAS : BLOOD\_DEDUCTIBLE

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to '06' move the corresponding value amount to NCH\_BENE\_BLOOD\_DDCTBL\_AMT.

COMMENTS :  
Prior to Version H, this field was named: BENE\_BLOOD\_DDCTBL\_LBLTY\_AMT and the field size was S9(5)V99. Also, for OP claims, this field was stored in a blood trailer. Version H eliminated the OP blood trailer.

SOURCE : NCH QA PROCESS

## 172. NCH Blood Total Charge Amount

6 1316 1321 PACK

Effective with Version H, the total charge for blood usage (for internal CWFMQA editing purposes).

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

DB2 ALIAS : BLOOD\_TOT\_CHRG\_AMT  
SAS ALIAS : BLDTCHRG  
STANDARD ALIAS : NCH\_BLOOD\_TOT\_CHRG\_AMT  
TITLE ALIAS : BLOOD\_CHARGES

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
REV\_CNTR\_CD

REV\_CNTR\_TOT\_CHRG\_AMT

DERIVATION RULES:

Based on the presence of revenue center codes  
0380 thru 0389 move the related total charge  
amount to the NCH\_BLOOD\_TOT\_CHRG\_AMT.

SOURCE : NCH QA Process

173. NCH Blood Non-Covered Charge Amount

6 1322 1327 PACK

Effective with Version H, the total noncovered  
charges for blood usage (for internal CWFMQA  
editing purposes).

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

DB2 ALIAS : BLOOD\_NCVR\_AMT  
SAS ALIAS : BLDNCHRG  
STANDARD ALIAS : NCH\_BLOOD\_NCOV\_CHRG\_AMT  
TITLE ALIAS : BLOOD\_NCV\_CHARGES

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :

DERIVED FROM:

REV\_CNTR\_CD

REV\_CNTR\_NCOV\_CHRG\_AMT

DERIVATION RULES:

Based on the presence of revenue center codes equal  
to 0380 thru 0389 move the related noncovered  
charges to NCH\_BLOOD\_NCOV\_CHRG\_AMT.

SOURCE : NCH QA Process

174. NCH Professional Component Charge Amount

6 1328 1333 PACK

Effective with Version H, for inpatient and out-  
patient claims, the amount of physician and other  
professional charges covered under Medicare Part B  
(used for internal CWFMQA editing purposes and other  
internal processes (e.g. if computing interim payment  
these charges are deducted)).

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

DB2 ALIAS : PROFNL\_CMPNT\_AMT



SAS ALIAS : PCCHGAMT  
STANDARD ALIAS : NCH\_PROFNL\_CMPNT\_CHRG\_AMT  
TITLE ALIAS : PROFNL\_CMPNT\_CHARGES

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :

1. IF INPATIENT - DERIVED FROM:

CLM\_VAL\_CD

Clm\_VAL\_AMT

DERIVATION RULES:

Based on the presence of value code 04 or 05  
move the related value amount to the  
NCH\_PROFNL\_CMPNT\_CHRG\_AMT.

2. IF OUTPATIENT - DERIVED FROM:

REV\_CNTR\_CD

REV\_CNTR\_TOT\_CHRG\_AMT

DERIVATION RULES (Effective 10/98):

Based on the presence of revenue center codes  
096X, 097X & 098X move the related total charge  
amount to NCH\_PROFNL\_CMPNT\_CHRG\_AMT.

NOTE1: During the Version H conversion, this  
field was populated with data throughout history  
BUT the derivation rule applied to the outpatient  
claim was incomplete (i.e., revenue codes 0972,  
0973, 0974 and 0979 were omitted from the calcu-  
lation).

SOURCE : NCH QA Process

#### 175. NCH Inpatient Noncovered Charge Amount

6 1334 1339 PACK

Effective with Version H, the noncovered charges  
for all accommodations and services, reported on  
an inpatient claim (used for internal CWFMQA  
editing purposes).

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

DB2 ALIAS : IP\_NCVR\_CHRG\_AMT

SAS ALIAS : NCCHGAMT

STANDARD ALIAS : NCH\_IP\_NCOV\_CHRG\_AMT

TITLE ALIAS : IP\_NCOV\_CHARGES

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
REV\_CNTR\_CD  
REV\_CNTR\_NCVR\_CHRG\_AMT

DERIVATION RULES:  
Based on the presence of revenue center code  
equal to 0001 move the related noncovered charge  
amount to NCH\_IP\_NCOV\_CHRG\_AMT.

SOURCE : NCH QA Process

176. NCH Inpatient Total Deduction Amount  
6 1340 1345 PACK

Effective with Version H, the total Part A  
deductions reported on the Inpatient claim (used  
for internal CWFMQA editing purposes).

NOTE: During the Version H conversion this field  
was populated with data throughout history (back  
to 1991), but the derivation rule applied was in-  
complete for claims processed prior to 10/93.  
Disregard any data present in this field on claims  
with NCH weekly process date earlier than 10/93.

DB2 ALIAS : IP\_TOT\_DDCTN\_AMT  
SAS ALIAS : TDEDAMT  
STANDARD ALIAS : NCH\_IP\_TOT\_DDCTN\_AMT  
TITLE ALIAS : IP\_TOT\_DEDUCTIONS

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES (Effective 10/93):  
Accumulate the value amounts associated with  
value codes equal to 06, 08 thru 11 and A1, B1  
or C1 and move to IP\_TOT\_DDCTN\_AMT.  
NOTE: Value codes 08-11 did not exist in the  
NCH prior to 2/93; values codes A1, B1, C1 did  
not exist prior to 10/93.

SOURCE : NCH QA Process

177. Claim Total PPS Capital Amount  
6 1346 1351 PACK

The total amount that is payable for capital  
PPS for the claim. This is the sum of the  
capital hospital specific portion, federal

specific portion, outlier portion,  
disproportionate share portion, indirect  
medical education portion, exception payments,  
and hold harmless payments.

DB2 ALIAS : TOT\_PPS\_CPTL\_AMT  
SAS ALIAS : PPS\_CPTL  
STANDARD ALIAS : CLM\_TOT\_PPS\_CPTL\_AMT  
TITLE ALIAS : PPS\_CAPITAL

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

178. Claim PPS Capital HSP Amount

6 1352 1357 PACK

Effective 3/2/92, the hospital specific portion  
of the PPS payment for capital.

DB2 ALIAS : PPS\_CPTL\_HSP\_AMT  
SAS ALIAS : CPTL\_HSP  
STANDARD ALIAS : CLM\_PPS\_CPTL\_HSP\_AMT  
TITLE ALIAS : PPS\_CAPITAL\_HSP

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

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

179. Claim PPS Capital FSP Amount

6 1358 1363 PACK

Effective 3/2/92, the amount of the federal specific  
portion of the PPS payment for capital.

DB2 ALIAS : PPS\_CPTL\_FSP\_AMT  
SAS ALIAS : CPTL\_FSP  
STANDARD ALIAS : CLM\_PPS\_CPTL\_FSP\_AMT  
TITLE ALIAS : PPS\_CAPITAL\_FSP

LENGTH : 9.2 SIGNED : Y

COMMENTS :

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

SOURCE : CWF

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

180. Claim PPS Capital Outlier Amount  
6 1364 1369 PACK

Effective 3/2/92, the amount of the outlier portion  
of the PPS payment for capital.

DB2 ALIAS : PPS\_OUTLIER\_AMT  
SAS ALIAS : CPTLOUTL  
STANDARD ALIAS : CLM\_PPS\_CPTL\_OUTLIER\_AMT  
TITLE ALIAS : PPS\_CPTL\_OUTLIER

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

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

181. Claim PPS Capital Disproportionate Share Amount  
6 1370 1375 PACK

Effective 3/2/92, the amount of disproportionate  
share (rate reflecting indigent population served)  
portion of the PPS payment for capital.

DB2 ALIAS : PPS\_DSPRPTNT\_AMT  
SAS ALIAS : DISP\_SHR  
STANDARD ALIAS : CLM\_PPS\_CPTL\_DSPRPTNT\_SHR\_AMT  
TITLE ALIAS : PPS\_DISP\_SHR

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

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

182. Claim PPS Capital IME Amount

6 1376 1381 PACK

Effective 3/2/92, the amount of the indirect medical education (IME) (reimbursable amount for teaching hospitals only; an added amount passed by Congress to augment normal PPS payments for teaching hospitals to compensate them for higher patient costs resulting from medical education programs for interns and residents) portion of the PPS payment for capital.

DB2 ALIAS : PPS\_CPTL\_IME\_AMT  
SAS ALIAS : IME\_AMT  
STANDARD ALIAS : CLM\_PPS\_CPTL\_IME\_AMT  
TITLE ALIAS : PPS\_CPTL\_IME

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

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

183. Claim PPS Capital Exception Amount  
6 1382 1387 PACK

Effective 3/2/92, the capital PPS amount of exception payments provided for hospitals with inordinately high levels of capital obligations. Exception payments expire at the end of the 10-year transition period.

DB2 ALIAS : PPS\_EXCPTN\_AMT  
SAS ALIAS : CPTL\_EXP  
STANDARD ALIAS : CLM\_PPS\_CPTL\_EXCPTN\_AMT  
TITLE ALIAS : PPS\_CPTL\_EXCP

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

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

184. Claim PPS Old Capital Hold Harmless Amount  
6 1388 1393 PACK

Effective 3/2/92, this amount is the hold harmless amount payable for old capital as computed by PRICER for providers with a payment code equal to 'A'. The hold harmless amount-old capital is 100 percent of the reasonable costs of old capital for sole community sole community hospitals, or 85 percent of the reasonable costs associated with old capital for all other hospitals, plus a payment for new capital.

DB2 ALIAS : PPS\_CPTL\_HRMLS\_AMT  
SAS ALIAS : HLDHRMLS  
STANDARD ALIAS : CLM\_PPS\_OLD\_CPTL\_HLD\_HRMLS\_AMT  
TITLE ALIAS : PPS\_CPTL\_HOLD\_HRMLS

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

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

#### 185. Claim PPS Capital Discharge Fraction Percent

3 1394 1396 PACK

Effective 3/2/92, the percent resulting from dividing the days by the average length of stay for capital PPS transfer cases (PRICER review codes 03, 05, 06) not to exceed 1.

DB2 ALIAS : PPS\_DSCHRG\_PCT  
SAS ALIAS : DSCHFRCT  
STANDARD ALIAS : CLM\_PPS\_CPTL\_DSCHRG\_FRCTN\_PCT  
TITLE ALIAS : PPS\_CAPITL\_DSCHRG\_FRACTION\_PCT

LENGTH : 1.4 SIGNED : Y

SOURCE : CWF

LIMITATIONS :

REFER TO :  
PPS\_CPTL\_DSCHRG\_FRCTN\_PCT\_LIM

#### 186. Claim PPS Capital DRG Weight Number

4 1397 1400 PACK

Effective 3/2/92, the number used to determine a transfer adjusted case mix index for capital PPS. The number is determined by multiplying

the DRG weight times the discharge fraction.

DB2 ALIAS : PPS\_DRG\_WT\_NUM  
SAS ALIAS : DRGWTAMT  
STANDARD ALIAS : CLM\_PPS\_CPTL\_DRG\_WT\_NUM  
TITLE ALIAS : PPS\_CAPITAL\_DRG\_WEIGHT\_NUM

LENGTH : 3.4 SIGNED : Y

SOURCE : CWF

LIMITATIONS :

REFER TO :  
PPS\_CPTL\_DRG\_WT\_NUM\_LIM

#### 187. Claim Utilization Day Count

2 1401 1402 PACK

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

DB2 ALIAS : CLM\_UTLZTN\_DAY\_CNT  
SAS ALIAS : UTIL\_DAY  
STANDARD ALIAS : CLM\_UTLZTN\_DAY\_CNT  
TITLE ALIAS : UTILIZATION\_DAYS

LENGTH : 3 SIGNED : Y

#### 188. Claim Cost Report Days Count

2 1403 1404 PACK

The number of days on an institutional claim which would have been Medicare covered days if another primary payer were not involved or if a beneficiary had fewer days available than were needed by a PPS bill.

DB2 ALIAS : CLM\_CR\_DAY\_CNT  
SAS ALIAS : CR\_DAY  
STANDARD ALIAS : CLM\_CR\_DAY\_CNT

LENGTH : 3 SIGNED : Y

#### 189. Beneficiary Total Coinsurance Days Count

2 1405 1406 PACK

The count of the total number of coinsurance days involved with the beneficiary's stay in a facility.

DB2 ALIAS : COINSRNC\_DAY\_CNT  
SAS ALIAS : COIN\_DAY  
STANDARD ALIAS : BENE\_TOT\_COINSRNC\_DAY\_CNT  
TITLE ALIAS : COINSRNC\_DAYS

LENGTH : 3 SIGNED : Y

SOURCE : CWF

190. Claim Coinsurance Year 1 Day Count  
2 1407 1408 PACK

Effective with Version H, the count of the number of coinsurance days during the first year of the bill (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 should contain zeroes in this field. Exception: during the Version 'H' conversion invalid data may have been populated for prior periods. Disregard any data in this field on claims with NCH weekly process date earlier than 10/3/97.

DB2 ALIAS : COINS\_YR1\_DAY\_CNT  
SAS ALIAS : COYR1DAY  
STANDARD ALIAS : CLM\_COINSRNC\_YR\_1\_DAY\_CNT  
TITLE ALIAS : COINS\_YR1\_DAYS

LENGTH : 3 SIGNED : Y

SOURCE : CWF

191. NCH Coinsurance Year 1 Rate Amount  
6 1409 1414 PACK

Effective with Version H, the charge for each day of coinsurance during the first year in the bill (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 should contain zeroes in this field. Exception: during the Version 'H' conversion invalid data may have been populated for prior periods. Disregard any data present in this field on claims with NCH weekly process date earlier than 10/3/97.

DB2 ALIAS : COINS\_YR1\_RATE\_AMT  
SAS ALIAS : COYR1AMT  
STANDARD ALIAS : NCH\_COINSRNC\_YR\_1\_RATE\_AMT



TITLE ALIAS : COINS\_YR1\_RATE

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT  
CLM\_COINSRNC\_YR\_1\_DAY\_CNT

DERIVATION RULES:  
Divide the value amount associated with value code  
equal to 09 by the coinsurance year 1 days and move  
to NCH\_COINSRNC\_YR\_1\_RATE\_AMT.

SOURCE : NCH QA Process

192. Claim Coinsurance Year 2 Day Count  
2 1415 1416 PACK

Effective with Version H, the count of the  
number of coinsurance days during the second  
year of the bill which spans two years (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 should contain  
zeroes in this field. Exception: during the  
Version 'H' conversion invalid data may have  
been populated for prior periods. Disregard  
any data in this field on claims with NCH  
weekly process date earlier than 10/3/97.

DB2 ALIAS : COINS\_YR2\_DAY\_CNT  
SAS ALIAS : COYR2DAY  
STANDARD ALIAS : CLM\_COINSRNC\_YR\_2\_DAY\_CNT  
TITLE ALIAS : COINS\_YR2\_DAYS

LENGTH : 3 SIGNED : Y

SOURCE : CWF

193. NCH Coinsurance Year 2 Rate Amount  
6 1417 1422 PACK

Effective with Version H, the charge for each  
day of coinsurance during the second year in a  
bill which spans two years (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 should contain

zeroes in this field. Exception: during the Version 'H' conversion invalid data may have been populated for prior periods. Disregard any data in this field on claims with NCH weekly process date earlier than 10/3/97.

DB2 ALIAS : COINS\_YR2\_RATE\_AMT  
SAS ALIAS : COYR2AMT  
STANDARD ALIAS : NCH\_COINSRNC\_YR\_2\_RATE\_AMT  
TITLE ALIAS : COINS\_YR2\_RATE

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT  
CLM\_COINSRNC\_YR\_2\_DAY\_CNT

DERIVATION RULES:  
Divide the value amount associated with value code equal to 11 by the coinsurance year 2 days and move to NCH\_COINSRNC\_YR\_2\_RATE\_AMT.

SOURCE : NCH QA Process

#### 194. Beneficiary LRD Used Count

2 1423 1424 PACK

The number of lifetime reserve days that the beneficiary has elected to use during the period covered by the institutional claim. Under Medicare, each beneficiary has a one-time reserve of sixty additional days of inpatient hospital coverage that can be used after 90 days of inpatient care have been provided in a single benefit period. This count is used to subtract from the total number of lifetime reserve days that a beneficiary has available.

DB2 ALIAS : BENE\_LRD\_USE\_CNT  
SAS ALIAS : LRD\_USE  
STANDARD ALIAS : BENE\_LRD\_USE\_CNT

LENGTH : 3 SIGNED : Y

#### 195. Claim Non Utilization Days Count

3 1425 1427 PACK

On an institutional claim, the number of days of care that are not chargeable to Medicare facility utilization.

DB2 ALIAS : NUTLZTN\_DAY\_CNT

SAS ALIAS : NUTILDAY  
STANDARD ALIAS : CLM\_NUTLZTN\_DAY\_CNT  
TITLE ALIAS : NUTLZTN\_DAYS

LENGTH : 5 SIGNED : Y

SOURCE : CWF

196. Beneficiary Prior Psychiatric Day Count

2 1428 1429 PACK

Effective with Version H, the number of days  
in a psychiatric hospital prior to the  
entitlement to Medicare.

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 : PRIOR\_PSYCH\_CNT  
SAS ALIAS : PSYCHDAY  
STANDARD ALIAS : BENE\_PRIOR\_PSYCH\_DAY\_CNT  
TITLE ALIAS : PRIOR\_PSYCH\_DAYS

LENGTH : 3 SIGNED : Y

SOURCE : CWF

197. NCH Blood Pints Furnished Quantity

2 1430 1431 PACK

Number of whole pints of blood furnished to the  
beneficiary.

DB2 ALIAS : NCH\_BLOOD\_PT\_FRNSH  
STANDARD ALIAS : NCH\_BLOOD\_PT\_FRNSH\_QTY  
TITLE ALIAS : BLOOD\_PINTS\_FURNISHED

LENGTH : 3 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to  
37 move the related value amount to the  
NCH\_BLOOD\_PT\_FRNSH\_QTY.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_BLOOD\_PT\_FRNSH\_QTY. Also for outpatient

claims this field was stored in a blood trailer. Version H eliminated the outpatient blood trailer.

SOURCE : NCH QA Process

EDIT RULES :  
NUMERIC

198. NCH Blood Pints Replaced Quantity  
2 1432 1433 PACK

Number of whole pints of blood replaced.

DB2 ALIAS : BLOOD\_PT\_RPLC\_QTY  
SAS ALIAS : BLD\_RPLC  
STANDARD ALIAS : NCH\_BLOOD\_PT\_RPLC\_QTY  
TITLE ALIAS : BLOOD\_PINTS\_REPLACED

LENGTH : 3 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to 39 move the related value amount to the NCH\_BLOOD\_PT\_RPLC\_QTY.

COMMENTS :  
Prior to Version H this field was named: CLM\_BLOOD\_PT\_RPLC\_QTY. Also for outpatient claims this field was stored in a blood trailer. Version H eliminated the outpatient blood trailer.

SOURCE : NCH QA Process

EDIT RULES :  
NUMERIC

199. NCH Blood Pints Not Replaced Quantity  
2 1434 1435 PACK

Number of whole pints of blood not replaced.

DB2 ALIAS : BLOOD\_PT\_NRPLC\_QTY  
SAS ALIAS : BLDNRPLC  
STANDARD ALIAS : NCH\_BLOOD\_PT\_NRPLC\_QTY  
TITLE ALIAS : BLOOD\_PINTS\_NOT\_REPLACED

LENGTH : 3 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Subtract value code 39 amount from value code  
37 amount and move the result to  
NCH\_BLOOD\_PT\_NRPLC\_QTY.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_BLOOD\_PT\_NRPLC\_QTY. Also for outpatient  
claims this field was stored in a blood  
trailer. Version H eliminated the outpatient  
blood trailer.

SOURCE : NCH QA Process

EDIT RULES :  
NUMERIC

200. NCH Blood Deductible Pints Quantity  
2 1436 1437 PACK

The quantity of blood pints applied (blood  
deductible).

DB2 ALIAS : BLOOD\_DDCTBL\_QTY  
SAS ALIAS : BLDDDEDPT  
STANDARD ALIAS : NCH\_BLOOD\_DDCTBL\_PT\_QTY  
TITLE ALIAS : BLOOD\_PINTS\_DEDUCTIBLE

LENGTH : 3 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to  
38 move the related value amount to the  
NCH\_BLOOD\_DDCTBL\_PT\_QTY.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_BLOOD\_DDCTBL\_PT\_QTY. Also for outpatient  
claims this field was stored in a blood  
trailer. Version H eliminated the outpatient  
blood trailer.

SOURCE : NCH QA Process

EDIT RULES :  
NUMERIC

201. NCH Qualified Stay From Date  
8 1438 1445 NUM

Effective with Version H, the beginning date of the beneficiary's qualifying stay (used for internal CWFMQA editing purposes). For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization to benefits. For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission is other than 'A'.

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

DB2 ALIAS : QLFY\_STAY\_FROM\_DT  
SAS ALIAS : QLFYFROM  
STANDARD ALIAS : NCH\_QLFY\_STAY\_FROM\_DT  
TITLE ALIAS : QLFYG\_STAY\_FROM\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_OCRNC\_SPAN\_CD  
CLM\_OCRNC\_SPAN\_FROM\_DT

DERIVATION RULES:  
Based on the presence of occurrence code 70  
move the related occurrence from date to  
NCH\_QLFY\_STAY\_FROM\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

202. NCH Qualify Stay Through Date  
8 1446 1453 NUM

Effective with Version H, the ending date of the beneficiary's qualifying stay (used for internal CWFMQA editing purposes.) For inpatient claims, the date relates to the PPS portion of the inlier for

which there is no utilization to benefits. For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission is other than 'A'.

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

DB2 ALIAS : QLFY\_STAY\_THRU\_DT  
SAS ALIAS : QLFYTHRU  
STANDARD ALIAS : NCH\_QLFY\_STAY\_THRU\_DT  
TITLE ALIAS : QLFYG\_STAY\_THRU\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_OCRNC\_SPAN\_CD  
CLM\_OCRNC\_SPAN\_THRU\_DT

DERIVATION RULES:  
Based on the presence of occurrence code 70  
move the related occurrence thru date to  
NCH\_QLFY\_STAY\_THRU\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

### 203. NCH Verified Noncovered Stay From Date 8 1454 1461 NUM

Effective with Version H, the beginning date of the beneficiary's noncovered stay (used for internal CWFMQA editing purposes.)

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

DB2 ALIAS : VRFY\_NCVR\_FROM\_DT  
SAS ALIAS : NCOVFROM  
STANDARD ALIAS : NCH\_VRFY\_NCOV\_STAY\_FROM\_DT  
TITLE ALIAS : VERIFIED\_NCOV\_FROM\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_OCRNC\_SPAN\_CD

CLM\_OCRNC\_SPAN\_FROM\_DT

DERIVATION RULES:

Based on the presence of occurrence code 74, 76,  
77 or 79 move the related occurrence from date to  
NCH\_VRFY\_NCOV\_STAY\_FROM\_DT.

SOURCE : NCH QA Process

EDIT RULES :

YYYYMMDD

204. NCH Verified Noncovered Stay Through Date

8 1462 1469 NUM

Effective with Version H, the ending date of  
the beneficiary's noncovered stay (used for  
internal CWFMQA editing purposes.)

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

DB2 ALIAS : VRFY\_NCVR\_THRU\_DT

SAS ALIAS : NCOVTHRU

STANDARD ALIAS : NCH\_VRFY\_NCOV\_STAY\_THRU\_DT

TITLE ALIAS : VERIFIED\_NCOV\_THRU\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :

DERIVED FROM:

CLM\_OCRNC\_SPAN\_CD

CLM\_OCRNC\_SPAN\_THRU\_DT

DERIVATION RULES:

Based on the presence of occurrence code 74, 76,  
77 or 79 move the related occurrence thru date to  
NCH\_VRFY\_NCOV\_STAY\_THRU\_DT.

SOURCE : NCH QA Process

EDIT RULES :

YYYYMMDD

205. NCH Provider Guaranteed Payment Start Date

8 1470 1477 NUM

The date that the guaranteed payment to the  
institutional provider started.

DB2 ALIAS : GUARNT\_PMT\_STRT\_DT

SAS ALIAS : GURPMTDT

STANDARD ALIAS : NCH\_PRVDR\_GUARNT\_PMT\_STRT\_DT



TITLE ALIAS : GARNT\_PMT\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_RLT\_OCRNC\_CD  
CLM\_RLT\_OCRNC\_DT

DERIVATION RULES:  
Based on the presence of occurrence code 20  
move the related occurrence date to  
NCH\_PRVDR\_GUARNT\_PMT\_STRT\_DT.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_PRVDR\_GUARNT\_PMT\_STRT\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

206. NCH Utilization Review Notice Received Date  
8 1478 1485 NUM

The date of receipt by the skilled nursing  
facility of a utilization review committee's  
finding that an admission or further stay was no  
longer medically necessary.

DB2 ALIAS : NCH\_UR\_NTC\_RCV\_DT  
SAS ALIAS : URNTCDT  
STANDARD ALIAS : NCH\_UR\_NTC\_RCV\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_RLT\_OCRNC\_CD  
CLM\_RLT\_OCRNC\_DT

DERIVATION RULES:  
Based on the presence of occurrence code 21  
move the related occurrence date to  
NCH\_UR\_NTC\_RCV\_DT.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_UR\_NTC\_RCV\_DT.

SOURCE : NCH QA Process

EDIT RULES :

YYYYMMDD

207. NCH Active or Covered Level Care Thru Date

8 1486 1493 NUM

The date on a claim for which the covered level of care ended in a general hospital or the active care ended in a psychiatric/TB hospital.

DB2 ALIAS : ACTV\_CARE\_THRU\_DT  
SAS ALIAS : CARETHRU  
STANDARD ALIAS : NCH\_ACTV\_CVR\_LVL\_CARE\_THRU\_DT  
TITLE ALIAS : ACTIVE\_CARE\_THRU\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_RLT\_OCRNC\_CD  
CLM\_RLT\_OCRNC\_DT

DERIVATION RULES:  
Based on the presence of occurrence code 22  
move the related occurrence date to  
NCH\_ACTV\_CVR\_LVL\_CARE\_THRU\_DT.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_ACTV\_CVR\_LVL\_CARE\_THRU\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

208. NCH Beneficiary Medicare Benefits Exhausted Date

8 1494 1501 NUM

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

DB2 ALIAS : MDCR\_BNFT\_EXHST\_DT  
SAS ALIAS : EXHST\_DT  
STANDARD ALIAS : NCH\_MDCR\_BNFT\_EXHST\_DT  
TITLE ALIAS : BENEFIT\_EXHST\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_RLT\_OCRNC\_CD

CLM\_RLT\_OCRNC\_DT

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

COMMENTS :  
Prior to Version H this field was named:  
CLM\_MDCR\_BNFT\_EXHST\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

209. NCH Beneficiary Discharge Date  
8 1502 1509 NUM

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

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

DB2 ALIAS : NCH\_BENE\_DSCHRG\_DT  
SAS ALIAS : DSCHRGDT  
STANDARD ALIAS : NCH\_BENE\_DSCHRG\_DT  
TITLE ALIAS : DISCHARGE\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
NCH\_PTNT\_STUS\_IND\_CD  
CLM\_THRU\_DT

DERIVATION RULES:  
Based on the presence of patient discharge status  
code not equal to 30 (still patient), move the claim  
thru date to the NCH\_BENE\_DSCHRG\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

210. Claim Diagnosis Related Group Code  
4 1510 1513 CHAR

The diagnostic related group to which a hospital claim belongs for prospective payment purposes.

NOTE: Effective with Version L (January 2021 release), this field was expanded from 3 bytes to 4 bytes in anticipation for future expansion. No date has been set for when 4 byte DRG codes will be adopted.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DRG\_CD

LENGTH : 4

#### 211. Claim Diagnosis Related Group Outlier Stay Code

1 1514 1514 CHAR

On an institutional claim, the code that indicates the beneficiary stay under the prospective payment system which, although classified into a specific diagnosis related group, has an unusually long length (day outlier) or exceptionally high cost (cost outlier).

DB2 ALIAS : DRG\_OUTLIER\_CD  
SAS ALIAS : OUTLR\_CD  
STANDARD ALIAS : CLM\_DRG\_OUTLIER\_STAY\_CD  
TITLE ALIAS : DRG\_OUTLIER\_STAY\_CODE

LENGTH : 1

SOURCE : CWF

CODE TABLE : DRG\_OUTLIER\_STAY\_TB

#### 212. NCH DRG Outlier Approved Payment Amount

6 1515 1520 PACK

On an institutional claim, the additional payment amount approved by the Peer Review Organization due to an outlier situation for a beneficiary's stay under the prospective payment system, which has been classified into a specific diagnosis related group.

DB2 ALIAS : DRG\_OUTLIER\_AMT  
SAS ALIAS : OUTLRPMT  
STANDARD ALIAS : NCH\_DRG\_OUTLIER\_APRV\_PMT\_AMT  
TITLE ALIAS : DRG\_OUTLIER\_PMT

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :

DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal  
to 17 move the related amount to  
NCH\_DRG\_OUTLIER\_APRV\_PMT\_AMT.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_DRG\_OUTLIER\_APRV\_PMT\_AMT and field size  
was S9(7)V99.

SOURCE : NCH QA Process

213. Claim KRON Indicator Code

1 1521 1521 CHAR

Effective with Version H, on inpatient claims  
only, the code indicating that the bill must force  
a new spell even if it is within 60 days of a  
prior spell.

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 : CLM\_KRON\_IND\_CD  
SAS ALIAS : KRON\_IND  
STANDARD ALIAS : CLM\_KRON\_IND\_CD

LENGTH : 1

214. Claim Inpatient Low Volume Payment Amount

5 1522 1526 PACK

Effective with CR#6, the amount field used to identify  
a payment adjustment given to hospitals to account for  
the higher costs per discharge for low income hospitals  
under the Inpatient Prospective Payment System (IPPS).

DB2 ALIAS : CLM\_LOW\_VOL\_AMT  
STANDARD ALIAS : CLM\_IP\_LOW\_VOL\_PMT\_AMT

LENGTH : 7.2 SIGNED : Y

SOURCE : CWF

215. Claim Attending Physician Specialty Code

2 1527 1528 CHAR

Effective with CR#7, the code used to identify the CMS

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

NOTE: These fields were added on Outpatient, Home Health and Hospice claims with CR#6 but was added to the Inpatient/SNF claims with CR#7.

DB2 ALIAS : CLM\_ATNDG\_SPCLTY\_C  
SAS ALIAS : ASPCLTY  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_SPCLTY\_CD

LENGTH : 2

CODE TABLE : CMS\_PRVDR\_SPCLTY\_TB

#### 216. Claim Operating Physician Specialty Code

2 1529 1530 CHAR

Effective with CR#7, the code used to identify the CMS specialty code corresponding to the operating physician. The Affordable Care Act (ACA) provides for incentive payments for physicians and non-physician practitioners with specific primary specialty designations. In order to determine if the physician or non-physicians is eligible for the incentive payment, the specialty code, NPI and name must be carried on the claims.

NOTE: These fields were added on Outpatient, Home Health and Hospice claims with CR#6 but was added to the Inpatient/SNF claims with CR#7.

DB2 ALIAS : CLM\_OPRTG\_SPCLTY\_C  
SAS ALIAS : OPSPCLTY  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_SPCLTY\_CD

LENGTH : 2

CODE TABLE : CMS\_PRVDR\_SPCLTY\_TB

#### 217. Claim Other Physician Specialty Code

2 1531 1532 CHAR

Effective with CR#7, the code used to identify the CMS specialty code corresponding to the other physician. The Affordable Care Act (ACA) provides for incentive payments for physicians and non-physician practitioners with specific primary specialty designations. In order to determine if the physician or non-physicians is eligible for the incentive payment, the specialty code,

NPI and name must be carried on the claims.

NOTE: These fields were added on Outpatient, Home Health and Hospice claims with CR#6 but was added to the Inpatient/ SNF claims with CR#7.

DB2 ALIAS : CLM\_OTHR\_SPCLTY\_CD  
SAS ALIAS : OTSPCLTY  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_SPCLTY\_CD

LENGTH : 2

CODE TABLE : CMS\_PRVDR\_SPCLTY\_TB

218. Claim Bundled Model 1 Discount Percent

2 1533 1534 PACK

Effective with CR#7, this field identifies the discount percentage which will be applied to payment for all hospitals' DRG over the lifetime of the initiative. The hospital must be participating in the Model 1 of the Bundled Payments for Care Improvement initiative.

Effective with CR#9, the field size changed from V9(2) to SV9(3).

DB2 ALIAS : BNDLD\_MODEL\_1\_PCT  
SAS ALIAS : M1PCT  
STANDARD ALIAS : CLM\_BNDLD\_MODEL\_1\_DSCNT\_PCT

LENGTH : .3 SIGNED : Y

219. Claim Base Operating DRG Amount

6 1535 1540 PACK

Effective with CR#7, the amount used to identify the wage-adjusted DRG operating payment plus the new technology add-on payment.

DB2 ALIAS : BASE\_OPRTG\_DRG\_AMT  
SAS ALIAS : OPRTGDRG  
STANDARD ALIAS : CLM\_BASE\_OPRTG\_DRG\_AMT

LENGTH : 8.2 SIGNED : Y

220. Claim Operating HSP Amount

6 1541 1546 PACK

Effective with CR#7, the amount used to identify the difference between the HSP rate payment (updated HSP x DRG weight) and the federal rate payment (includes DSH, IME, outliers, etc. as applicable) when HSP rate payment exceeds Federal rate payment (otherwise \$0).

DB2 ALIAS : CLM\_OPRTG\_HSP\_AMT  
SAS ALIAS : OPRTGHSP  
STANDARD ALIAS : CLM\_OPRTG\_HSP\_AMT

LENGTH : 8.2 SIGNED : Y

221. Claim VBP Participant Indicator Code

1 1547 1547 CHAR

Effective with CR#7, the code used to identify a reason a hospital is excluded from the Hospital Value Based Purchasing (HVBP) program. The ACA (Section 3001) excludes from the HVBP program hospitals that meet certain conditions.

DB2 ALIAS : VBP\_PRTCNT\_IND\_CD  
SAS ALIAS : VBPIIND  
STANDARD ALIAS : CLM\_VBP\_PRTCNT\_IND\_CD

LENGTH : 1

CODE TABLE : CLM\_VBP\_PRTCNT\_IND\_TB

222. Claim VBP Adjustment Percent

7 1548 1554 PACK

Effective with CR#7, under the Hospital Value Based Purchasing (HVBP) program, an adjustment made to certain subsection (d) IPPS hospital base operating DRG amount, in accordance with their Total Performance Score (TPS) as required by the Affordable Care Act (ACA). This is the Value Based Purchasing Score.

Effective with CR#9, the picture clause changed from 9V9(11) to S9V9(11).

DB2 ALIAS : CLM\_VBP\_ADJSTMT\_PC  
SAS ALIAS : VBPPCT  
STANDARD ALIAS : CLM\_VBP\_ADJSTMT\_PCT

LENGTH : 1.11 SIGNED : Y

223. Claim HRR Participant Indicator Code

1 1555 1555 CHAR

Effective with CR#7, the code used to identify whether the facility is participating in the Hospital Readmission Reduction Program.

DB2 ALIAS : HRR\_PRTCNT\_IND\_CD  
SAS ALIAS : HRRIND  
STANDARD ALIAS : CLM\_HRR\_PRTCNT\_IND\_CD

LENGTH : 1



CODE TABLE : CLM\_HRR\_PRTCNT\_IND\_TB

224. Claim HRR Adjustment Percent

3 1556 1558 PACK

Effective with CR#7, Under the Hospital Readmission Reduction (HRR) Program, the amount used to identify the readmission adjustment factor that will be applied in determining a "subsection (d)" hospital's operating IPPS payment amount in accordance with Section 3025 of the Affordable Care Act (ACA).

Effective with CR#9, we changed the field picture clause from 9V9(4) COMP-3 to S9V9(4) COMP-3.

DB2 ALIAS : CLM\_HRR\_ADJSTMT\_PC  
SAS ALIAS : HRRPCT  
STANDARD ALIAS : CLM\_HRR\_ADJSTMT\_PCT

LENGTH : 1.4 SIGNED : Y

225. Claim Model 4 Readmission Indicator Code

1 1559 1559 CHAR

Effective with Version 'K', this field identifies the method of payment of a claim billed within 30 days of a Model 4 Bundled Payments for Care Improvement (BPCI) admission. Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients. Under the Model 4 BPCI pilot, CMS will reimburse qualified acute care hospitals a blended payment for hospital inpatient care and physician services connected with a single episode of care. This will occur in association with inpatient hospital claims that the BPCI participating hospital will bill to their jurisdictional A/B MAC as type of bill 11X claims.

DB2 ALIAS : MODEL\_4\_READMSN\_CD  
SAS ALIAS : READMSN  
STANDARD ALIAS : CLM\_MODEL\_4\_READMSN\_IND\_CD

LENGTH : 1

CODE TABLE : CLM\_MODEL\_4\_READMSN\_IND\_CD\_TB

226. Claim Uncompensated Care Payment Amount

6 1560 1565 PACK

Effective with CR#8, this field identifies the payment for DSH hospitals as part of Section 3133 of

the Affordable Care Act (ACA). It represents the uncompensated care amount of the payment.

This amount is included in the claim payment amount.

Prior to CR#9, this field was named:  
CLM\_IPPS\_FLEX\_PMT\_1\_AMT.

DB2 ALIAS : CLM\_UNCOMPD\_CARE\_P  
SAS ALIAS : CAREAMT  
STANDARD ALIAS : CLM\_UNCOMPD\_CARE\_PMT\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$cc

#### 227. Claim Bundled Adjustment Payment Amount

6 1566 1571 PACK

Effective with CR#8, this field represents the amount the claim was reduced by for those hospitals participating in BPCI Model 1.

Prior to CR#9, this field was named:  
CLM\_IPPS\_FLEX\_PMT\_2\_AMT.

DB2 ALIAS : CLM\_BNDLD\_ADJSTMT\_  
SAS ALIAS : BNDLDAMT  
STANDARD ALIAS : CLM\_BNDLD\_ADJSTMT\_PMT\_AMT

LENGTH : 9.2 SIGNED : Y

#### 228. Claim Value Based Purchasing Adjustment Payment Amount

6 1572 1577 PACK

Effective with CR#8, this field represents the Hospital Value Based Purchasing Amount. This could be an additional payment on the claim or a reduction, depending on the hospital's score.

Effective with CR#9, this field was renamed:  
CLM\_VBP\_ADJSTM\_PMT\_AMT. Prior to CR#9, the field was named: CLM\_IPPS\_FLEX\_PMT\_3\_AMT.

DB2 ALIAS : CLM\_VBP\_ADJSTMT\_AM  
SAS ALIAS : VBPAMT  
STANDARD ALIAS : CLM\_VBP\_ADJSTMT\_PMT\_AMT

LENGTH : 9.2 SIGNED : Y

#### 229. Claim Hospital Readmission Reduction (HRR) Adjustment Payment Amount

6 1578 1583 PACK

Effective with CR#8, this field represents the Hospital Readmission Reduction Program Amount. The amount is the reduction to the claim for readmissions.

Effective with CR#9, this field was renamed: CLM\_HRR\_ADJSTM\_PMT\_AMT. Prior to CR#9, this field was named: CLM\_IPPS\_FLEX\_PMT\_4\_AMT.

DB2 ALIAS : CLM\_HRR\_ADJSTMT\_AM  
SAS ALIAS : HRRAMT  
STANDARD ALIAS : CLM\_HRR\_ADJSTMT\_PMT\_AMT

LENGTH : 9.2 SIGNED : Y

230. Claim Electronic Health Record (EHR) Payment Adjustment Amount

6 1584 1589 PACK

Effective with CR#9 (October 2014 release), this field represents the dollar amount of the Electronic Health Record (EHR) reduction for eligible hospitals that are not meaningful EHR users.

NOTE: This field only applies to Inpatient claims.

DB2 ALIAS : CLM\_EHR\_AMT  
SAS ALIAS : EHRAmt  
STANDARD ALIAS : CLM\_EHR\_PMT\_ADJSTMT\_AMT

LENGTH : 9.2 SIGNED : Y

231. Claim PPS Standard Value Payment Amount

6 1590 1595 PACK

This amount identifies the PRICER output standardized amount. This amount is never used for payments. It is used for comparisons across different regions of the country for the value-based purchasing initiatives and for research. It is a standard amount, without the geographical payment adjustments and some of the other add-on payments that actually go to the hospitals.

NOTE: This field was added to Inpatient claims with CR#9 (October 2014 release) and to Home Health claims with the Part A expansion changes (January 2019 release).

DB2 ALIAS : CLM\_STD\_VAL\_AMT  
SAS ALIAS : PSTDAMT  
STANDARD ALIAS : CLM\_PPS\_STD\_VAL\_PMT\_AMT

LENGTH : 9.2 SIGNED : Y

232. Claim Final Standard Amount

6 1596 1601 PACK

Effective with CR#9 (October 2014 release), this amount field identifies the result of application of additional standardization requirements (e.g. sequestration) to the PPS Standardized Payment Amount. This amount is never used for payments. It is used for comparisons across different regions of the country for the value-based purchasing initiatives and for research. It is a standard amount, without the geographical payment adjustments and some of the other add-on payments that actually go to the providers.

NOTE: With CR#9, the field only applied to Inpatient claims.

Effective with CR#13 (January 2018 release), this amount field identifies the result of application of additional standardization requirements (e.g. sequestration) to the PPS Standardized Payment Amount. This amount is never used for payments. It is used for comparisons across different regions of the country for the value-based purchasing initiatives and for research. It is a standard amount, without the geographical payment adjustments and some of the other add-on payments that actually go to the providers.

NOTE1: With CR#13, the field was added to Home Health claims.

NOTE2: Even though the field will be found on the Home Health claims with the January 2018 release, data will not be found in the field until October 2018.

DB2 ALIAS : CLM\_FINL\_STD\_AMT  
SAS ALIAS : FSTDAMT  
STANDARD ALIAS : CLM\_FINL\_STD\_AMT

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
(CMS CR10257 - formerly CMS CR10167) - CWF April 2018 Release. Data won't be available in NCH/NMUD until July 2018

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$cc

233. Claim Hospital Acquired Condition (HAC) Reduction Payment Amount

6 1602 1607 PACK

Effective with CR#10, this field identifies the reduction amount from the IPPS payment for hospitals that rank in

the lowest performing quartile of selected Hospital Acquired Conditions.

The total payment amount is reduced by 1%.

NOTE: Prior to CR#10, this field was a placeholder field and was named: CLM\_IPPS\_FLEX\_PMT\_6\_AMT.

DB2 ALIAS : HAC\_RDCTN\_PMT\_AMT  
SAS ALIAS : HACAMT  
STANDARD ALIAS : CLM\_HAC\_RDCTN\_PMT\_AMT

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Renamed in CR10. Previous name was  
CLM-IPPS-FLEX-PMT-6-AMT.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$cc

234. Claim IPPS Flex Payment 7 Amount  
6 1608 1613 PACK

Effective with CR#9 (October 2014 release), this field is a placeholder for a dollar amount to be used for future policy.

NOTE: This field only applies to Inpatient claims.

DB2 ALIAS : CLM\_FLEX\_PMT\_7\_AMT  
SAS ALIAS : FLEX7  
STANDARD ALIAS : CLM\_IPPS\_FLEX\_PMT\_7\_AMT

LENGTH : 9.2 SIGNED : Y

235. Claim Hospital Acquired Condition (HAC) Program Reduction Indicator Switch  
1 1614 1614 CHAR

Effective with CR#9 (October 2014 release), this field identifies hospitals subject to a Hospital Acquired Condition (HAC) reduction of what they would otherwise be paid under IPPS.

NOTE1: This field only applies to Inpatient claims.

DB2 ALIAS : CLM\_HAC\_RDCTN\_SW  
SAS ALIAS : HACIND  
STANDARD ALIAS : CLM\_HAC\_PGM\_RDCTN\_IND\_SW

LENGTH : 1

CODE TABLE : CLM\_HAC\_PGM\_RDCTN\_IND\_TB

236. Claim Electronic Health Records (EHR) Program Reduction Indicator Switch

1 1615 1615 CHAR

Effective with CR#9 (October 2014 release), this field identifies which hospitals are Electronic Health Record meaningful users.

This field only applies to Inpatient claims.

DB2 ALIAS : CLM\_EHR\_RDCTN\_SW

SAS ALIAS : EHRIND

STANDARD ALIAS : CLM\_EHR\_PGM\_RDCTN\_IND\_SW

LENGTH : 1

CODE TABLE : CLM\_EHR\_PGM\_RDCTN\_IND\_TB

237. Claim Prior Authorization Indicator Code

4 1616 1619 CHAR

Effective with CR#9 (October 2014 release), this field represents 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 : PRIOR\_AUTHRZTN\_CD

SAS ALIAS : CLMPRIOR

STANDARD ALIAS : CLM\_PRIOR\_AUTHRZTN\_IND\_CD

LENGTH : 4

CODE TABLE : CLM\_PRIOR\_AUTHRZTN\_TB

238. Claim Unique Tracking Number

14 1620 1633 CHAR

Effective with CR#9 (October 2014 release), this field represents the number assigned to each prior authorization request.

NOTE: This field only applies to Inpatient/SNF claims.

DB2 ALIAS : CLM\_UNIQ\_TRKNG\_NUM

SAS ALIAS : CLMTRKNG

LENGTH : 14

DERIVATIONS :

Position 1 - 2 = MAC Identifier (e.g. RR for Railroad,  
OF = Jurisdiction F, 05 = Jurisdiction  
5, etc.)

Position 3 = Line of Business (e.g. A = Part A,

B = Part B, D = DME & H = Home Health  
Hospice)  
Position 4- 14 = a unique sequence number assigned by  
the Shared System

239. Claim Site Neutral Payment Based on Cost Amount

6 1634 1639 PACK

Effective with CR#10, under the Long Term Care (LTCH) PPS,  
the claim payment amount based on estimated cost of the  
case.

This amount is included in the claim payment amount.

DB2 ALIAS : SITE\_NTRL\_CST\_AMT  
SAS ALIAS : SITECOST  
STANDARD ALIAS : CLM\_SITE\_NTRL\_PMT\_CST\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$cc

240. Claim Site Neutral Payment Based on Inpatient Prospective Payment System (IPPS) Amount

6 1640 1645 PACK

Effective with CR#10, under the Long Term Care Hospital  
(LTCH) Prospective Payment System (PPS), the claim payment  
amount based on the Inpatient Prospective Payment System  
(IPPS) comparable amount. This amount does not include any  
applicable outlier payment amount.

This amount is included in the claim payment amount.

DB2 ALIAS : SITE\_NTRL\_IPPS\_AMT  
SAS ALIAS : SITEIPPS  
STANDARD ALIAS : CLM\_SITE\_NTRL\_PMT\_IPPS\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$cc

241. Claim Full Standard Payment Amount

6 1646 1651 PACK

Effective with CR #10, under the Long Term Care Hospital  
(LTCH) Prospective Payment System (PPS), the payment amount based  
on the MS-LTC-DRG. This amount does not include any applicable  
outlier payment amount.

This amount is included in the claim payment amount.

DB2 ALIAS : CLM\_FULL\_STD\_AMT  
SAS ALIAS : FULLSTD  
STANDARD ALIAS : CLM\_FULL\_STD\_PMT\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$cc

242. Claim Short Stay Outlier (SSO) Standard Payment Amount

6 1652 1657 PACK

Effective CR#10, under the Long Term Care Hospital (LTCH) Prospective Payment System (PPS), the payment based on the MS-LTC-DRG payment with a short stay outlier (SSO) adjustment. This amount does not include any applicable outlier payment amount.

This amount is included in the claim payment amount.

DB2 ALIAS : CLM\_SSO\_STD\_AMT  
SAS ALIAS : SSOSTD  
STANDARD ALIAS : CLM\_SSO\_STD\_PMT\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$cc

243. Claim Representative Payee (RP) Indicator Code

1 1658 1658 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 : CLM\_RP\_IND\_CD  
SAS ALIAS : RPIND  
STANDARD ALIAS : CLM\_RP\_IND\_CD

LENGTH : 1

SOURCE : CWF



CODE TABLE : RP\_IND\_TB

244. Claim Inpatient Initial MS DRG Code

4 1659 1662 CHAR

Effective with CR#14 (April 2019 release), This field identifies the initial MS DRG code assigned by MS DRG Grouper prior to application Hospital Acquired Condition (HAC) logic. The data will only be populated on Inpatient claims.

NOTE: Field is being added during the April 2019 release as a placeholder. Data will not start coming in until July 1, 2019.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : MSDRGCD  
STANDARD ALIAS : CLM\_IP\_INITL\_MS\_DRG\_CD

LENGTH : 4

245. Claim Long Term Care Hospital (LTCH) Discharge Payment Percentage (DPP) Amount

6 1663 1668 PACK

Effective with Version L (January 2021 release), this field is used to identify the amount of a Long Term Care Hospitals (LTCH) discharge payment percentage adjustment that will be applied to their payment rate for failure to maintain the required discharge payment percentage. This adjustment has been applied to the claim payment amount (CLM\_PMT\_AMT).

NOTE: This field only impacts Inpatient claims.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : LTCHDPP  
STANDARD ALIAS : CLM\_LTCH\_DSCHRG\_PMT\_PCT\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

246. FILLER

390 1669 2058 CHAR

DB2 ALIAS : H\_FILLER\_5

LENGTH : 390

247.

VAR 2059 31656

248. NCH Edit Group

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 : IP\_NCH\_EDIT\_CD\_CNT

249. NCH Edit Trailer Indicator Code

1 2059 2059 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

250. NCH Edit Code

4 2060 2063 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

251. NCH Patch Group

330 2124 2453 GRP

STANDARD ALIAS : NCH\_PATCH\_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : IP\_NCH\_PATCH\_CD\_I\_CNT

252. NCH Patch Trailer Indicator Code

1 2124 2124 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

253. NCH Patch Code

2 2125 2126 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

254. NCH Patch Applied Date

8 2127 2134 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

255. MCO Period Group

74 2454 2527 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 : IP\_MCO\_PRD\_CNT

256. NCH MCO Trailer Indicator Code

1 2454 2454 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

257. MCO Contract Number

5 2455 2459 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

258. MCO Option Code

1 2460 2460 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

259. MCO Period Effective Date

8 2461 2468 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

#### 260. MCO Period Termination Date

8 2469 2476 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

#### 261. MCO Health PLANID Number

14 2477 2490 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

262. Claim Demonstration Identification Group  
90 2528 2617 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 : IP\_CLM\_DEMO\_ID\_CNT

263. NCH Demonstration Trailer Indicator Code  
1 2528 2528 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

264. Claim Demonstration Identification Number  
2 2529 2530 CHAR

Effective with Version H, the number assigned to identify a demo. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).

NOTE: Prior to Version H, Demo ID was stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4. During the H conversion, this field was populated with data throughout history (as appropriate either by moving ID on Version G or by deriving from specific demo criteria).

01 = Nursing Home Case-Mix and Quality: NHCMQ (RUGS) Demo -- testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a RUGS indicator and one or more revenue center codes in the 9,000 series.

NOTE1: Effective for SNF claims with NCH weekly process date after 2/8/96 (and service date after 12/31/95) -- beginning 4/97, Demo ID '01' was derived in NCH based on presence of RUGS phase # '2','3' or '4' on incoming claim; since 7/97, CWF has been adding ID to claim.

NOTE2: During the Version H conversion, Demo ID '01' was populated back to NCH weekly process date 2/9/96 based on the RUGS phase indicator (stored in Claim Edit Group, 3rd occurrence, 4th position, in Version G).

02 = National HHA Prospective Payment Demo -- testing PPS for HHAs in 5 states, using two alternate methods of paying HHAs: per visit by type of HHA visit and per episode of HH care.

NOTE1: Effective for HHA claims with NCH weekly process date after 5/31/95 -- beginning 4/97, Demo ID '02' was derived in NCH based on HCFA/CHPP-supplied listing of provider # and start/stop dates of participants.

NOTE2: During the Version H conversion, Demo ID '02' was populated back to NCH weekly process date 6/95 based on the CHPP criteria.

03 = Telemedicine Demo -- testing covering traditionally noncovered physician services for medical consultation furnished via two-way, interactive video systems (i.e. teleconsultation) in 4 states. The claims contain line items with 'QQ' HCPCS code.

NOTE1: Effective for physician/supplier (nonDMERC) claims with NCH weekly process date after 12/31/96



(and service date after 9/30/96) -- since 7/97,  
CWF has been adding Demo ID '03' to claim.

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

04 = United Mine Workers of America (UMWA) Managed  
Care Demo -- testing risk sharing for Part A  
services, paying special capitation rates for  
all UMWA beneficiaries residing in 13 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 SENSITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO HCFA BUT NOT STORED IN THE NEARLINE FILE (access is restricted to study evaluators only).

31 = VA Pricing Special Processing (SPN) -- not really a demo but special request from VA due to court settlement; not Medicare services but VA inpatient and physician services submitted to FI 00400 and Carrier 00900 to obtain Medicare pricing -- CWF WILL PROCESS VA CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL NOT TRANSMIT TO HCFA (not in Nearline File).

37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries improves outcome of care and reduces Medicare expenditures under Part A and Part B. There will be at least 14 Coordinated Care Entities (CCEs). The selected entities will be assigned a provider number specifically for the demonstration services.

NOTE: All claims will be processed by carriers; no FI processing (except for Georgetown site)

37 = Medicare Disease Management (DMD) -- the purpose of this demonstration is to study the impact on costs and health outcomes of applying disease management services supplemented with coverage for prescription drugs for certain Medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease. Three demonstration sites will be used for this demonstration and it will last for 3 years. (Effective 4/1/2003).

NOTE: All claims will be processed by NHIC-California (Carrier). FIs will only serve as a conduit for transmitting information to and from CWF about the NOEs.

38 = Physician Encounter Claims - the purpose of this demo id is to identify the physician encounter claims being processed at the HCFA Data Center (HDC). This number will help EDS in making the claim go through the appropriate processing logic, which differs from that for fee-for-service. \*\*NOT IN NCH.\*\*

NOTE: Effective October, 2000. Demo ids will not be assigned to Inpatient and Outpatient encounter claims.

39 = Centralized Billing of Flu and PPV Claims -- The purpose of this demo is to facilitate the processing carrier, Trailblazers, paying flu and PPV claims based on payment localities. Providers will be giving the shots throughout the country and transmitting the claims to Trailblazers for processing.

NOTE: Effective October, 2000 for carrier claims.

40 = Payment of Physician and Nonphysician Services in certain Indian Providers -- the purpose of this demo is to extend payment for services of physician and nonphysician practitioners furnished in hospitals and ambulatory care clinics. Prior to the legislation change in BIPA, reimbursement for Medicare services provided in IHS

facilities was limited to services provided in hospitals and skilled nursing facilities. This change will allow payment for IHS, Tribe and Tribal Organization providers under the Medicare physician fee schedule.

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

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 Globulin (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 population of fee-for-service Medicare beneficiaries over a defined period of time (5 years, separated into 1-year increments called Performance Years (PYs)). eff. 4/2021

94 = ESRD Treatment Choices (ETC) - eff. 1/2020 - Outpatient and Carrier Only (eff. 1/2020)

95 = Oncology Care Model Plus (OCM+) - eff. 1/2020

96 = New Primary Care First (PCF) model - has two separate but related components: (1) the PCF component and (2) the Seriously Ill Population (SIP) component. Both components will test alternative payments and the provision of technical support to primary care practices. These PCF and/or SIP participants will receive a combination of claims and non-claims-based payments based on their attributed Medicare fee-for-service (FFS) beneficiaries. Every participating practice will be given a unique practice ID by the CMS implementation support contractor. Providers in a practice will be uniquely defined by the combination of each provider's tax ID number (TIN) and national provider identifier (NPI). Eff. 1/2021

97 = Kidney Care Choices (KCC) Kidney Care First (KCF) - For the CMS Kidney Care First (KCF) Option, nephrologists and 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 = Opioid 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

265. Claim Demonstration Information Text  
15 2531 2545 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

266. Claim Present on Admission (POA) Diagnosis Group  
50 2618 2667 GRP

The number of claim POA trailers is determined by the claim POA diagnosis code count. This group contains those POA codes associated with the diagnosis (principal and other) codes (excluding diagnosis E codes). The POAs for the diagnosis E codes are stored in the POA diagnosis E trailer.

STANDARD ALIAS : CLM\_POA\_DGNS\_GRP

OCCURS MIN: 0 OCCURS MAX: 25

DEPENDING ON : IP\_CLM\_POA\_DGNS\_CD\_CNT

267. NCH POA Diagnosis Trailer Indicator Code  
1 2618 2618 CHAR

Effective with Version 'J', the code indicating the

presence of a POA Diagnosis trailer.

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

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PTRLRIND  
STANDARD ALIAS : NCH\_POA\_DGNS\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_POA\_DGNS\_TRLR\_IND\_TB

## 268. Claim POA Diagnosis Indicator Code

1 2619 2619 CHAR

Effective September 1, 2008, with the implementation of CR#3, on Inpatient claims only, the code used to indicate a condition was present at the time the beneficiary was admitted to a general acute care facility.

NOTE: Prior to Version 'J', the POA indicators were housed in a 10 byte field. There could be up to 9 POA indicators for each diagnosis code reflected in the diagnosis trailer. The field also contained a 1 byte indicator ('Z' or 'X' to identify the end of the POA codes.

NOTE1: Effective with Version 'J', a POA trailer was created for both diagnosis codes and diagnosis 'E' codes. There is a POA diagnosis trailer (up to 25 occurrences) that is associated with the diagnosis trailer. There is also a POA diagnosis 'E' trailer (up to 12 occurrences) that is associated with the diagnosis 'E' trailer. \*\*Medicare requires a POA for 'E' codes in the regular diagnosis trailer but not for 'E' codes in the 'E' diagnosis trailer. However, 5010 has POA indicators as situational for 'E' codes in the 'E' code trailer, so a POA could be reported.

DB2 ALIAS : CLM\_POA\_IND\_CD  
SAS ALIAS : POAINDCD  
STANDARD ALIAS : CLM\_POA\_DGNS\_IND\_CD

LENGTH : 1

### COMMENTS :

Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD.

SOURCE : CWF

CODE TABLE : CLM\_POA\_IND\_TB

269. Claim Present on Admission (POA) Diagnosis E Group  
24 2668 2691 GRP

The number of claim POA diagnosis E trailers is determined by the claim POA diagnosis E code count. This group contains those POA codes associated with the diagnosis E codes.

STANDARD ALIAS : CLM\_POA\_DGNS\_E\_GRP

OCCURS MIN: 0 OCCURS MAX: 12

DEPENDING ON : IP\_CLM\_POA\_DGNS\_E\_CD\_CNT

270. NCH POA Diagnosis E Trailer Indicator Code  
1 2668 2668 CHAR

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

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

DB2 ALIAS : UNDEFINED

SAS ALIAS : PETRLR

STANDARD ALIAS : NCH\_POA\_DGNS\_E\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_POA\_DGNS\_E\_TRLR\_IND\_TB

271. Claim POA Diagnosis E Indicator Code  
1 2669 2669 CHAR

Effective with Version 'J', the code used to identify the present on admission (POA) indicator code associated with the diagnosis E codes.

DB2 ALIAS : CLM\_POA\_IND\_CD

SAS ALIAS : POAEIND

STANDARD ALIAS : CLM\_POA\_DGNS\_E\_IND\_CD

LENGTH : 1

COMMENTS :

Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field

was named: CLM\_POA\_IND\_CD.

SOURCE : CWF

CODE TABLE : CLM\_POA\_IND\_TB

272. Claim Diagnosis Group

225 2692 2916 GRP

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

NOTE:

Prior to Version H this group was named: CLM\_OTHR\_DGNS\_GRP and did not contain the CLM\_PRNCPAL\_DGNS\_CD.

STANDARD ALIAS : CLM\_DGNS\_GRP

OCCURS MIN: 0 OCCURS MAX: 25

DEPENDING ON : IP\_CLM\_DGNS\_CD\_J\_CNT

273. NCH Diagnosis Trailer Indicator Code

1 2692 2692 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

274. Claim Diagnosis Version Code

1 2693 2693 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

#### 275. Claim Diagnosis Code

7 2694 2700 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

#### 276. Claim Diagnosis E Group

108 2917 3024 GRP

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

STANDARD ALIAS : CLM\_DGNS\_E\_GRP

OCCURS MIN: 0 OCCURS MAX: 12

DEPENDING ON : IP\_CLM\_DGNS\_E\_CD\_CNT

277. NCH Diagnosis E Trailer Indicator Code

1 2917 2917 CHAR

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

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

DB2 ALIAS : DGNS\_E\_TRLR\_IND\_CD  
SAS ALIAS : ETRLRIND  
STANDARD ALIAS : NCH\_DGNS\_E\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_DGNS\_E\_TRLR\_IND\_TB

278. Claim Diagnosis Version Code

1 2918 2918 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 10/2014.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : EVRSNCD  
STANDARD ALIAS : CLM\_DGNS\_E\_VRSN\_CD

LENGTH : 1

CODE TABLE : CLM\_DGNS\_VRSN\_TB

279. Claim Diagnosis E Code

7 2919 2925 CHAR

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

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

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

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

DB2 ALIAS : CLM\_DGNS\_E\_CD  
SAS ALIAS : EDGNSCD  
STANDARD ALIAS : CLM\_DGNS\_E\_CD

LENGTH : 7

SOURCE : CWF

EDIT RULES :  
ICD-9-CM

#### 280. Claim Procedure Group

425 3025 3449 GRP

The number of claim procedure trailers is determined by the claim procedure code count. Effective with Version 'J', up to 25 occurrences may be reported on a claim. Beginning 10/93, up to six occurrences (one principal; five others) may be reported.

STANDARD ALIAS : CLM\_PRCDR\_GRP

OCCURS MIN: 0 OCCURS MAX: 25

DEPENDING ON : IP\_CLM\_PRCDR\_CD\_J\_CNT

#### 281. NCH Procedure Trailer Indicator Code

1 3025 3025 CHAR

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

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

DB2 ALIAS : NCH\_PRCDR\_TRLR\_IND  
SAS ALIAS : PRCDRIND  
STANDARD ALIAS : NCH\_PRCDR\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_PRCDR\_TRLR\_IND\_TB

#### 282. Claim Procedure Version Code

1 3026 3026 CHAR

Effective with Version 'J', the code used to indicate if the surgical procedure 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\_PRCDR\_VRSN\_CD  
SAS ALIAS : PVRSNCD  
STANDARD ALIAS : CLM\_PRCDR\_VRSN\_CD

LENGTH : 1

CODE TABLE : CLM\_PRCDR\_VRSN\_TB

### 283. Claim Procedure Code

7 3027 3033 CHAR

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

#### NOTE:

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

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

DB2 ALIAS : CLM\_PRCDR\_CD  
SAS ALIAS : PRCDR\_CD  
STANDARD ALIAS : CLM\_PRCDR\_CD

LENGTH : 7

DERIVATIONS :  
DERIVED FROM:  
NCH CLM\_PRCDR\_CD

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

SOURCE : CWF

EDIT RULES :



ICD-9-CM

284. Claim Procedure Performed Date

8 3034 3041 NUM

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

DB2 ALIAS : CLM\_PRCDR\_PRFRM\_DT  
SAS ALIAS : PRCDR\_DT  
STANDARD ALIAS : CLM\_PRCDR\_PRFRM\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

LIMITATIONS :

REFER TO :  
CLM\_PRCDR\_PRFRM\_DT\_LIM

EDIT RULES :  
YYYYMMDD

285. Claim Related Condition Group

90 3450 3539 GRP

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

STANDARD ALIAS : CLM\_RLT\_COND\_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : IP\_CLM\_RLT\_COND\_CD\_CNT

286. NCH Condition Trailer Indicator Code

1 3450 3450 CHAR

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

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

DB2 ALIAS : COND\_TRLR\_IND\_CD  
SAS ALIAS : CONDIND  
STANDARD ALIAS : NCH\_COND\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_COND\_TRLR\_IND\_TB

287. Claim Related Condition Code

2 3451 3452 CHAR

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

DB2 ALIAS : CLM\_RLT\_COND\_CD

SAS ALIAS : RLT\_COND

STANDARD ALIAS : CLM\_RLT\_COND\_CD

TITLE ALIAS : RELATED\_CONDITION\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_RLT\_COND\_TB

288. Claim Related Occurrence Group

330 3540 3869 GRP

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

STANDARD ALIAS : CLM\_RLT\_OCRNC\_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : IP\_CLM\_RLT\_OCRNC\_CD\_CNT

289. NCH Occurrence Trailer Indicator Code

1 3540 3540 CHAR

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

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

DB2 ALIAS : OCRNC\_TRLR\_IND\_CD

SAS ALIAS : OCRNCIND

STANDARD ALIAS : NCH\_OCRNC\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_OCRNC\_TRLR\_IND\_TB

290. Claim Related Occurrence Code

2 3541 3542 CHAR

The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date.

DB2 ALIAS : CLM\_RLT\_OCRNC\_CD

SAS ALIAS : OCRNC\_CD

STANDARD ALIAS : CLM\_RLT\_OCRNC\_CD

TITLE ALIAS : OCCURRENCE\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_RLT\_OCRNC\_TB

291. Claim Related Occurrence Date

8 3543 3550 NUM

The date associated with a significant event related to an institutional claim that may affect payer processing.

DB2 ALIAS : CLM\_RLT\_OCRNC\_DT

SAS ALIAS : OCRNCDT

STANDARD ALIAS : CLM\_RLT\_OCRNC\_DT

TITLE ALIAS : RLT\_OCRNC\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :

YYYYMMDD

292. Claim Occurrence Span Group

190 3870 4059 GRP

The number of claim occurrence span trailers is determined by the claim occurrence span code count. Up to 10 occurrences may be reported on an institutional claim.

STANDARD ALIAS : CLM\_OCRNC\_SPAN\_GRP

OCCURS MIN: 0 OCCURS MAX: 10

DEPENDING ON : IP\_CLM\_OCRNC\_SPAN\_CD\_CNT

293. NCH Span Trailer Indicator Code

1 3870 3870 CHAR

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

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

DB2 ALIAS : SPAN\_TRLR\_IND\_CD

SAS ALIAS : SPANIND

STANDARD ALIAS : NCH\_SPAN\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_SPAN\_TRLR\_IND\_TB

294. Claim Occurrence Span Code

2 3871 3872 CHAR

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

DB2 ALIAS : CLM\_OCRNC\_SPAN\_CD

SAS ALIAS : SPAN\_CD

STANDARD ALIAS : CLM\_OCRNC\_SPAN\_CD

TITLE ALIAS : SPAN\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_OCRNC\_SPAN\_TB

295. Claim Occurrence Span From Date

8 3873 3880 NUM

The from date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.

DB2 ALIAS : OCRNC\_SPAN\_FROM\_DT  
SAS ALIAS : SPANFROM  
STANDARD ALIAS : CLM\_OCRNC\_SPAN\_FROM\_DT  
TITLE ALIAS : SPAN\_FROM\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

296. Claim Occurrence Span Through Date

8 3881 3888 NUM

The thru date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.

DB2 ALIAS : OCRNC\_SPAN\_THRU\_DT  
SAS ALIAS : SPANTHRU  
STANDARD ALIAS : CLM\_OCRNC\_SPAN\_THRU\_DT  
TITLE ALIAS : SPAN\_THRU\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

297. Claim Value Group

324 4060 4383 GRP

The number of claim value data trailers present is determined by the claim value code count. Effective 10/93, up to 36 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

STANDARD ALIAS : CLM\_VAL\_GRP

OCCURS MIN: 0 OCCURS MAX: 36

DEPENDING ON : IP\_CLM\_VAL\_CD\_CNT

298. NCH Value Trailer Indicator Code

1 4060 4060 CHAR

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

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

DB2 ALIAS : VAL\_TRLR\_IND\_CD  
SAS ALIAS : VALIND  
STANDARD ALIAS : NCH\_VAL\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_VAL\_TRLR\_IND\_TB

299. Claim Value Code

2 4061 4062 CHAR

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

DB2 ALIAS : CLM\_VAL\_CD  
SAS ALIAS : VAL\_CD  
STANDARD ALIAS : CLM\_VAL\_CD  
TITLE ALIAS : VALUE\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_VAL\_TB

300. Claim Value Amount

6 4063 4068 PACK

The amount related to the condition identified in the CLM\_VAL\_CD which was used by the intermediary to process the institutional claim.

DB2 ALIAS : CLM\_VAL\_AMT  
SAS ALIAS : VAL\_AMT  
STANDARD ALIAS : CLM\_VAL\_AMT  
TITLE ALIAS : VALUE\_AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

301.

27270 4384 31653

OCCURS MIN: 0 OCCURS MAX: 45

DEPENDING ON : IP\_REV\_CNTR\_CD\_I\_CNT

302. NCH Revenue Center Trailer Indicator Code

1 4384 4384 CHAR

Effective with Version H, the code identifying the revenue center trailer.

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

DB2 ALIAS : REV\_CNTR\_TRLR\_CD

SAS ALIAS : REVIND

STANDARD ALIAS : NCH\_REV\_CNTR\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_REV\_TRLR\_IND\_TB

303. Revenue Center Code

4 4385 4388 CHAR

The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology).

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

DB2 ALIAS : REV\_CNTR\_CD

SAS ALIAS : REV\_CNTR

STANDARD ALIAS : REV\_CNTR\_CD

TITLE ALIAS : REVENUE\_CENTER\_CD

LENGTH : 4

SOURCE : CWF

CODE TABLE : REV\_CNTR\_TB

304. Revenue Center Date

8 4389 4396 NUM

Effective with Version H, the date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills

with from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS.

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

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

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

DB2 ALIAS : REV\_CNTR\_DT  
STANDARD ALIAS : REV\_CNTR\_DT  
TITLE ALIAS : REV\_CNTR\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

### 305. Revenue Center 1st ANSI Code

5 4397 4401 CHAR

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

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



lines would not have data in this field.

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

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

DB2 ALIAS : REV\_CNTR\_ANSI1\_CD  
SAS ALIAS : REVANSI1  
STANDARD ALIAS : REV\_CNTR\_ANSI\_1\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV\_CNTR\_ANSI\_TB

### 306. Revenue Center 2nd ANSI Code

5 4402 4406 CHAR

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

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

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

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

DB2 ALIAS : REV\_CNTR\_ANSI2\_CD  
SAS ALIAS : REVANSI2  
STANDARD ALIAS : REV\_CNTR\_ANSI\_2\_CD

TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

307. Revenue Center 3rd ANSI Code

5 4407 4411 CHAR

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

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

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

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

DB2 ALIAS : REV\_CNTR\_ANSI3\_CD

SAS ALIAS : REVANSI3

STANDARD ALIAS : REV\_CNTR\_ANSI\_3\_CD

TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

308. Revenue Center 4th ANSI Code

5 4412 4416 CHAR

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

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to

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

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

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

DB2 ALIAS : REV\_CNTR\_ANSI4\_CD  
SAS ALIAS : REVANSI4  
STANDARD ALIAS : REV\_CNTR\_ANSI\_4\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

309. Revenue Center APC/HIPPS Code  
5 4417 4421 CHAR

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

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

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

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

NOTE3: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS : REV\_APC\_HIPPS\_CD  
SAS ALIAS : APCHIPPS  
STANDARD ALIAS : REV\_CNTR\_APC\_HIPPS\_CD  
TITLE ALIAS : APC\_HIPPS

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV\_CNTR\_APC\_TB

310. Revenue Center Healthcare Common Procedure Coding System Code  
5 4422 4426 CHAR

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

DB2 ALIAS : REV\_CNTR\_HCPCS\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_CD  
TITLE ALIAS : HCPCS\_CD

LENGTH : 5

COMMENTS :

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

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

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

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

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

For SNF PPS, HH PPS & IRF PPS HIPPS values see CLM\_HIPPS\_TB.

#### Level I

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

\*\*\*\* Note: \*\*\*\*

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

#### Level II

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

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

#### Level III

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

#### LIMITATIONS :

REFER TO :  
HHA\_HCPCS\_LIM

CODE TABLE : CLM\_HIPPS\_TB

### 311. Revenue Center HCPCS Initial Modifier Code

2 4427 4428 CHAR

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

DB2 ALIAS : REV\_HCPCS\_MDFR\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_INITL\_MDFR\_CD  
TITLE ALIAS : INITIAL\_MODIFIER

LENGTH : 2

#### COMMENTS :

Prior to Version H this field was named: HCPCS\_INITL\_MDFR\_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV\_CNTR and non-institutional: LINE).

SOURCE : CWF

EDIT RULES :  
Carrier Information File

### 312. Revenue Center HCPCS Second Modifier Code

2 4429 4430 CHAR

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

DB2 ALIAS : REV\_HCPCS\_2ND\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_2ND\_MDFR\_CD

TITLE ALIAS : SECOND\_MODIFIER

LENGTH : 2

COMMENTS :

Prior to Version H this field was named:  
HCPCS\_2ND\_MDFR\_CD. With Version H, a prefix  
was added to denote the location of this field  
on each claim type (institutional: REV\_CNTR and  
non-institutional: LINE).

SOURCE : CWF

EDIT RULES :

CARRIER INFORMATION FILE

313. Revenue Center HCPCS Third Modifier Code

2 4431 4432 CHAR

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

DB2 ALIAS : REV\_HCPCS\_3RD\_CD

STANDARD ALIAS : REV\_CNTR\_HCPCS\_3RD\_MDFR\_CD

TITLE ALIAS : THIRD\_MODIFIER

LENGTH : 2

COMMENTS :

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

SOURCE : CWF

EDIT RULES :

CARRIER INFORMATION FILE

314. Revenue Center HCPCS Fourth Modifier Code

2 4433 4434 CHAR

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

DB2 ALIAS : REV\_HCPCS\_4TH\_CD

STANDARD ALIAS : REV\_CNTR\_HCPCS\_4TH\_MDFR\_CD

TITLE ALIAS : FOURTH\_MODIFIER

LENGTH : 2

COMMENTS :

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

SOURCE : CWF

EDIT RULES :

CARRIER INFORMATION FILE

315. Revenue Center HCPCS Fifth Modifier Code

2 4435 4436 CHAR

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

DB2 ALIAS : REV\_HCPCS\_5TH\_CD

SAS ALIAS : MDFR\_CD5

STANDARD ALIAS : REV\_CNTR\_HCPCS\_5TH\_MDFR\_CD

TITLE ALIAS : FIFTH\_MODIFIER

LENGTH : 2

COMMENTS :

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

SOURCE : CWF

EDIT RULES :

CARRIER INFORMATION FILE

316. Revenue Center Payment Method Indicator Code

2 4437 4438 CHAR

Effective with Version 'I', the code used to identify how the service is priced for payment. This field is made up of two pieces of data, 1st position being the service indicator and the 2nd position being the payment indicator.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if



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

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

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

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

DB2 ALIAS : REV\_PMT\_MTHD\_CD  
SAS ALIAS : PMTMTHD  
STANDARD ALIAS : REV\_CNTR\_PMT\_MTHD\_IND\_CD  
TITLE ALIAS : PMT\_MTHD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV\_CNTR\_PMT\_MTHD\_IND\_TB

### 317. Revenue Center Discount Indicator Code

1 4439 4439 CHAR

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

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to

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

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

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

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

D = Discounting fraction (currently 0.5)

U = Number of units

T = Terminated procedure discount (currently 0.5)

DB2 ALIAS : REV\_DSCNT\_IND\_CD

SAS ALIAS : DSCNTIND

STANDARD ALIAS : REV\_CNTR\_DSCNT\_IND\_CD

TITLE ALIAS : REV\_CNTR\_DSCNT\_IND\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_DSCNT\_IND\_TB

### 318. Revenue Center Packaging Indicator Code

1 4440 4440 CHAR

Effective with Version 'I', the code used to identify those services that are packaged/ bundled with another service.

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

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

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

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

DB2 ALIAS : REV\_PACKG\_IND\_CD  
SAS ALIAS : PACKGIND  
STANDARD ALIAS : REV\_CNTR\_PACKG\_IND\_CD  
TITLE ALIAS : REV\_CNTR\_PACKG\_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_PACKG\_IND\_TB

### 319. Revenue Center Pricing Indicator Code

2 4441 4442 CHAR

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

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

lines would not have data in this field.

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

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

DB2 ALIAS : REV\_PRICNG\_IND\_CD  
SAS ALIAS : PRICNG  
STANDARD ALIAS : REV\_CNTR\_PRICNG\_IND\_CD  
TITLE ALIAS : REV\_CNTR\_PRICNG\_IND

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV\_CNTR\_PRICNG\_IND\_TB

### 320. Revenue Center Obligation to Accept As Full (OTAF) Payment Code

1 4443 4443 CHAR

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

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

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

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

DB2 ALIAS : REV\_OTAF\_IND\_CD  
SAS ALIAS : OTAF  
STANDARD ALIAS : REV\_CNTR\_OTAF\_IND\_CD

LENGTH : 1

SOURCE : CWF

EDIT RULES :

Y = provider is obligated to accept the payment as payment in full for the service.

N or blank = provider is not obligated to accept the payment, or there is no payment by a prior payer.

321. Revenue Center IDE, NDC, UPC Number  
24 4444 4467 CHAR

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

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

NOTE2: Effective with Version 'I', this field was renamed to eventually accommodate the National Drug Code (NDC) and the Universal Product Code (UPC). This field

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

DB2 ALIAS : IDE\_NDC\_UPC\_NUM  
SAS ALIAS : IDENDC  
STANDARD ALIAS : REV\_CNTR\_IDE\_NDC\_UPC\_NUM  
TITLE ALIAS : IDE\_NDC\_UPC

LENGTH : 24

SOURCE : CWF

LIMITATIONS :

REFER TO :  
REV\_CNTR\_IDE\_NDC\_UPC\_LIM

### 322. Revenue Center NDC Quantity Qualifier Code

2 4468 4469 CHAR

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

DB2 ALIAS : NDC\_QTY\_QLFR\_CD  
SAS ALIAS : QTYQLFR  
STANDARD ALIAS : REV\_CNTR\_NDC\_QTY\_QLFR\_CD

LENGTH : 2

CODE TABLE : REV\_CNTR\_NDC\_QTY\_QLFR\_TB

### 323. Revenue Center NDC Quantity

6 4470 4475 PACK

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

DB2 ALIAS : NDC\_QTY\_NUM  
SAS ALIAS : NDCQTY  
STANDARD ALIAS : REV\_CNTR\_NDC\_QTY

LENGTH : 7.3 SIGNED : Y

### 324. Revenue Center Unit Count

4 4476 4479 PACK

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

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

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

DB2 ALIAS : REV\_CNTR\_UNIT\_CNT  
SAS ALIAS : REV\_UNIT  
STANDARD ALIAS : REV\_CNTR\_UNIT\_CNT  
TITLE ALIAS : UNITS

LENGTH : 7 SIGNED : Y

SOURCE : CWF

### 325. Revenue Center Rate Amount

6 4480 4485 PACK

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

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

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

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

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

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

DB2 ALIAS : REV\_CNTR\_RATE\_AMT  
SAS ALIAS : REV\_RATE  
STANDARD ALIAS : REV\_CNTR\_RATE\_AMT  
TITLE ALIAS : CHARGE\_PER\_UNIT

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

### 326. Revenue Center Blood Deductible Amount 6 4486 4491 PACK

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

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

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

NOTE2: It has been discovered that this field may be



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

DB2 ALIAS : REV\_BLOOD\_DDCTBL  
SAS ALIAS : REVBLOOD  
STANDARD ALIAS : REV\_CNTR\_BLOOD\_DDCTBL\_AMT  
TITLE ALIAS : BLOOD\_DDCTBL\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

### 327. Revenue Center Cash Deductible Amount

6 4492 4497 PACK

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

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

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

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

dates of service.

DB2 ALIAS : REV\_CASH\_DDCTBL  
SAS ALIAS : REVDCTBL  
STANDARD ALIAS : REV\_CNTR\_CASH\_DDCTBL\_AMT  
TITLE ALIAS : CASH\_DDCTBL

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

328. Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount  
6 4498 4503 PACK

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

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

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

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

DB2 ALIAS : ADJSTD\_COINSRNC  
SAS ALIAS : WAGEADJ  
STANDARD ALIAS : REV\_CNTR\_WAGE\_ADJSTD\_COINS\_AMT  
TITLE ALIAS : WAGE\_ADJSTD\_COINS

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

### 329. Revenue Center Reduced Coinsurance Amount

6 4504 4509 PACK

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

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

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

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

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

DB2 ALIAS : RDCD\_COINSRNC

SAS ALIAS : RDCDCOIN  
STANDARD ALIAS : REV\_CNTR\_RDCD\_COINS\_AMT  
TITLE ALIAS : REDUCED\_COINS

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

### 330. Revenue Center 1st Medicare Secondary Payer Paid Amount

6 4510 4515 PACK

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

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

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

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

DB2 ALIAS : REV\_MSP1\_PD\_AMT  
SAS ALIAS : REV\_MSP1  
STANDARD ALIAS : REV\_CNTR\_MSP1\_PD\_AMT  
TITLE ALIAS : MSP PAID AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

### 331. Revenue Center 2nd Medicare Secondary Payer Paid Amount

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

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

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

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

DB2 ALIAS : REV\_MSP2\_PD\_AMT  
 SAS ALIAS : REV\_MSP2  
 STANDARD ALIAS : REV\_CNTR\_MSP2\_PD\_AMT  
 TITLE ALIAS : MSP PAID AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

### 332. Revenue Center Provider Payment Amount

6 4522 4527 PACK

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

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to

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

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

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

FISS: populated correctly with provider payment amount

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

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

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

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

DB2 ALIAS : REV\_PRVDR\_PMT\_AMT  
SAS ALIAS : RPRVDPMT

STANDARD ALIAS : REV\_CNTR\_PRVDR\_PMT\_AMT  
TITLE ALIAS : REV\_PRVDR\_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

333. Revenue Center Beneficiary Payment Amount

6 4528 4533 PACK

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

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

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

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

DB2 ALIAS : REV\_BENE\_PMT\_AMT  
SAS ALIAS : RBENEPMT  
STANDARD ALIAS : REV\_CNTR\_BENE\_PMT\_AMT  
TITLE ALIAS : REV\_BENE\_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

334. Revenue Center Patient Responsibility Payment Amount

6 4534 4539 PACK

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

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

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

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

FISS: populating correctly (sum of coinsurance and deductible)

APASS: not populating this field

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

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

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



through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_PTNT\_RESP\_AMT  
SAS ALIAS : PTNTRESP  
STANDARD ALIAS : REV\_CNTR\_PTNT\_RESP\_PMT\_AMT  
TITLE ALIAS : REV\_PTNT\_RESP

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

### 335. Revenue Center Payment Amount

6 4540 4545 PACK

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

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

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

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

FISS: this field contains provider reimbursement.

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

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

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

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

DB2 ALIAS : REV\_CNTR\_PMT\_AMT  
SAS ALIAS : REVPMT  
STANDARD ALIAS : REV\_CNTR\_PMT\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

### 336. Revenue Center Total Charge Amount 6 4546 4551 PACK

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

#### EXCEPTIONS:

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

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

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

the '0023' line.

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

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

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

DB2 ALIAS : REV\_TOT\_CHRG\_AMT  
SAS ALIAS : REV\_CHRG  
STANDARD ALIAS : REV\_CNTR\_TOT\_CHRG\_AMT  
TITLE ALIAS : REVENUE\_CENTER\_CHARGES

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

LIMITATIONS :

REFER TO :  
MLTPL\_REV\_CNTR\_0001\_CD\_LIM  
REV\_CNTR\_TOT\_CHRG\_AMT\_LIM

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

337. Revenue Center Non-Covered Charge Amount  
6 4552 4557 PACK

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

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

DB2 ALIAS : REV\_NCVR\_CHRG\_AMT  
SAS ALIAS : REV\_NCVR  
STANDARD ALIAS : REV\_CNTR\_NCVR\_CHRG\_AMT  
TITLE ALIAS : REV\_CENTER\_NONCOVERED\_CHARGES

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

338. Revenue Center Deductible Coinsurance Code

1 4558 4558 CHAR

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

DB2 ALIAS : DDCTBL\_COINSRNC\_CD  
SAS ALIAS : REVDEDCD  
STANDARD ALIAS : REV\_CNTR\_DDCTBL\_COINSRNC\_CD  
TITLE ALIAS : REVENUE\_CENTER\_DEDUCTIBLE\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_DDCTBL\_COINSRNC\_TB

339. Revenue Center Consolidated Billing Code

1 4559 4559 CHAR

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

NOTE1: Prior to 10/2005 (implementation of NCH/NMUD CR#2), this data was stored in position 175 (FILLER) in the revenue center trailer.

NOTE2: Effective July 2005, this data will no longer be coming into the NCH. This process is being handled in the new CWF override processing.

DB2 ALIAS : CNSLDTD\_BLG\_CD  
SAS ALIAS : RCNSLDTD  
STANDARD ALIAS : REV\_CNTR\_CNSLDTD\_BLG\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_CNSLDTD\_BLG\_TB

340. Revenue Center Status Indicator Code  
2 4560 4561 CHAR

Effective 10/3/2005 with the implementation of NCH/NMUD CR#2, the code used to identify the status of the line item service. This field along with the payment method indicator field is used to identify how the service was priced for payment.

NOTE1: This 2-byte indicator is being added due to an expansion of a field that currently exist on the revenue center trailer. The status indicator is currently the 1st position of the Revenue Center Payment Method Indicator Code. The payment method indicator code is being split into two 2-byte fields (payment indicator and status indicator). The expanded payment indicator will continue to be stored in the existing payment method indicator field. The split of the current payment method indicator field is due to the expansion of both pieces of data from 1-byte to 2-bytes.

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

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

DB2 ALIAS : REV\_STUS\_IND\_CD  
SAS ALIAS : RSTUSIND  
STANDARD ALIAS : REV\_CNTR\_STUS\_IND\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV\_CNTR\_STUS\_IND\_TB

341. Revenue Center Duplicate Claim Check Indicator Code  
1 4562 4562 CHAR

Effective 1/1/2009 with the implementation of NCH/NMUD CR#4, the code used to identify an item or service that

appeared to be a duplicate but has been reviewed by an FI or MAC and appropriately approved for payment.

DB2 ALIAS : DUP\_CLM\_CHK\_IND\_CD  
SAS ALIAS : DUP-CHK  
STANDARD ALIAS : REV\_CNTR\_DUP\_CLM\_CHK\_IND\_CD

LENGTH : 1

CODE TABLE : REV\_CNTR\_DUP\_CLM\_CHK\_IND\_TB

#### 342. Revenue Center APC Buffer Code

2 4563 4564 CHAR

APC - Ambulatory Payment Classification  
Effective 1/1/2009 with the implementation of CR#4, the code used to identify related line items that make up a composite APC group. This field is only applicable to outpatient PPS claims.

DB2 ALIAS : REV\_CNTR\_BUFR\_CD  
SAS ALIAS : APCBUFR  
STANDARD ALIAS : REV\_CNTR\_APC\_BUFR\_CD

LENGTH : 2

CODE TABLE : REV\_CNTR\_APC\_BUFR\_TB

#### 343. Revenue Center Rendering Physician NPI Num

10 4565 4574 CHAR

Effective with Version 'J', the NPI of the rendering physician who performed the service.

DB2 ALIAS : RNRNG\_NPI\_NUM  
SAS ALIAS : REVNPI  
STANDARD ALIAS : REV\_CNTR\_RNRNG\_PHYSN\_NPI\_NUM

LENGTH : 10

LIMITATIONS :

REFER TO :  
REV\_RNRNG\_PHYSN\_NPI\_NUM\_LIM

#### 344. Revenue Center Rendering Physician Surname

6 4575 4580 CHAR

Effective with Version 'J', the 6 position last name of the rendering physician who performed the service.

DB2 ALIAS : RNRNG\_SRNM\_NAME  
SAS ALIAS : REVS\_RNM  
STANDARD ALIAS : REV\_CNTR\_RNRNG\_SRNM\_NAME

LENGTH : 6

345. Revenue Center Paperwork (PWK) Code

2 4581 4582 CHAR

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

DB2 ALIAS : REV\_CNTR\_PWK\_CD  
STANDARD ALIAS : REV\_CNTR\_PWK\_CD

LENGTH : 2

CODE TABLE : REV\_CNTR\_PWK\_TB

346. Rendering Physician Specialty Code

2 4583 4584 CHAR

Effective with CR#7, the code used to identify the CMS specialty code corresponding to the rendering physician at the revenue center line.

NOTE: Medicare needs to identify primary physicians/practitioners of service not only for use in standard claims transactions but also for review, fraud detection, and planning purposes. In order to do this, CMS must be able to determine the rendering physician/practitioner for each service billed to Medicare and store this information in our databases that serve as the source for data analysis.

DB2 ALIAS : REV\_CNTR\_SPCLTY\_CD  
SAS ALIAS : RSPCLTY  
STANDARD ALIAS : REV\_CNTR\_PHYSN\_SPCLTY\_CD

LENGTH : 2

COMMENTS :  
(CMS CR7578)

LIMITATIONS :

REFER TO :  
REV\_CNTR\_RNDRNG\_SPCLTY\_CD\_LIM

CODE TABLE : CMS\_PRVDR\_SPCLTY\_TB

347. Revenue Center Therapy CAP Indicator 1 Code

1 4585 4585 CHAR

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

DB2 ALIAS : REV\_THRPY\_CAP\_1\_CD  
SAS ALIAS : RTHRPY1  
STANDARD ALIAS : REV\_CNTR\_THRPY\_CAP\_IND\_1\_CD  
  
LENGTH : 1  
  
CODE TABLE : REV\_CNTR\_THRPY\_CAP\_IND\_CD\_TB

348. Revenue Center Therapy CAP Indicator 2 Code

1 4586 4586 CHAR

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

DB2 ALIAS : REV\_THRPY\_CAP\_2\_CD  
SAS ALIAS : RTHRPY2  
STANDARD ALIAS : REV\_CNTR\_THRPY\_CAP\_IND\_2\_CD  
  
LENGTH : 1  
  
CODE TABLE : REV\_CNTR\_THRPY\_CAP\_IND\_CD\_TB

349. Revenue Center Therapy CAP Indicator 3 Code

1 4587 4587 CHAR

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

DB2 ALIAS : REV\_THRPY\_CAP\_3\_CD  
SAS ALIAS : RTHRPY3  
STANDARD ALIAS : REV\_CNTR\_THRPY\_CAP\_IND\_3\_CD  
  
LENGTH : 1  
  
CODE TABLE : REV\_CNTR\_THRPY\_CAP\_IND\_CD\_TB

350. Revenue Center Therapy CAP Indicator 4 Code

1 4588 4588 CHAR

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

DB2 ALIAS : REV\_THRPY\_CAP\_4\_CD  
SAS ALIAS : RTHRPY4  
STANDARD ALIAS : REV\_CNTR\_THRPY\_CAP\_IND\_4\_CD  
  
LENGTH : 1  
  
CODE TABLE : REV\_CNTR\_THRPY\_CAP\_IND\_CD\_TB

351. Revenue Center Therapy CAP Indicator 5 Code

1 4589 4589 CHAR



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

DB2 ALIAS : REV\_THRPY\_CAP\_5\_CD  
SAS ALIAS : RTHRPY5  
STANDARD ALIAS : REV\_CNTR\_THRPY\_CAP\_IND\_5\_CD

LENGTH : 1

CODE TABLE : REV\_CNTR\_THRPY\_CAP\_IND\_CD\_TB

### 352. Revenue Center FPS Model Number

2 4590 4591 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 : REV\_FPS\_MODEL\_NUM  
SAS ALIAS : RMODEL  
STANDARD ALIAS : REV\_CNTR\_FPS\_MODEL\_NUM

LENGTH : 2

### 353. Revenue Center FPS Reason Code

3 4592 4594 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 : REV-FPS-RSN-CD  
SAS ALIAS : RFPSRSN  
STANDARD ALIAS : REV\_CNTR\_FPS\_RSN\_CD

LENGTH : 3

CODE TABLE : CLM\_ADJ\_RSN\_TB

### 354. Revenue Center FPS Remark Code

5 4595 4599 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 : REV\_FPS\_RMRK\_CD  
SAS ALIAS : RFPSRMRK  
STANDARD ALIAS : REV\_CNTR\_FPS\_RMRK\_CD

LENGTH : 5

CODE TABLE : CLM\_RMTNC\_ADVC\_TB

355. Revenue Center FPS MSN 1 Code

5 4600 4604 CHAR

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

DB2 ALIAS : REV\_FPS\_MSN\_1\_CD

SAS ALIAS : RFPSMSN1

STANDARD ALIAS : REV\_CNTR\_FPS\_MSN\_1\_CD

LENGTH : 5

CODE TABLE : CLM\_FPS\_MSN\_CD\_TB

356. Revenue Center FPS MSN 2 Code

5 4605 4609 CHAR

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

DB2 ALIAS : REV\_FPS\_MSN\_2\_CD

SAS ALIAS : RFPSMSN2

STANDARD ALIAS : REV\_CNTR\_FPS\_MSN\_2\_CD

LENGTH : 5

CODE TABLE : CLM\_FPS\_MSN\_CD\_TB

357. Revenue Center Patient/Initial Visit Add-On Payment Amount

6 4610 4615 PACK

Effective with CR#9 (October 2014 release), this field represents a base rate increase factor of 1.3516 for new patient initial preventive physical examination (IPPE) and annual wellness visit.

NOTE: This field only applies to Outpatient claims.

DB2 ALIAS : REV\_ADD\_ON\_AMT

SAS ALIAS : ADDONAMT

STANDARD ALIAS : REV\_CNTR\_PTNT\_ADD\_ON\_PMT\_AMT

LENGTH : 9.2 SIGNED : Y

358. Revenue Center Prior Authorization Indicator Code

4 4616 4619 CHAR

Effective with CR#9 (October 2014 release), this indicator is 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).

NOTE: This field applies to all institutional claim.

DB2 ALIAS : REV\_AUTHRZTN\_CD  
SAS ALIAS : REVPRIOR  
STANDARD ALIAS : REV\_CNTR\_PRIOR\_AUTHRZTN\_IND\_CD

LENGTH : 4

CODE TABLE : REV\_CNTR\_PRIOR\_AUTHRZTN\_TB

### 359. Revenue Center Unique Tracking Number

14 4620 4633 CHAR

Effective with CR#9 (October 2014 release), this field represents the number assigned to each prior authorization request.

NOTE: This field applies to all institutional claims.

DB2 ALIAS : REV\_UNIQ\_TRKNG\_NUM  
SAS ALIAS : REVTRKNG  
STANDARD ALIAS : REV\_CNTR\_UNIQ\_TRKNG\_NUM

LENGTH : 14

#### DERIVATIONS :

Position 1 - 2 = MAC Identifier (e.g. RR for Railroad, OF = Jurisdiction F, 05 = Jurisdiction 5, etc.)

Position 3 = Line of Business (e.g. A = Part A, B = Part B, D = DME & H = Home Health Hospice)

Position 4- 14 = a unique sequence number assigned by the Shared System

### 360. Revenue Center Representative Payee (RP) Indicator Code

1 4634 4634 CHAR

Effective with CR#11, this field will be used to designate bypassing 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 : REV\_CNTR\_RP\_IND\_CD  
SAS ALIAS : RCRPIND  
STANDARD ALIAS : REV\_CNTR\_RP\_IND\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : RP\_IND\_TB

361. Revenue Center Transitional Drug Add-On Payment Amount  
6 4635 4640 PACK

Effective with CR#13 (January 2018 release), the amount for the Transitional Drug Add-On Payment Adjustment (TDAPA) for ESRD claims (72X) with injectable, intravenous, and oral calcimimetics when reported with an AX modifier. These services qualify for an add-on payment from the ESRD Pricer.

NOTE: This field only applies to Outpatient claims.

DB2 ALIAS : TRNSTNL\_DRUG\_AMT

SAS ALIAS : TDAPAAMT

STANDARD ALIAS : REV\_CNTR\_TRNSTNL\_DRUG\_AMT

LENGTH : 7.4 SIGNED : Y

SOURCE : CWF

EDIT RULES :

\$\$\$\$\$\$c

362. Revenue Center Model Reimbursement Amount  
6 4641 4646 PACK

Effective with CR#16, this line-level field will be used to identify the "Net Reimbursement Amount" of what Medicare would have paid for the Global Budget Service reflected at the line level, from a hospital participating in the particular model.

Note: For the participating hospitals in the PA model all inpatient and outpatient services (Facility/Technical Services) are considered part of the Model/Global Budget Services. Basically, all of the services for a participating hospital would be global except for CAH Method II (85X) claim lines with revenue center codes 096X, 097X and 098X. The CAH Method II professional services (rev codes 096X, 097X and 098X) process as they do today, they have nothing to do with the model.

DB2 ALIAS : UNDEFINED

SAS ALIAS : RCMODELA

STANDARD ALIAS : REV\_CNTR\_MODEL\_REIMBRSMT\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :

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

363. Revenue Center Ordering Physician NPI Number

10 4647 4656 CHAR

Effective with Version L (January 2021 release), this line level field will be used to identify the ordering physicians National Provider Identifier (NPI).

NOTE: This data element will be reflected on all institutional claim types but only impacts Outpatient, Home Health and Hospice claims. No data will be sent in on Inpatient/SNF claims. The field is reflected in the revenue center trailer on all claim types for consistency.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : ORDRGNPI  
STANDARD ALIAS : REV\_CNTR\_ORDRG\_PHYSN\_NPI\_NUM

LENGTH : 10

SOURCE : CWF

364. Revenue Center Voluntary Service Indicator Code

1 4657 4657 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 for this field will not start coming in until the July 2021 release (July 6, 2021).

Valid Values:

V = A Voluntary procedure code

Blank = A Required procedure code

DB2 ALIAS : UNDEFINED  
SAS ALIAS : RCVLNTRY  
STANDARD ALIAS : REV\_CNTR\_VLNTRY\_SRVC\_IND\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_VLNTRY\_SRVC\_IND\_TB

365. Revenue Center Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) Amount

6 4658 4663 PACK

Effective with CR#17, this line level field will be used to represent the ESRD PPS payment adjustment for new and inno-

vative equipment and supplies and is included in the full ESRD PPS payment.

NOTE: This field will only come in on Outpatient claims. We are adding it to all institutional claim types to keep the revenue center trailer consistent.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : RCTPNIES  
STANDARD ALIAS : REV\_CNTR\_TPNIES\_AMT

LENGTH : 7.4 SIGNED : Y

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

366.

326 4664 4989 CHAR

DB2 ALIAS : H\_FILLER\_6

LENGTH : 326

367. End of Record Code

3 31654 31656 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:

FI\_IP\_SNF\_CLM\_REC\*\*\*\*\*

1

TABLE OF CODES APPENDIX FOR RECORD: FI\_IP\_SNF\_CLM\_REC, STATUS: PROD, VERSION: 21104

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

#### 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.

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\_ADMTG\_DGNS\_VRSN\_TB

Claim Admitting Diagnosis Version Code Table

Valid Values:

9 = ICD-9

0 = ICD-10



## CLM\_BENE\_ID\_TYPE\_TB

## Claim Beneficiary Identifier Type Table

M = MBI

H = HICN

## CLM\_BILL\_TYPE\_TB

## Claim Bill Type Table

- 11 = Hospital-inpatient (Part A)
- 12 = Hospital-inpatient or home health visits (Part B only)
- 13 = Hospital-outpatient (HHA-A also) (under OPPTS 13X must be used for ASC claims submitted for OPPTS payment -- eff. 7/00)
- 14 = Hospital-Laboratory Services Provided to Non-patients
- 15 = Hospital-intermediate care - level I (obsolete)
- 16 = Hospital-intermediate care - level II (obsolete)
- 17 = Hospital-intermediate care - level III (obsolete)
- 18 = Hospital-swing beds
- 19 = Reserved for national assignment
- 21 = SNF-inpatient (including Part A)
- 22 = SNF-inpatient or home health visits (Part B only)
- 23 = SNF-outpatient (HHA-A also)
- 24 = SNF-other (Part B) - (obsolete)
- 25 = SNF-intermediate care - level I (obsolete)
- 26 = SNF-intermediate care - level II (obsolete)
- 27 = SNF-intermediate care - level III (obsolete)
- 28 = SNF-swing beds
- 29 = SNF-reserved for national assignment
- 31 = HHA-inpatient (including Part A) (obsolete)
- 32 = HHA-Home Health Services under a Plan of Treatment (name revised 10/2013)
- 33 = HHA-outpatient (plan of treatment under Part A, including DME under Part A) (term. 10/2013)
- 34 = HHA-other (for medical and surgical services not under a plan of treatment) (obsolete)
- 35 = HHA-intermediate care - level I (obsolete)
- 36 = HHA-intermediate care - level II (obsolete)
- 37 = HHA-intermediate care - level III (obsolete)
- 38 = HHA-swing beds (obsolete)
- 39 = HHA-reserved for national assignment
- 41 = Religious Nonmedical Health Care Institution (RNHCI) hospital-inpatient (including Part A) (all references to Christian Science (CS) is obsolete eff. 8/00 and replaced with RNHCI)
- 42 = RNHCI hospital-inpatient or home health visits (Part B only)
- 43 = RNHCI hospital-outpatient (HHA-A also)
- 44 = RNHCI hospital-other (Part B) - (obsolete)
- 45 = RNHCI hospital-intermediate care - level I (obsolete)
- 46 = RNHCI hospital-intermediate care - level II (obsolete)
- 47 = RNHCI hospital-intermediate care - level III (obsolete)
- 48 = RNHCI hospital-swing beds (obsolete)
- 49 = RNHCI hospital-reserved for national assignment

- 51 = CS extended care-inpatient (including Part A) OBSOLETE  
eff. 7/00 - implementation of Religious Nonmedical  
Health Care Institutions (RNHCI)
- 52 = RNHCI extended care-inpatient or home health visits  
(Part B only) (eff. 7/00) - OBSOLETE; prior to 7/00  
Christian Science (CS)
- 53 = RNHCI extended care-outpatient (HHA-A also) (eff. 7/00);  
OBSOLETE - prior to 7/00 referenced CS
- 54 = RNHCI extended care-other (Part B)(eff. 7/00)- OBSOLETE;  
prior to 7/00 referenced CS
- 55 = RNHCI extended care-intermediate care - level I (eff. 7/00)  
OBSOLETE - prior to 7/00 referenced CS
- 56 = RNHCI extended care-intermediate care - level II (eff. 7/00)  
OBSOLETE - prior to 7/00 referenced CS
- 57 = RNHCI extended care-intermediate care - level III (eff. 7/00)  
OBSOLETE - prior to 7/00 referenced CS
- 58 = RNHCI extended care-swing beds (eff. 7/00)- OBSOLETE  
prior to 7/00 referenced CS
- 59 = RNHCI extended care-reserved for national assignment  
(eff. 7/00) - OBSOLETE; prior to 7/00 referenced CS
- 61 = Intermediate care-inpatient (including Part A)  
OBSOLETE
- 62 = Intermediate care-inpatient or home health visits (Part B only)  
OBSOLETE
- 63 = Intermediate care-outpatient (HHA-A also) - OBSOLETE
- 64 = Intermediate care-other (Part B)- OBSOLETE
- 65 = Intermediate care-intermediate care - level I
- 66 = Intermediate care-intermediate care - level II
- 67 = Intermediate care-intermediate care - level III - OBSOLETE
- 68 = Intermediate care-swing beds - OBSOLETE
- 69 = Reserved for national assignment
- 71 = Clinic-rural health
- 72 = Clinic-hospital based or independent renal dialysis facility
- 73 = Clinic-Freestanding
- 74 = Clinic-ORF only (eff 4/97);  
ORF and CMHC (10/91 - 3/97)
- 75 = Clinic-CORF
- 76 = Clinic-CMHC (eff 4/97)
- 77 = Clinic-Federally Qualified Health Center (FQHC)  
eff. 4/2010
- 78 = Clinic-reserved for national assignment
- 79 = Clinic-other
- 81 = Hospice (non-hospital based)
- 82 = Hospice (hospital based)
- 83 = Ambulatory Aurgical Center  
(Discontinued for Hospitals Subject to Outpatient PPS;  
hospitals must use 13X for ASC claims submitted for OP  
PPS payment -- eff. 7/00)
- 84 = Freestanding Birthing Center
- 85 = Critical Access Hospital (eff. 10/94)
- 86 = Residential Facility (eff. 4/1/2010)
- 87 = Freestanding Non-residential Opioid Treatment  
Programs (eff. 1/2021)
- 88 = Reserved for national assignment

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

CLM\_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\_EHR\_PGM\_RDCTN\_IND\_TB  
Table

Claim Electronic Health Records (EHR) Program Reduction Indicator

Y = hospital is subject to a reduction under the EHR  
program  
Blank

## CLM\_EXCPTD\_NEXCPTD\_TRTMT\_TB

## Claim Excepted/Nonexcepted Treatment Table

- 0 = No Entry
- 1 = Excepted
- 2 = Nonexcepted

## CLM\_FAC\_TYPE\_TB

## Claim Facility Type Table

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

## CLM\_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](http://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 received 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 symptom 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" columns. ----->

- 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](http://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](http://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](http://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 regarding 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](http://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](http://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](http://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\_FREQ\_TB

Claim Frequency Table

- 0 = Non-payment/zero claims
- 1 = Admit thru discharge claim
- 2 = Interim - first claim
- 3 = Interim - continuing claim (not valid for PPS claims)

- 4 = Interim - last claim (not valid for PPS claims)
- 5 = Late charge(s) only claim
- 6 = Reserved for national assignment; Adjustment of prior claim.  
Obsolete
- 7 = Replacement of prior claim;  
eff 10/93, provider debit
- 8 = Void/cancel prior claim  
eff 10/93, provider cancel
- 9 = Final claim -- used in an HH PPS  
episode to indicate the claim  
should be processed like debit/  
credit adjustment to RAP (initial  
claim) (eff. 10/00)
- A = Admission election notice - used when hospice  
or Religious Nonmedical Health Care Institution  
is submitting the HCFA-1450 as an  
admission notice - hospice NOE only  
NOTE: This value is not present in the NCH  
claims data because when they are used the  
transaction does not represent a claim. This  
frequency code is used on hospice notices of  
election. Their purpose is to create a hospice  
benefit period in CWF. No paymmentor utilization  
is reported on them.
- B = Hospice/Medicare Coordinated Care Demonstration/  
RNCHI - Termination/Revocation Notice - hospice  
NOE only (eff 9/93)  
NOTE: This value is not present in the NCH  
claims data because when they are used the  
transaction does not represent a claim. This  
frequency code is used on hospice notices of  
election. Their purpose is to create a hospice  
benefit period in CWF. No paymmentor utilization  
is reported on them.
- C = Hospice change of provider notice  
- hospice NOE only (eff 9/93)  
NOTE: This value is not present in the NCH  
claims data because when they are used the  
transaction does not represent a claim. This  
frequency code is used on hospice notices of  
election. Their purpose is to create a hospice  
benefit period in CWF. No paymmentor utilization
- D = Hospice/Medicare Coordinated Care Demonstration/  
RNHCI - void/cancel  
- hospice NOE only (eff 9/93)  
NOTE: This value is not present in the NCH  
claims data because when they are used the  
transaction does not represent a claim. This  
frequency code is used on hospice notices of  
election. Their purpose is to create a hospice  
benefit period in CWF. No paymmentor utilization
- E = Hospice change of ownership  
- hospice NOE only (eff 1/97)  
NOTE: This value is not present in the NCH

claims data because when they are used the transaction does not represent a claim. This frequency code is used on hospice notices of election. Their purpose is to create a hospice benefit period in CWF. No payment or utilization

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

CLM\_HAC\_PGM\_RDCTN\_IND\_TB                      Claim Hospital Acquired Condition (HAC) Program Reduction Indicator Table

- Y = hospital subject to a reduction under the HAC Reduction Program
- N = hospital is not subject to a reduction under the HAC Reduction Program

CLM\_HIPPS\_TB                                      Claim SNF, HHA & IRF Health Insurance PPS Table

\*\*\*\*\*

Please refer to the CMS website for the latest information on the HIPPS Codes. The URL is <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/>

ProspMedicareFeeSvcPmtGen/HIPPSCodes.html  
(paste into browser address bar without any spaces)

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CLM\_HRR\_PRTCPNT\_IND\_TB                      Claim HRR Participant Indicator Code Table

- 0 = Not participating
- 1 = Participating and not equal to 1.0000
- 2 = Participating and equal to 1.0000

CLM\_IP\_ADMSN\_TYPE\_TB                      Claim Inpatient Admission Type Table

- 0 = Blank
- 1 = Emergency - The patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
- 2 = Urgent - The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.
- 3 = Elective - The patient's condition permitted adequate time to schedule the availability of suitable accommodations.
- 4 = Newborn - Necessitates the use of special source of admission codes.
- 5 = Trauma Center - visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.
- 6 THRU 8 = Reserved
- 9 = Unknown - Information not available.

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\_MCO\_PD\_TB                      Claim MCO Paid Switch Code Table

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

#### CLM\_MDCD\_INFO\_TB

#### Claim Medicaid Information Table

164 = Number of attachments submitted  
166 = Abortion/sterilization code  
167 = Child Health Assurance Program Referral Code  
168 = Civilian Health and Medical Program of the  
Uniformed Services Code

#### CLM\_MDCR\_NPMT\_RSN\_TB

#### Claim Medicare Non-Payment Reason Table

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

A = Covered worker's compensation (Obsolete)  
B = Benefit exhausted  
C = Custodial care - noncovered care  
(includes all 'beneficiary at fault'  
waiver cases) (Obsolete)  
E = HMO out-of-plan services not emergency  
or urgently needed (Obsolete)  
E = MSP cost avoided - IRS/SSA/HCFA Data  
Match (eff. 7/00)  
F = MSP cost avoid HMO Rate Cell (eff. 7/00)  
G = MSP cost avoided Litigation Settlement  
(eff. 7/00)  
H = MSP cost avoided Employer Voluntary  
Reporting (eff. 7/00)  
J = MSP cost avoid Insurer Voluntary  
Reporting (eff. 7/00)  
K = MSP cost avoid Initial Enrollment  
Questionnaire (eff. 7/00)  
N = All other reasons for nonpayment  
P = Payment requested  
Q = MSP cost avoided Voluntary Agreement  
(eff. 7/00)  
R = Benefits refused, or evidence not  
submitted  
T = MSP cost avoided - IEQ contractor  
(eff. 9/76) (obsolete 6/30/00)  
U = MSP cost avoided - HMO rate cell  
adjustment (eff. 9/76) (Obsolete 6/30/00)  
V = MSP cost avoided - litigation  
settlement (eff. 9/76) (Obsolete 6/30/00)  
W = Worker's compensation (Obsolete)  
X = MSP cost avoided - generic  
Y = MSP cost avoided - IRS/SSA data  
match project (obsolete 6/30/00)

- Z = Zero reimbursement RAPs -- zero reimbursement made due to medical review intervention or where provider specific zero payment has been determined. (effective with HHPPS - 10/00)
- 00 = MSP cost avoided - COB Contractor
- 12 = MSP cost avoided - BCBS Voluntary Agreements
- 13 = MSP cost avoided - Office of Personnel Management
- 14 = MSP cost avoided - Workman's Compensation (WC) Datamatch
- 15 = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006)
- 16 = MSP cost avoided - Liability Insurer VDSA (eff. 4/2006)
- 17 = MSP cost avoided - No-Fault Insurer VDSA (eff. 4/2006)
- 18 = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement (eff. 4/2006)
- 19 = MSP cost avoided - Worker's Compensation Medicare Set-Aside Arrangement
- 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

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

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

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

- < = MSP cost avoided - MIR Group Health Plan ('21' 2-byte code) (eff. 1/2009)
- > = MSP cost avoided - MIR non-Group Health Plan ('22' 2-byte code) (eff. 1/2009)
- % = MSP cost avoided - Recovery Audit Contractor - California ('25' 2-byte code) (eff. 10/2005)
- & = MSP cost avoided - Recovery Audit Contractor - Florida ('26' 2-byte code) (eff. 10/2005)

#### CLM\_MODEL\_4\_READMSN\_IND\_CD\_TB

#### Claim Model 4 Readmission Indicator Code Table

1 = claim is related readmission to a Model 4 BPCI claim and shall pay IME, DSH, and Capital Only.

2 = two Model 4 BPCI claims within 30 days of each other, first claim in episode shall process as it would in the absence of Model 4 BPCI.

3 = two Model 4 BPCI claims within 30 days of each other, this is the second claim in the episode and paid as Model 4.

#### CLM\_OCRNC\_SPAN\_TB

#### Claim Occurrence Span Table

- 70 = Qualifying Stay Dates for SNF Use Only - the from/through dates of at least a 3-day inpatient hospital stay that qualifies the resident for Medicare payment of SNF services billed. Code can only be used by SNF for billing.
- 71 = Hospital prior stay dates - the from/ thru dates of any hospital stay that ended within 60 days of this hospital or SNF admission.
- 72 = First/last visit - the dates of the first and last visits occurring in this billing period if the dates are different from those in the statement covers period.
- 73 = Benefit eligibility period - the inclusive dates during which CHAMPUS medical benefits are available to a sponsor's bene as shown on the bene's ID card.
- 74 = Non-covered level of care - The from/ thru dates of a period at a noncovered level of care in an otherwise covered stay, excluding any period reported with occurrence span code 76, 77, or 79.



- 75 = The from/thru dates of SNF level of care during IP hospital stay. Shows PRO approval of patient remaining in hospital because SNF bed not available. not applicable to swing bed cases. PPS hospitals use in day outlier cases only.
- 76 = Patient liability - From/thru dates of period of noncovered care for which hospital may charge bene. The FI or PRO must have approved such charges in advance. patient must be notified in writing 3 days prior to noncovered period
- 77 = Provider liability (utilization charged) - The from/thru dates of period of noncovered care for which the provider is liable. Eff 3/92, applies to provider liability where bene is charged with utilization and is liable for deductible/coinsurance
- 78 = SNF prior stay dates - The from/thru dates of any SNF stay that ended within 60 days of this hospital or SNF admission.
- 79 = Provider Liability (non-utilization) (Payer code) - Eff 3/92, from/thru dates of period of noncovered care where bene is not charged with utilization, deductible, or coinsurance. and provider is liable. Eff 9/93, noncovered period of care due to lack of medical necessity.
- 80 = Prior Same-SNF Stay Dates for Payment Ban Purposes - the from/thru dates of a prior same-SNF stay indicating a patient resided in the SNF prior to, and if applicable, during a payment ban period up until their discharge to a hospital.
- 81 = Antepartum Days (CR7716) - eff. 7/2/12
- 82 - 99 = Reserved for state assignment
- M0 = QIO/UR approved stay dates - Eff 10/93, the first and last days that were approved where not all of the stay was approved.
- M1 = Provider Liability-No Utilization -- from/thru dates of a period of noncovered care that is denied due to lack of medical necessity or custodial care for which the provider is liable. (eff. 10/01)
- M2 = Dates of Inpatient Respite Care -- from/thru dates of a period of inpatient respite care for hospice patients. (eff. 10/00)
- M3 = ICF Level of Care -- the from/through dates of a period of intermediate level of care

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

## CLM\_POA\_IND\_TB

## Claim Present on Admission (POA) Indicator Table

Y = Diagnosis was present at the time of inpatient admission.  
CMS will pay the CC/MCC DRG for those selected HACs that are coded as 'Y' for the POA Indicator.

N = Diagnosis was not present at the time of inpatient admission.  
CMS will not pay the CC/MCC DRG for those selected HACs that are coded as 'N' for the POA Indicator.

U = Documentation is insufficient to determine if the condition was present at the time of inpatient admission.  
CMS will not pay the CC/MCC DRG for those selected HACs that are coded as 'U' for the POA Indicator. NOTE: From 4/15/10 to 12/31/10, the MQR process assigned a 'U' to those POAs that came in blank. They did this because of the POA/DGNS issue.

W = Clinically undetermined. Provider is unable to clinically determine whether condition was present at the time of inpatient admission.  
CMS will pay the CC/MCC DRG for those selected HACs that are coded as 'W' for the POA Indicator.

### NOTE:

Inpatient claims received with a POA exempt ICD-9 code effective 10/1/11 are currently being returned to provider requesting a valid POA indicator. CMS has created a workaround to resolve this issue by adding a POA indicator 'W' to the affected ICD-9 code instead of leaving it blank.

1 = Unreported/not used - diagnosis codes exempt from POA reporting --  
This code is equivalent to a blank on the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A.

CMS will not pay the CC/MCC DRG for those selected HACs that are coded as '1' for the POA Indicator. The '1' POA Indicator should not be applied to any codes on the HAC list.

Obsolete eff. 1/3/11

0 = This value was created by the NCH front-end system to replace a blank received in the POA field.

Z = Denotes the end of the POA indicators (obsolete 1/2011).

X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future (obsolete 1/2011).

Blank = identifies diagnosis codes that are exempt from the

POA reporting requirements (replaces the '1'). NOTE: NCH/NMUD will carry a '0' in place of a blank.

CLM\_PPS\_IND\_TB Claim PPS Indicator Table

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

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

\*\*\*Effective NCH weekly process date 6/5/98\*\*\*

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

CLM\_PRCR\_VRSN\_TB Claim Procedure Version Code Table

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

CLM\_PRCR\_RTRN\_TB Claim Pricer Return Code Table

\*\*\*\*\*Home Health Pricer Return Codes\*\*\*\*\*  
\*\*\*\*\*TOB 32X or 33X, DOS 10/1/2000 and after\*\*\*\*\*

Home Health Payment Return Codes:  
00 = Final payment where no outlier applies  
01 = Final payment where outlier applies  
03 = Initial percentage payment, 0%  
04 = Initial percentage payment, 50%  
05 = Initial percentage payment, 60%  
06 = LUPA payment only  
07 = Final payment, SCIC  
08 = Final payment, SCIC with outlier  
09 = Final payment, PEP  
11 = Final payment, PEP with outlier  
12 = Final payment, SCIC within PEP  
13 = Final payment, SCIS within PEP with outlier

Home Health Error Return Codes:  
10 = Invalid TOB

15 = Invalid PEP Days  
16 = Invalid HRG Days, >60  
20 = PEP indicator invalid  
25 = Med review indicator invalid  
30 = Invalid MSA code  
35 = Invalid Initial Payment Indicator  
40 = Dates < October 1, 2000 or invalid  
70 = Invalid HRG Code  
75 = No HRG present in 1st occurrence  
80 = Invalid Revenue code  
85 = No revenue code present on HH final claim/  
adjustment

\*\*\*\*\*Hospice Pricer Return Codes\*\*\*\*\*  
\*\*\*\*\*TOB 81X or 82X\*\*\*\*\*

Hospice Payment Return Codes:  
00 = Home rate returned

Hospice Error Return Codes:  
10 = Bad units  
20 = Bad units2 < 8  
30 = Bad MSA code  
40 = Bad hospice wage index from MSA file  
50 = Bad bene wage index from MSA file  
51 = Bad provider number

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

SNF Payment return codes:  
00 = RUG III group rate returned

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

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

Inpatient Hospital Payment return codes:  
00 = Paid normal DRG payment  
01 = Paid as a day outlier (Note: day outlier no longer  
being paid as of 10/1/97)  
02 = Paid as a cost outlier  
03 = Transfer paid on a per diem basis up to and  
including the full DRG  
05 = Transfer paid on a per diem basis up to and  
including the full DRG which also qualified

for a cost outlier payment  
06 = Provider refused cost outlier  
10 = DRG is 209, 210, or 211 and post-acute transfer  
12 = Post-acute transfer with specific DRGs. The following DRG's: 14, 113, 236, 263, 264, 429, 483  
14 = Paid normal DRG payment with per diem days = or > GM ALOS  
16 = Paid as a cost outlier with per diem days = or > GM ALOS

Inpatient Hospital Error return codes:

51 = No provider specific information found  
52 = Invalid MSA# in provider file  
53 = Waiver state - not calculated by PPS  
54 = DRG < 001 or > 511, or = 214, 215, 221, 222, 438, 456, 457, 458  
55 = Discharge date < provider effective start date or discharge date < MSA effective start date for PPS  
56 = Invalid length of stay  
57 = Review code invalid (Not 00, 03, 06, 07, 09)  
58 = Total charges not numeric  
61 = Lifetime reserve days not numeric or BILL-LTR-DAYS > 60  
62 = Invalid number of covere days  
65 = PAY-CODE not = A, B or C on provider specific file for capital  
67 = Cost outlier with LOS > covered days

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

Outpatient PPS Payment return codes:

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

Outpatient PPS Error return codes:

30 = Missing, deleted or invalid APC  
38 = Missing or invalid discount factor  
40 = Invalid service indicator passed by the OCE  
41 = Service indicator invalid for OPPS PRICER  
42 = APC = '00000' or (packaging flag = 1 or 2)  
43 = Payment indicator not = to 1 or 5 thru 9  
44 = Service indicator = 'H' but payment indicator not = to 6  
45 = Packaging flag not = to 0  
46 = Line item denial/reject flag not = to 0 or line item denial/reject flag = to 1 and (APC not = 0033 or 0034 or 0322 or 0323 or 0324 or 0325 or 0373 or 0374)) or line item action flag not = to 1  
47 = Line item action flag = 2 or 3  
48 = Payment adjustment flag not valid  
49 = Site of service flag not = to 0 or (APC 0033 is not

on the claim and service indicator = 'P' or APC =  
0322, 0325, 0373, 0374)  
50 = Wage index not located  
51 = Wage index equals zero  
52 = Provider specific file wage index reclassification  
code invalid or missing  
53 = Service from date not numeric or < 20000801  
54 = Service from date < provider effective date  
or service from date > provider termination date

\*\*\*Inpatient Rehab Facility (IRF) Pricer Return Codes\*\*\*

IRF Payment return codes:

00 = Paid normal CMG payment without outlier  
01 = Paid normal CMG payment with outlier  
02 = Transfer paid on a per diem basis without outlier  
03 = Transfer paid on a per diem basis with outlier  
04 = Blended CMG payment -- 2/3 Federal PPS rate +  
1/3 provider specific rate -- without outlier  
05 = Blended CMG payment -- 2/3 Federal PPS rate +  
1/3 provider specific rate -- with outlier  
06 = Blended transfer payment -- 2/3 Federal PPS  
transfer rate + 1/3 provider specific rate --  
without outlier  
07 = Blended transfer payment -- 2/3 Federal PPS  
transfer rate + 1/3 provider specific rate --  
with outlier  
10 = Paid normal CMG payment with penalty without  
outlier  
11 = Paid normal CMG payment with penalty with  
outlier  
12 = Transfer paid on a per diem basis with penalty  
without outlier  
13 = Transfer paid on a per diem basis with penalty  
with outlier  
14 = Blended CMG payment -- 2/3 Federal PPS rate +  
1/3 provider specific rate -- with penalty  
without outlier  
15 = Blended CMG payment -- 2/3 Federal PPS rate +  
1/3 provider specific rate -- with penalty  
with outlier  
16 = Blended transfer payment -- 2/3 Federal PPS  
transfer rate + 1/3 provider specific rate --  
with penalty without outlier  
17 = Blended transfer payment -- 2/3 Federal PPS  
transfer rate + 1/3 provider specific rate --  
with penalty with outlier

IRF Error return codes:

50 = Provider specific rate not numeric  
51 = Provider record terminated  
52 = Invalid wage index  
53 = Waiver state - not calculated by PPS  
54 = CMG on claim not found in table

- 55 = Discharge date < provider effective start date or discharge date < MSA effective start date for PPS
- 56 = Invalid length of stay
- 57 = Provider specific rate zero when blended payment requested
- 58 = Total covered charges not numeric
- 59 = Provider specific record not found
- 60 = MSA wage index record not found
- 61 = Lifetime reserve days not numeric or BILL-LTR-DAYS > 60
- 62 = Invalid number of covered days
- 65 = Operating cost-to-charge ratio not numeric
- 67 = Cost outlier with LOS > covered days or cost outlier threshold calculation
- 72 = Invalid blend indicator (not 3 or 4)
- 73 = Discharged before provider FY begin date
- 74 = Provider FY begin date not in 2002

\*Long Term Care Hospital (LTCH) Pricer Return Codes\*

LTCH Payment return codes:

- 00 = Normal DRG payment without outlier
- 01 = Normal DRG payment with outlier
- 02 = Short stay payment without outlier
- 03 = Short stay payment with outlier
- 04 = Blend year 1 - 80% facility rate plus 20% normal DRG payment without outlier
- 05 = Blend year 1 - 80% facility rate plus 20% normal DRG payment with outlier
- 06 = Blend year 1 - 80% facility rate plus 20% short stay payment without outlier
- 07 = Blend year 1 - 80% facility rate plus 20% short stay payment with outlier
- 08 = Blend year 2 - 60% facility rate plus 40% normal DRG payment without outlier
- 09 = Blend year 2 - 60% facility rate plus 40% normal DRG payment with outlier
- 10 = Blend year 2 - 60% facility rate plus 40% short stay payment without outlier
- 11 = Blend year 2 - 60% facility rate plus 40% short stay payment with outlier
- 12 = Blend year 3 - 40% facility rate plus 60% normal DRG payment without outlier
- 13 = Blend year 3 - 40% facility rate plus 60% normal DRG payment with outlier
- 14 = Blend year 3 - 40% facility rate plus 60% short stay payment without outlier
- 15 = Blend year 3 - 40% facility rate plus 60% short stay payment with outlier
- 16 = Blend year 4 - 20% facility rate plus 80% normal DRG payment without outlier
- 17 = Blend year 4 - 20% facility rate plus 80% normal DRG payment with outlier

18 = Blend year 4 - 20% facility rate plus 80%  
short stay payment without outlier  
19 = Blend year 4 - 20% facility rate plus 80%  
short stay payment with outlier

LTCH Error return codes:

50 = Provider specific rate not numeric  
51 = Provider record terminated  
52 = Invalid wage index  
53 = Waiver state - not calculated by PPS  
54 = DRG on claim not found in table  
55 = Discharge date < provider effective start date  
or discharge date < MSA effective start date  
for PPS  
56 = Invalid length of stay  
57 = Provider specific rate zero when blended payment  
requested  
58 = Total covered charges not numeric  
59 = Provider specific record not found  
60 = MSA wage index record not found  
61 = Lifetime reserve days not numeric or BILL-LTR-DAYS  
> 60  
62 = Invalid number of covered days  
65 = Operating cost-to-charge ratio not numeric  
67 = Cost outlier with LOS > covered days or cost  
outlier threshold calculation  
72 = Invalid blend indicator (not 1 thru 5)  
73 = Discharged before provider FY begin date  
74 = Provider FY begin date not in 2002

\*\*\*End Stage Renal Disease (ESRD) Pricer Return Codes\*\*\*

ESRD Payment return codes:

00 = ESRD PPS payment calculated  
01 = ESRD facility rate > zero

ESRD Error return codes:

50 = ESRD facility rate not numeric  
52 = Provider type not = '40' or '41'  
53 = Special payment indicator not = '1'  
or blank  
54 = Date of birth not numeric or = zero  
55 = Patient weight not numeric or = zero  
56 = Patient height not numeric or = zero  
57 = Revenue center code not in range  
58 = Condition code not = '73' or '74' or blank  
60 = MSA wage adjusted rate record not found  
98 = Claim through date before 4/1/2005 or not numeric

CLM\_PRIOR\_AUTHRZTN\_TB

Claim Prior Authorization Indicator Table

A = Part A



B = Part B  
D = DME  
H = Home Health and Hospice  
+ 3 digit number

CLM\_PRVDR\_VLDTN\_TB

Claim Provider Validation Code Table

RP = Rendering Provider  
OP = Operating Physician  
CP = Ordering/Referring Physician  
AP = Attending Physician  
FA = Facility

CLM\_PTNT\_RLTNSHP\_TB

Claim Patient Relationship Table

01 = Spouse  
04 = Grandparent  
05 = Grandchild  
07 = Niece/Nephew  
10 = Foster child  
15 = Ward of the court  
17 = Step child  
18 = Patient is insured  
19 = Natural child/insured financial responsibility  
20 = Employee  
21 = Unknown  
22 = Handicapped dependent  
23 = Sponsored dependent  
24 = Minor dependent of a minor dependent  
32 = Mother  
33 = Father  
39 = Organ donor  
40 = Cadaver donor  
41 = Injured plaintiff  
43 = Natural child/insured does not have financial responsibility

CLM\_PWK\_TB

Claim Paperwork Code Table

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

P0 = ten iterations are present

## CLM\_QUERY\_TB

## Claim Query Table

- 0 = Credit adjustment
- 1 = Interim bill
- 2 = Home Health Agency (HHA) benefits exhausted (obsolete 7/98)
- 3 = Final bill
- 4 = Discharge notice (obsolete 7/98)
- 5 = Debit adjustment

## CLM\_RAC\_ADJSTMT\_TB

## Recovery Audit Contractor (RAC) Adjustment Indicator Table

R = RAC adjusted claim  
Spaces

## CLM\_RLT\_COND\_TB

## Claim Related Condition Table

- 01 = Military service related - Medical condition incurred during military service.
- 02 = Employment related - Patient alleged that the medical condition causing this episode of care was due to environment/ events resulting from employment.
- 03 = Patient covered by insurance not reflected here - Indicates that patient or patient representative has stated that coverage may exist beyond that reflected on this bill.
- 04 = Information Only Bill - Health Maintenance Organization (HMO) enrollee - Medicare beneficiary is enrolled in an HMO. Eff 9/93, hospital must also expect to receive payment from HMO.
- 05 = Lien has been filed - Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.
- 06 = ESRD patient in 1st 30 months of entitlement covered by employer group health insurance - indicates Medicare may be secondary insurer. Eff 3/1/96, ESRD patient in 1st 30 months of entitlement covered by employer group health insurance.
- 07 = Treatment of nonterminal condition for hospice patient - The patient is a

- hospice enrollee, but the provider is not treating a terminal condition and is requesting Medicare reimbursement.
- 08 = Beneficiary would not provide information concerning other insurance coverage.
- 09 = Neither patient nor spouse is employed  
- Code indicates that in response to development questions, the patient and spouse have denied employment.
- 10 = Patient and/or spouse is employed but no EGHP coverage exists or (eff 9/93) other employer sponsored/provided health insurance covering patient.
- 11 = The disabled beneficiary and/or family member has no group coverage from a LGHP or (eff 9/93) other employer sponsored/provided health insurance covering patient.
- 12 = Payer code - Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them.
- 13 = Payer code - Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them.
- 14 = Payer code - Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them.
- 15 = Payer code - reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them. Prior to 3/07, clean claim (eff 10/92) OBSOLETE
- 16 = Payer code - reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them. Prior to 3/07. SNF transition exemption - An exemption from the post-hospital requirement applies for this SNF stay for the qualifying stay dates are more than 30 days prior to the admission date. OBSOLETE
- 17 = Patient is homeless (eff. 3/07). Prior to 3/07, code indicated Patient is over 100 years old - patient was over 100 years old at the date of admission.
- 18 = Maiden name retained - A dependent spouse entitled to benefits who does not use her husband's last name.
- 19 = Child retains mother's name - A patient who is a dependent child entitled to CHAMPVA benefits that does

- not have father's last name.
- 20 = Bene requested billing - Provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the bene has requested formal determination
- 21 = Billing for denial notice - The SNF or HHA realizes services are at a noncovered level of care or excluded, but requests a Medicare denial in order to bill medicaid or other insurer
- 22 = Patient on multiple drug regimen - A patient who is receiving multiple intravenous drugs while on home IV therapy
- 23 = Homecaregiver available - The patient has a caregiver available to assist him or her during self-administration of an intravenous drug
- 24 = Home IV patient also receiving HHA services - the patient is under care of HHA while receiving home IV drug therapy services
- 25 = Patient is Non-U.S. resident
- 26 = VA eligible patient chooses to receive services in Medicare certified facility rather than a VA facility (eff 3/92)
- 27 = Patient referred to a sole community hospital for a diagnostic laboratory test - (sole community hospital only). (eff 9/93)
- 28 = Patient and/or spouse's EGHP is secondary to Medicare - Qualifying EGHP for employers who have fewer than 20 employees. (eff 9/93)
- 29 = Disabled beneficiary and/or family member's LGHP is secondary to Medicare - Qualifying LGHP for employer having fewer than 100 full and part-time employees
- 30 = Qualifying Clinical Trials - Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.
- 31 = Patient is student (full time - day) - Patient declares that he or she is enrolled as a full time day student.
- 32 = Patient is student (cooperative/work study program)
- 33 = Patient is student (full time - night) - Patient declares that he or she is enrolled as a full time night student.
- 34 = Patient is student (part time) - Patient declares that he or she is

- enrolled as a part time student.
- 36 = General care patient in a special unit - Patient is temporarily placed in special care unit bed because no general care beds were available.
- 37 = Ward accommodation is patient's request - Patient is assigned to ward accommodations at patient's request.
- 38 = Semi-private room not available - Indicates that either private or ward accommodations were assigned because semi-private accommodations were not available.
- 39 = Private room medically necessary - Patient needed a private room for medical reasons.
- 40 = Same day transfer - Patient transferred to another facility before midnight of the day of admission.
- 41 = Partial hospitalization - Eff 3/92, indicates claim is for partial hospitalization services. For OP services, this includes a variety of psych programs.
- 42 = Continuing Care Not Related to Inpatient Admission - continuing care not related to the condition or diagnosis for which the beneficiary received inpatient hospital services. (eff. 10/01)
- 43 = Continuing Care Not Provided Within Prescribed Postdischarge Window - continuing care was related to the inpatient admission but the prescribed care was not provided within the post-discharge window.(eff. 10/01)
- 44 = Inpatient Admission Changed to Outpatient - For use on outpatient claims only, when the physician ordered inpatient services, but upon internal review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria. (eff. 4/1/04)
- 45 = Ambiguous Gender Category - claim indicates patient has ambiguous gender characteristics (e.g. transgendered or hermaphrodite).
- 46 = Nonavailability statement on file for CHAMPUS claim for nonemergency IP care for CHAMPUS bene residing within the catchment area (usually a 40 mile radius) of a uniform services hospital.
- 47 = Transfer from another Home Health Agency. (eff. 7/1/10)
- 48 = Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)

- 49 = Product Replacement within Product Lifecycle- replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly (eff. 4/2006)
- 50 = Product Replacement for Known Recall of a Product - Manufacturer or FDA has identified the product for recall and therefore replacement. (eff. 4/2006)
- 51 = Reserved for national assignment.
- 52 = Used to indicate a discharge due to the patient's unavailability/inability to receive hospice services from the hospice which has been responsible for the patient. (effective 7/2/12 - CR7677)
- 53 = Reserved for national assignment.
- 54 = No skilled HH visits in billing period (eff. 7/2016)
- 55 = SNF bed not available - The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
- 56 = Medical appropriateness - Patient's SNF admission was delayed more than 30 days after hospital discharge because physical condition made it inappropriate to begin active care within that period
- 57 = SNF readmission - Patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
- 58 = Payment of SNF claims for beneficiaries disenrolling from terminating M+C plans plans who have not met the 3-day hospital stay requirement (eff. 10/1/00)
- 59 = Non-primary ESRD facility - code indicates that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.
- 60 = Operating cost day outlier - A hospital being paid under a prospective payment system (PPS) is reporting this stay as a day outlier.
- 61 = Operating cost cost outlier - A hospital is being paid under a prospective payment system (PPS) is requesting additional payment for this stay as a cost outlier.
- 62 = Payer Code - providers do not report this code. PIP bill - This bill is a periodic interim payment bill. Obsolete
- 63 = Payer Code - providers do not report this code. PRO denial received before batch clearance report - The HCSSACL receipt date is used on PRO adjustment if the PRO's notification is before orig bill's acceptance

- report. (Payer only code eff 9/93)
- 64 = Payer Code - providers do not report this code.  
Other than clean claim - the claim is not a 'clean claim'. Obsolete
- 65 = Payer Code - Providers do not report this code.  
Non-PPS code - The bill is not a prospective payment system bill. Obsolete
- 66 = Outlier not claimed - Bill may meet the criteria for cost outlier, but the hospital did not claim the cost outlier (PPS)
- 67 = Beneficiary elects not to use LTR days
- 68 = Beneficiary elects to use LTR days
- 69 = IME/DGME/N&AH Payment Only - providers request for supplemental IME/DGME/N&AH payment for each discharge of MCO enrollee, beginning 1/1/98, from teaching hospitals (facilities with approved medical residency training program); not stored in NCH. Exception: problem in startup year may have resulted in this special IME payment request being erroneously stored in NCH. If present, disregard claim as condition code '69' is not valid NCH claim.
- 70 = Self-administered EPO - Billing is for a home dialysis patient who self administers EPO.
- 71 = Full care in unit - Billing is for a patient who received staff assisted dialysis services in a hospital or renal dialysis facility.
- 72 = Self care in unit - Billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
- 73 = Self care training - Billing is for special dialysis services where the patient and helper (if necessary) were learning to perform dialysis.
- 74 = Home - Billing is for a patient who received dialysis services at home.
- 75 = Home 100% reimbursement - (not to be used for services after 4/15/90)  
The billing is for home dialysis patient using a dialysis machine that was purchased under the 100% program.
- 76 = Back-up facility - Billing is for a patient who received dialysis services in a back-up facility.
- 77 = Provider accepts or is obligated/required due to contractual agreement or law to accept payment by a primary payer as payment in full - Medicare pays nothing.

- 78 = New coverage not implemented by HMO - eff 3/92, indicates newly covered service under Medicare for which HMO does not pay.
- 79 = CORF services provided off site - Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.
- 80 = Home Dialysis - Nursing Facility - Home dialysis furnished in a SNF or nursing facility. (eff. 4/4/05)
- 81 - 99 = Reserved for state assignment.
- 85 = Delayed Recertification of Hospice Terminal Illness (eff. 1/2017)
- 89 = Opioid Treatment Program (OTP) - indicates claim is for opioid treatment services (eff. 1/2021)
- 90 = Service provided as part of an Expanded Access Approval (EA) to the IPPS Pricer. Code is for Inpatient and Outpatient claims that have reported Expanded Access (EA) services. Eff. 7/2021
- 91 = Service provided as part of an an Emergency Use Authorization (EUA) to the IPPS Pricer. Code is for Inpatient and Outpatient claims that have reported Emergency Use Authorization (EUA) services. Eff. 7/2021
- A0 = TRICARE External Partnership Program - This code identifies TRICARE claims submitted under the External Partnership Program.
- A0 = Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (eff. 9/01) Obsolete
- A0 = CHAMPUS external partnership program special program indicator code. (eff 10/93) (obsolete)
- A1 = EPSDT/CHAP - Early and periodic screening diagnosis and treatment special program indicator code. (eff 10/93)
- A2 = Physically handicapped children's program - Services provided receive special funding through Title 8 of the Social Security Act or the CHAMPUS program for the handicapped. (eff 10/93)
- A3 = Special federal funding - Designed for uniform use by state uniform billing committees. Special program indicator code (eff 10/93)
- A4 = Family planning - Designed for uniform use by state uniform billing committees. Special program indicator code (eff 10/93)
- A5 = Disability - Designed for uniform



use by state uniform billing committees.

Special program indicator code (eff 10/93)

A6 = PPV/Medicare 100% Payment - Identifies that pneumococcal pneumonia 100% payment vaccine (PPV) services should be reimbursed under a special Medicare program provision.

Special program indicator code (eff 10/93)

A7 = Induced abortion to avoid danger to woman's life. (terminated)

Special program indicator code (eff 10/93)

A7 = Hospital services provided in a mobile facility or with portable units (eff. 4/2020)

A8 = Induced abortion - Victim of rape/incest.

Special program indicator code (eff 10/93)

A9 = Second opinion surgery - Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.

Special program indicator code (eff 10/93)

AA = Abortion Performed due to Rape (eff. 10/1/02)

AB = Abortion Performed due to Incest (eff. 10/1/02)

AC = Abortion Performed due to Serious Fetal Genetic Defect, Deformity or Abnormality (eff. 10/1/02)

AD = Abortion Performed due to a Life Endangering Physical Condition Caused by, arising from or exacerbated by the Pregnancy itself (eff. 10/1/02)

AE = Abortion Performed due to physical health of mother that is not life endangering (eff. 10/1/02)

AF = Abortion Performed due to emotional/psychological health of mother (eff. 10/1/02)

AG = Abortion performed due to social economic reasons (eff. 10/1/02)

AH = Elective Abortion (eff. 10/1/02)

AI = Sterilization (eff. 10/1/02)

AJ = Payer Responsible for copayment (4/1/03)

AK = Air Ambulance Required - For ambulance claims. Time needed to transport poses a threat. (eff. 10/16/03)

AL = Specialized Treatment/bed Unavailable - For ambulance claims. Specialized treatment bed unavailable. Transported to alternate facility. (eff. 10/16/03)

AM = Non-emergency Medically Necessary Stretcher Transport Required - For ambulance claims. Non-emergency medically necessary stretcher transport required. (eff. 10/16/03)

AN = Preadmission Screening Not Required - person meets the criteria for an exemption from

- preadmission screening. (eff. 1/1/04)
- B0 = Medicare Coordinated Care Demonstration Program - patient is a participant in a Medicare Coordinated Care Demonstration (eff. 10/01)
- B1 = Beneficiary ineligible for demonstration program (eff. 10/01).
- B2 = Critical Access Hospital Ambulance Attestation - Attestation by CAH that it meets the criteria for exemption from the Ambulance Fee Schedule
- B3 = Pregnancy Indicator - Indicates the patient is pregnant. Required when mandated by law. (eff. 10/16/03)
- B4 = Admission Unrelated to Discharge - Admission unrelated to discharge on same day. This code is for discharges starting on January 1, 2004.
- B5 = Special program indicator  
Reserved for national assignment.
- B6 = Special program indicator  
Reserved for national assignment.
- B7 = Special program indicator  
Reserved for national assignment.
- B8 = Special program indicator  
Reserved for national assignment.
- B9 = Special program indicator  
Reserved for national assignment.
- BP = Gulf Oil Spill of 2010 - The code identifies claims where the provision of all services on the claim are related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico and/or circumstances related to such spill, including but not limited to subsequent clean-up activities.
- C0 = Reserved for national assignment.
- C1 = Approved as billed - The services provided for this billing period have been reviewed by the QIO/UR or intermediary and are fully approved including any day or cost outlier. (eff 10/93)  
NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C2 = Automatic approval as billed based on focused review. (No longer used for Medicare)  
QIO approval indicator services (eff 10/93)  
NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C3 = Partial approval - The services provided for this billing period have

been reviewed by the QIO/UR or intermediary and some portion has been denied (days or services). (eff 10/93)

NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).

C4 = Admission/services denied - Indicates that all of the services were denied by the QIO/UR.

QIO approval indicator services (eff 10/93)

NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).

C5 = Postpayment review applicable - QIO/UR review to take place after payment.

QIO approval indicator services (eff 10/93)

NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).

C6 = Admission preauthorization - The QIO/UR authorized this admission/ service but has not reviewed the services provided.

QIO approval indicator services (eff 10/93)

NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).

C7 = Extended authorization - the QIO has authorized these services for an extended length of time but has not reviewed the services provided.

QIO approval indicator services (eff 10/93)

NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).

C8 = Reserved for national assignment.

QIO approval indicator services (eff 10/93)

C9 = Reserved for national assignment.

QIO approval indicator services (eff 10/93)

D0 = Changes to service dates.

Change condition (eff 10/93)

D1 = Changes in charges.

Change condition (eff 10/93)

D2 = Changes in revenue codes/HCP/PCS/HIPPS

Rate Code

Change condition (eff 10/93)

D3 = Second or subsequent interim

PPS bill.

Change condition (eff 10/93)

D4 = Change in ICD-9-CM diagnosis and/or

procedure code

Change condition (eff 10/93)

D5 = Cancel only to correct a beneficiary

claim account number or provider

identification number.  
 change condition (eff 10/93)  
 D6 = Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an OP bill containing services required to be included on the IP bill). Change condition eff 10/93.  
 D7 = Change to make Medicare the secondary payer.  
 Change condition (eff 10/93)  
 D8 = Change to make Medicare the primary payer.  
 Change condition (eff 10/93)  
 D9 = Any other change.  
 Change condition (eff 10/93)  
 DR = Disaster Relief (eff. 10/2005) - Code used to facilitate claims processing and track services and items provided to victims of Hurricane Katrina and any future disasters.  
 E0 = Change in patient status.  
 Change condition (eff 10/93)  
 EY = National Emphysema Treatment Trial (NETT) or Lung Volume Reduction Surgery (LVRS) clinical study (eff. 11/97) Obsolete  
 G0 = Multiple medical visits occur on the same day in the same revenue center but visits are distinct and constitute independent visits (allows for payment under outpatient PPS -- eff. 7/3/00).  
 H0 = Delayed Filing, Statement of Intent Submitted -- statement of intent was submitted within the qualifying period to specifically identify the existence of another third party liability situation. (eff. 9/01)  
 H2 = Discharge by a Hospice Provider for Cause (eff. 1/1/09).  
 M0 = Reserved for national assignment.  
 M0 = All inclusive rate for outpatient services. (payer only code). Obsolete  
 M1 = Reserved for national assignment.  
 M1 = Roster billed influenza virus vaccine. (payer only code)  
 Eff 10/96, also includes pneumococcal pneumonia vaccine (PPV) Obsolete  
 M2 = Reserved for national assignment.  
 M2 = HH override code - home health total reimbursement exceeds the \$150,000 cap or the number of total visits exceeds the 150 limitation. (eff 4/3/95) Obsolete (payer only code)  
 M6 = Pennsylvania (PA) Rural Health Model (PARHM) (payer only code)  
 MH = Acute Hospital Care at Home

- (payer only code) eff. 7/2021
- P1 = Do Not Resuscitate Order (DNR) - for public health reporting only - code indicates that a DNR order was written at the time of or within the first 24 hours of the patient's admission to the hospital and is clearly documented in the patient's medical record.
- P7 = Direct Inpatient Admission from Emergency Room - for public health reporting only when required by state or federal law or regulations. Code indicates that patient was admitted directly from this facility's emergency room department. (eff. 7/1/10)
- W0 = United Mine Workers of America (UMWA) SNF demonstration indicator (eff 1/97); but no claims transmitted until 2/98)
- W2 = Duplicate of Original Bill - code indicates bill is exact duplicate of the original bill submitted. (eff. 10/1/08)
- W3 = Level I Appeal - code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (I) is specified/ defined by the payer. (eff. 10/1/08)
- W4 = Level II Appeal - Code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (II) is specified/ defined by the payer. (eff. 10/1/08)
- W5 = Level III Appeal - Code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (III) is specified/ defined by the payer. (eff. 10/1/08)
- XX = Transgender/Hermaphrodite Beneficiaries (eff. 1/2/07) Obsolete
- ZA = Inpatient. Positive test result is not included in the patient's medical record. Eff. 7/2021 (payer only code)
- ZB = Inpatient. Service provided as part of an Expanded Access Approval. Eff. 10/2020 (payer only code)
- ZC = Inpatient. Clinical Trial of a different product. (payer only code). eff. 10/2020
- ZD-ZZ = Reserved. Not currently in use by Medicare.

## CLM\_RLT\_OCRNC\_TB

## Claim Related Occurrence Table

- 01 = Auto accident - The date of an auto accident.
- 02 = No-fault insurance involved, including auto accident/other - The date of an accident where the state has applicable

- no-fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt).
- 03 = Accident/tort liability - The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
- 04 = Accident/employment related - The date of an accident relating to the patient's employment.
- 05 = Accident/No medical liability coverage - code indicating accident related injury for which there is no medical payment or third party liability coverage. Provide the date of accident/injury.
- 05 = Other accident - The date of an accident not described by the codes 01 thru 04. (obsolete)
- 06 = Crime victim - Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
- 07 = Reserved for national assignment.
- 08 = Reserved for national assignment.
- 09 = Start of Infertility Treatment Cycle - code indicating the start date of infertility treatment cycle.
- 10 = Last Menstrual Period - code indicating the date of the last menstrual period; ONLY applies when patient is being treated for maternity related conditions.
- 11 = Onset of symptoms/illness - The date the patient first became aware of symptoms/illness.
- 12 = Date of onset for a chronically dependent individual - Code indicates the date the patient/bene became a chronically dependent individual.
- 13 = Reserved for national assignment.
- 14 = Reserved for national assignment.
- 15 = Reserved for national assignment.
- 16 = Date of Last Therapy - code denotes last day of therapy services (e.g., physical therapy, occupational therapy, speech therapy).
- 17 = Date outpatient occupational therapy plan established or last reviewed - Code indicating the date an occupational therapy plan was established or last reviewed (eff 3/93)
- 18 = Date of retirement (patient/bene)

- Code indicates the date of retirement for the patient/bene.
- 19 = Date of retirement spouse - Code indicates the date of retirement for the patient's spouse.
- 20 = Guarantee of payment began - The date on which the provider began claiming Medicare payment under the guarantee of payment provision.
- 21 = UR notice received - Code indicating the date of receipt by the hospital & SNF of the UR committee's finding that the admission or future stay was not medically necessary.
- 22 = Active care ended - The date on which a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.
- 23 = Cancellation of Hospice benefits - The date the RHHI cancelled the hospice benefit. (eff. 10/00). NOTE: this will be different than the revocation of the hospice benefit by beneficiaries.  
Benefits exhausted - The last date for which benefits can be paid. (term 9/30/93; replaced by code A3)
- 24 = Date insurance denied - The date the insurer's denial of coverage was received by a higher priority payer.
- 25 = Date benefits terminated by primary payer - The date on which coverage (including worker's compensation benefits or no-fault coverage) is no longer available to the patient.
- 26 = Date skilled nursing facility (SNF) bed available - The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
- 27 = Date of Hospice Certification or Re-Certification -- code indicates the date of certification or recertification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods. (eff. 9/01)
- 27 = Date home health plan established or last reviewed - Code indicating the date a home health plan of treatment was established or last reviewed. (Obsolete)

- not used by hospital unless owner of facility
- 28 = Date comprehensive outpatient rehabilitation plan established or last reviewed - Code indicating the date a comprehensive outpatient rehabilitation plan was established or last reviewed.  
not used by hospital unless owner of facility
- 29 = Date OPT plan established or last reviewed - the date a plan of treatment was established for outpatient physical therapy.  
Not used by hospital unless owner of facility
- 30 = Date speech pathology plan treatment established or last reviewed - The date a speech pathology plan of treatment was established or last reviewed.  
Not used by hospital unless owner of facility
- 31 = Date bene notified of intent to bill (accommodations) - The date of the notice provided to the patient by the hospital stating that he no longer required a covered level of IP care.
- 32 = Date bene notified of intent to bill (procedures or treatment) - The date of the notice provided to the patient by the hospital stating requested care (diagnostic procedures or treatments) is not considered reasonable or necessary.
- 33 = First day of the Medicare coordination period for ESRD bene - During which Medicare benefits are secondary to benefits payable under an EGHP. Required only for ESRD beneficiaries.
- 34 = Date of election of extended care facilities - The date the guest elected to receive extended care services (used by Religious Nonmedical Health Care Institutions only).
- 35 = Date treatment started for physical therapy - Code indicates the date services were initiated by the billing provider for physical therapy.
- 36 = Date of discharge for the IP hospital stay when patient received a transplant procedure - Hospital is billing for immunosuppressive drugs.
- 37 = The date of discharge for the IP hospital stay when patient received a noncovered transplant procedure - Hospital is billing for immunosuppressive drugs.
- 38 = Date treatment started for home IV therapy - Date the patient was first



- treated in his home for IV therapy.
- 39 = Date discharged on a continuous course of IV therapy - Date the patient was discharged from the hospital on a continuous course of IV therapy.
- 40 = Scheduled date of admission - The date on which a patient will be admitted as an inpatient to the hospital.  
(This code may only be used on an outpatient claim.)
- 41 = Date of First Test for Pre-admission Testing - The date on which the first outpatient diagnostic test was performed as part of a pre-admission testing (PAT) program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s). (eff. 10/01)
- 42 = Date of discharge/termination of hospice care - for the final bill for hospice care. Eff 5/93, definition revised to apply only to date patient revoked hospice election.
- 43 = Scheduled Date of Canceled Surgery - date which ambulatory surgery was scheduled. (eff. 9/01)
- 44 = Date treatment started for occupational therapy - Code indicates the date services were initiated by the billing provider for occupational therapy.
- 45 = Date treatment started for speech therapy - Code indicates the date services were initiated by the billing provider for speech therapy.
- 46 = Date treatment started for cardiac rehabilitation - Code indicates the date services were initiated by the billing provider for cardiac rehabilitation.
- 47 = Date Cost Outlier Status Begins - code indicates that this is the first day the cost outlier threshold is reached. For Medicare purposes, a bene must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments. (eff. 9/01)
- 48 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.
- 49 = Payer code - Code reserved for internal use only by third party

- payers. HCFA assigns as needed for your use. Providers will not report it.
- 50 = Assessment Date - code indicating an assessment date as defined by the assessment instrument applicable to this provider type (e.g. Minimum Data Set (MDS) for skilled nursing). eff. 1/1/11
- 51 = Date of Last Kt/V Reading - for in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this date may be before the current billing period but should be within 4 months of the date of service. eff. 7/1/10
- 52 = Medical Certification/recertification date - the date of the most recent non-hospice medical certification or recertification of the patient. Use occurrence code 27 for Date of Hospice Certification or Recertification. eff. 1/1/11
- 54 = Physician Follow-up Date - Last date of a physician follow-up with the patient. eff. 1/1/11
- 55 = Used to report date of death.  
NOTE: The date of death will be present when the patient discharge status code is 20, 40, 41 or 42.
- A1 = Birthdate, Insured A - The birthdate of the individual in whose name the insurance is carried. (Eff 10/93)
- A2 = Effective date, Insured A policy - A code indicating the first date insurance is in force. (eff 10/93)
- A3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer A. (eff 10/93)
- A4 = Split Bill Date - date patient became eligible due to medically needy spend down (sometimes referred to as "Split Bill Date").
- B1 = Birthdate, Insured B - The birthdate of the individual in whose name the insurance is carried. (eff 10/93)
- B2 = Effective date, Insured B policy - A code indicating the first date insurance is in force. (eff 10/93)
- B3 = Benefits exhausted - code indicating the last date for which benefits are available and after which no payment can be made to payer B. (eff 10/93)
- C1 = Birthdate, Insured C - The birthdate of the individual in whose name the insurance

- is carried. (eff 10/93)  
C2 = Effective date, Insured C policy - A code indicating the first date insurance is in force. (eff 10/93) Obsolete  
C3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer C. (eff 10/93) Obsolete

CLM\_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 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 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 begin with 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 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.  
Start: 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 using 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](http://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](http://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

11834(a)(18) of the Social Security Act (and in 11834(j)(4) and 1879(h) by cross-reference to 11834(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](http://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

## CLM\_RRB\_EXCLSN\_IND\_TB

## Claim RRB Exclusion Indicator Table

Y = Exclude RRB beneficiary services from the prior authorization program

Blank = Subject RRB beneficiary services to prior authorization

## CLM\_SRC\_IP\_ADMSN\_TB

## Claim Source Of Inpatient Admission Table

**\*\*For Inpatient/SNF Claims:\*\***

- 0 = ANOMALY: invalid value, if present, translate to '9'
- 1 = Non-Health Care Facility Point of Origin (Physician Referral) - The patient was admitted to this facility upon an order of a physician.
- 2 = Clinic referral - The patient was admitted upon the recommendation of this facility's clinic physician.
- 3 = HMO referral - Reserved for national assignment. (eff. 3/08)  
Prior to 3/08, HMO referral - The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician.
- 4 = Transfer from hospital (Different Facility) - The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient.
- 5 = Transfer from a skilled nursing facility (SNF) or Intermediate Care Facility (ICF) - The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.
- 6 = Transfer from another health care facility - The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list where he or she was an inpatient.
- 7 = Emergency room - The patient was admitted to this facility after receiving services in this facility's emergency room department. Obsolete - eff. 7/1/10
- 8 = Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative. Includes transfers from incarceration facilities.
- 9 = Information not available - The means by which the patient was admitted is not known.
- A = Reserved for National Assignment. (eff. 3/08)  
Prior to 3/08 defined as: Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.
- B = Transfer from Another Home Health Agency - The patient was admitted to this home health agency as a transfer from another home health agency.(Discontinued July 1,2010- See Condition Code 47)

- C = Readmission to Same Home Health Agency -  
The patient was readmitted to this home health agency within the same home health episode period. (Discontinued July 1,2010)
- D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer - The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.
- E = Transfer from Ambulatory Surgery Center -  
The patient was admitted to this facility as a transfer from an ambulatory surgery center. (eff. 10/1/2007)
- F = Transfer from Hospice and is under a Hospice Plan of Care or Enrolled in a Hospice Program -  
The patient was admitted to this facility as a transfer from a hospice. (eff. 10/1/2007)

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\*\*For Newborn Type of Admission\*\*

- 1 = Normal delivery - A baby delivered with out complications. Obsolete eff. 10/1/07
- 2 = Premature delivery - A baby delivered with time and/or weight factors qualifying it for premature status. Obsolete eff. 10/1/07
- 3 = Sick baby - A baby delivered with medical complications, other than those relating to premature status. Obsolete eff. 10/1/07
- 4 = Extramural birth - A baby delivered in a nonsterile environment. Obsolete eff. 10/1/07
- 5 = Born Inside this Hospital - eff. 10/1/07
- 6 = Born Outside of this Hospital - eff. 10/1/07
- 7-9 = Reserved for national assignment.

CLM\_SRVC\_CLSFCTN\_TYPE\_TB

Claim Service Classification Type Table

For facility type code 1 thru 6, and 9

- 1 = Inpatient (including Part A)
- 2 = Hospital based or Inpatient (Part B only) or home health visits under Part B
- 3 = Outpatient (HHA-A also)
- 4 = Other (Part B) -- (Includes HHA medical and other health services not under a plan of treatment, hospital or SNF for diagnostic clinical laboratory services for "nonpatients," and referenced diagnostic services. For HHAs under PPS, indicates an osteoporosis claim.)



- 5 = Intermediate care - level I
- 6 = Intermediate care - level II
- 7 = Subacute Inpatient (revenue code 019X required)  
(formerly Intermediate care - level III)  
NOTE: 17X & 27X are discontinued effective  
10/1/05.
- 8 = Swing beds (used to indicate billing for  
SNF level of care in a hospital with an  
approved swing bed agreement)
- 9 = Reserved for national assignment

For facility type code 7

- 1 = Rural Health Clinic (RHC)
- 2 = Hospital based or independent renal  
dialysis facility
- 3 = Free-standing provider based federally  
qualified health center (FQHC) (eff 10/91)
- 4 = Other Rehabilitation Facility (ORF) and  
Community Mental Health Center (CMHC)  
(eff 10/91 - 3/97); ORF only (eff. 4/97)
- 5 = Comprehensive Rehabilitation Center  
(CORF)
- 6 = Community Mental Health Center (CMHC) (eff 4/97)
- 7-8 = Reserved for national assignment
- 9 = Other

For facility type code 8

- 1 = Hospice (non-hospital based)
- 2 = Hospice (hospital based)
- 3 = Ambulatory surgical center in hospital  
outpatient department
- 4 = Freestanding birthing center
- 5 = Critical Access Hospital (eff. 10/99)  
formerly Rural primary care hospital  
(eff. 10/94)
- 6-8 = Reserved for national use
- 9 = Other

CLM\_TRANS\_TB

Claim Transaction Table

- 0 = Religious NonMedical Health Care Institutions (RNHCI)  
bill (prior to 8/00, Christian Science bill), SNF bill,  
or state buy-in
- 1 = Psychiatric hospital facility bill or dummy psychiatric
- 2 = Tuberculosis hospital facility bill
- 3 = General care hospital facility bill or dummy LRD
- 4 = Regular SNF bill
- 5 = Home health agency bill (HHA)
- 6 = Outpatient hospital bill
- C = CORF bill - type of OP bill in the HHA bill format

(obsoleted 7/98)

H = Hospice bill

CLM\_VAL\_TB

Claim Value Table

- 01 = Most Common Semi-Private Rate - to provide for the recording of hospital's most common semi-private rate.
- 02 = Hospital Has No Semi-Private Rooms - Entering this code requires \$0.00 amount.
- 03 = Reserved for national assignment.
- 04 = Inpatient professional component charges which are combined billed - For use only by some all inclusive rate hospitals. (Eff 9/93)
- 05 = Professional component included in charges and also billed separately to carrier - For use on Medicare and Medicaid bills if the state requests this information.
- 06 = Medicare blood deductible - Total cash blood deductible (Part A blood deductible).
- 07 = Medicare cash deductible (term 9/30/93) Reserved for national assignment.
- 08 = Medicare Part A lifetime reserve amount in first calendar year - Lifetime reserve amount charged in the year of admission. (not stored in NCH until 2/93)
- 09 = Medicare Part A coinsurance amount in the first calendar year - Coinsurance amount charged in the year of admission. (not stored in NCH until 2/93)
- 10 = Medicare Part A lifetime reserve amount in the second calendar year - Lifetime reserve amount charged in the year of discharge where the bill spans two calendar years. (in NCH until 2/93)
- 11 = Medicare Part A coinsurance amount in the second calendar year - Coinsurance amount charged in the year of discharge where the bill spans two calendar years (not stored in NCH until 2/93)
- 12 = Amount is that portion of higher priority EGHP insurance payment made on behalf of aged bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.

- 13 = Amount is that portion of higher priority EGHP insurance payment made on behalf of ESRD bene provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 14 = That portion of payment from higher priority no fault auto/other liability insurance made on behalf of bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional payment
- 15 = That portion of a payment from a higher priority WC plan made on behalf of a bene that the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 16 = That portion of a payment from higher priority PHS or other federal agency made on behalf of a bene the provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.
- 17 = Operating Outlier amount - Providers do not report this. For payer internal use only. Indicates the amount of day or cost outlier payment to be made. (Do not include any PPS capital outlier payment in this entry). Obsolete
- 18 = Operating Disproportionate share amount - Providers do not report this. For payer internal use only. Indicates the disproportionate share amount applicable to the bill. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry). Obsolete
- 19 = Operating Indirect medical education amount - Providers do not report this. For payer internal use only. Indicates the indirect medical education amount applicable to the bill. (Do not include PPS capital IME adjustment in this entry). Obsolete
- 20 = Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount. (used 10/1/91 - 3/1/92 for provider reporting. Payer only code eff 9/93.) Obsolete

- 21 = Catastrophic - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
- 22 = Surplus - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
- 23 = Recurring monthly income - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
- 24 = Medicaid rate code - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
- 25 = Offset to the Patient Payment Amount (Prescription Drugs) - Prescription drugs paid for out of a long-term care facility resident/patient's fund in the billing period submitted (Statement Covers Period).
- 26 - Prescription Drugs Offset to Patient (Payment Amount - Hearing and Ear Services) Hearing and ear services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement covers period).
- 27 = Offset to the Patient (Payment Amount - Vision and Eye Services) - Vision and eye services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
- 28 = Offset to the Patient (Payment Amount - Dental Services) - Dental services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
- 29 = Offset to the Patient (Payment Amount - Chiropractic Services) - Chiropractic services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
- 30 = Preadmission Testing - the code used to reflect the charges for preadmission outpatient diagnostic services in preparation for a previously scheduled admission.
- 31 = Patient liability amount - Amount shown is that which you or the PRO approved to charge the bene for noncovered accommodations, diagnostic procedures or treatments.
- 32 = Multiple patient ambulance transport - The number of patients transported during one ambulance ride to the same destination. (eff. 4/1/2003)

- 33 = Offset to the Patient Payment Amount (Podiatric Services) -- Podiatric services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
- 34 = Offset to the Patient Payment Amount (Medical Services) -- Other medical services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
- 35 = Offset to the Patient Payment Amount (Health Insurance Premiums) -- Other medical services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
- 37 = Pints of blood furnished - Total number of pints of whole blood or units of packed red cells furnished to the patient. (eff 10/93)
- 38 = Blood deductible pints - The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. (eff 10/93)
- 39 = Pints of blood replaced - The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient. (eff 10/93)
- 40 = New coverage not implemented by HMO - amount shown is for inpatient charges covered by HMO (eff 3/92). (use this code when the bill includes inpatient charges for newly covered services which are not paid by HMO.)
- 41 = Amount is that portion of a payment from higher priority Black Lung federal program made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 42 = Amount is that portion of a payment from higher priority VA made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 43 = Disabled bene under age 65 with LGHP - Amount is that portion of a payment from a higher priority LGHP made on behalf of a disabled Medicare bene the provider applied to Medicare covered services on this bill.
- 44 = Amount provider agreed to accept from

- primary payer when amount less than charges but more than payment received -  
When a lesser amount is received and the received amount is less than charges, a Medicare secondary payment is due.
- 45 = Accident Hour - The hour the accident occurred that necessitated medical treatment.
- 46 = Number of grace days - Following the date of the PRO/UR determination, this is the number of days determined by the PRO/UR to be necessary to arrange for the patient's post-discharge care.  
(eff 10/93)
- 47 = Any liability insurance - Amount is that portion from a higher priority liability insurance made on behalf of Medicare bene the provider is applying to Medicare covered services on this bill. (Eff 9/93)
- 48 = Hemoglobin reading - The patient's most recent hemoglobin reading taken before the start of the billing period (eff. 1/3/2006). Prior to 1/3/2006 defined as the latest hemoglobin reading taken during the billing cycle.
- 49 = Hematocrit reading - The patient's most recent hematocrit reading taken before the start of the billing period (eff. 1/3/2006). Prior to 1/3/2006 defined as hematocrit reading taken during the billing cycle.
- 50 = Physical therapy visits - Indicates the number of physical therapy visits from onset (at billing provider) through this billing period.
- 51 = Occupational therapy visits - Indicates the number of occupational therapy visits from onset (at the billing provider) through this billing period.
- 52 = Speech therapy visits - Indicates the number of speech therapy visits from onset (at billing provider) through this billing period.
- 53 = Cardiac rehabilitation - Indicates the number of cardiac rehabilitation visits from onset (at billing provider) through this billing period.
- 54 = New birth weight in grams - Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type of admission of '4' and on other claims as required by law.
- 55 = Eligibility Threshold for Charity Care - code identifies the corresponding value amount at which a health care facility determines the

- eligibility threshold of charity care.
- 56 = Hours skilled nursing provided - The number of hours skilled nursing provided during the billing period. Count only hours spent in the home.
- 57 = Home health visit hours - The number of home health aide services provided during the billing period. Count only the hours spent in the home.
- 58 = Arterial blood gas - Arterial blood gas value at beginning of each reporting period for oxygen therapy. This value or value 59 will be required on the initial bill for oxygen therapy and on the fourth month's bill.
- 59 = Oxygen saturation - Oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 will be required on the initial bill for oxygen therapy and on the fourth month's bill.
- 60 = HHA branch MSA - MSA in which HHA branch is located.
- 61 = Location of HHA service or hospice service - the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of the provider.

NOTE: HHA claims with a thru date on or before 12/31/05, the value code amount field reflects the MSA code (followed by zeroes to fill the field). HHA claims with a thru date after 12/31/05, the value code amount field reflects the CBSA code.

- 62 = Number of Part A home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
- 63 = Number of Part B home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
- 64 = Amount of home health payments attributed to the Part A trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
- 65 = Amount of home health payments attributed to the Part B trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS

(eff. 10/00)

66 = Medicare Spend-down Amount -- The dollar amount that was used to meet the recipient's spend-down liability for this claim.

67 = Peritoneal dialysis - The number of hours of peritoneal dialysis provided during the billing period (only the hours spent in the home).

(eff. 10/97)

68 = EPO drug - Number of units of EPO administered relating to the billing period.

69 = State Charity Care Percent - code indicates the percentage of charity care eligibility for the patient.

70 = Interest amount - (Providers do not report this.) Report the amount applied to this bill.

71 = Funding of ESRD networks - (Providers do not report this.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.

72 = Flat rate surgery charge - Code indicates the amount of the charge for outpatient surgery where the hospital has such a charging structure.

73 = Drug deductible - (For internal use by third party payers only). Report the amount of the drug deductible to be applied to the claim.

74 = Drug coinsurance - (For internal use by third party payers only). Report the amount of drug coinsurance to be applied to the claim.

75 = Gramm/Rudman/Hollings - (Providers do not report this.) Report the amount of the sequestration applied to this bill.

76 = Report provider's percentage of billed charges interim rate during billing period. Applies to OP hospital, SNF and HHA claims where interim rate is applicable. Report to left of dollar/cents delimiter. (TP payers internal use only)

77 = New Technology Add-on Payment Amount - Amount of payments made for discharges involving approved new technologies. If the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for IME and disproportionate share hospitals (DSH) but excluding outlier payments) an add-on amount is made indicating a new technology was used in the treatment of the beneficiary.



- (eff. 4/1/03, under Inpatient PPS)
- 78 = Payer code - This codes is set aside for payer use only. Providers do not report these codes.
- 79 = Payer code - This code is set aside for payer use only. Providers do not report these codes.
- 80 = Covered days - the number of days covered by the primary payer as qualified by the payer.
- 81 = Non-covered Days - days of care not covered by the primary payer.
- 82 = Co-insurance Days - The inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/Swing bed days occurring after the 20th and before the 101st day in a single spell of illness.
- 83 = Lifetime Reserve Days - Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.
- 84 = Medicare Lifetime Reserve Amount in the third or greater calendar years'. Eff. 1/7/2013
- 85 = Medicare Coinsurance Amount in the third or greater calendar years'. Eff. 1/7/2013
- 86 = Invoice Cost (term. 3/2020)
- 87 = Gene Therapy Invoice Cost (eff. 4/2020)
- 88 = Allogeneic Stem Cell Transplant - Number of Related Donors Evaluation (eff. 7/2020)
- 89 = Allogeneic Stem Cell Transplant - Total All-inclusive Donor Charges (eff. 7/2020)
- 90 = Cell Therapy Invoice Cost (eff. 4/2020)
- 91 - 99 = Reserved for national assignment.
- A0 = Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (eff. 9/01)
- A1 = Deductible Payer A - The amount assumed by the provider to be applied to the patient's deductible amount to the involving the indicated payer. (eff. 10/93)  
- Prior value 07
- A2 = Coinsurance Payer A - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)
- A3 = Estimated Responsibility Payer A - The amount estimated by the provider to be paid by the indicated payer.
- A4 = Self-administered drugs administered in an emergency situation - Ordinarily the only noncovered self-administered drug paid for under Medicare in an emergency situation is insulin administered to a

- patient in a diabetic coma. (eff 7/97)
- A5 = Covered self-administered drugs -- The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administered in the form and situation in which it was furnished to the patient.
- A6 = Covered self-administered drugs -Diagnostic study and Other --- the amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons. For use with Revenue Center 0637.
- A7 = Copayment A -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.
- A8 = Patient Weight -- Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight.
- A9 = Patient Height - Height of patient in centimeters Report this data only when the health plan has a predefined change in reimbursement that is affected by height.
- AA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer A) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).
- AB = Other Assessments or Allowances (Payer A) -- The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).
- B1 = Deductible Payer B - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93)  
- Prior value 07
- B2 = Coinsurance Payer B - the amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)
- B3 = Estimated Responsibility Payer B - The amount estimated by the provider to be paid by the indicated payer.
- B7 = Copayment B -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.
- BA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer B) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).
- BB = Other Assessments or Allowances (Payer B) -- The amount of other assessments or allowances

pertaining to the indicated payer. (eff. 10/2003).

C1 = Deductible Payer C - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93)  
- Prior value 07

C2 = Coinsurance Payer C - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)

C3 = Estimated Responsibility Payer C - The

C7 = Copayment C -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.

CA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer C) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).

CB = Other Assessments or Allowances (Payer C) -- The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).

D3 = Estimated Responsibility Patient - The amount estimated by the provider to be paid by the indicated patient.

D4 = Clinical Trial Number Assigned by NLM/NIH - Eight digit numeric National Library of Medicine/National Institute of Health clinical trial registry number or a default number of '99999999' if the trial does not have an 8-digit registry number. (Eff. 10/1/07)

D5 = Last Kt/V Reading - result of last Kt/V reading. For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within 4 months of the date of service. (eff. 7/1/10)

FC = Patient Paid Amount - The amount the provider has received from the patient toward payment of this bill (7/1/08).

FD = Credit Received from the Manufacturer for a Replaced Medical Device - the amount the provider has received from a medical device manufacturer as credit for a replaced device. (eff. 7/1/08)

G8 = Facility Where Inpatient Hospice Service Is Delivered - MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice is delivered. (Eff. 1/1/08)

Q0 = ACO Payment Adjustment Amount (Pioneer Reduction)- the amount that would have been paid if not for

the Pioneer reduction. (eff. 1/2014)

Q1 = ACO Payment Reduction Amount (Pioneer Reduction)-  
the actual amount of the Pioneer reduction.  
(eff. 1/2014)

Q4 = Pennsylvania (PA) Rural Health Exclusion - Physician  
Services Claim Reimbursement

Q5 = EHR Reduction

Q7 = ISLET Add-On Payment Amount (eff. 10/2016)

Q8 = Total Transitional Drug Add-On Payment Adjustment  
(TDAPA) Amount (eff. 1/2018)

Q9 = Medicare Advantage (MA) Plan Amount (eff. 10/2014)

QB = OCM+ Payment Adjustment Amount (payer only)  
(eff. 1/2020)

QG = Total TPNIES Amount - used to capture the TPNIES  
add-on payment. eff. 4/2021

QN = First APC device offset

QO = Second APC device offset

QP = Placeholder reserved for future use

QQ = Terminated procedure with pass-through device OR  
condition for device credit present

QR = First APC pass-through drug or biological offset

QS = Second APC pass-through drug or biological offset

QT = Third APC pass-through drug or biological offset

QU = Reserved for future use

QV = Home Health Value Based Purchasing (HHVBP) adjustment  
amount (negative or positive) - eff. 4/2018

QW = Reserved for future use

XX = Total Charge Amount for all Part A visits  
on RIC 'U' claims - for Home Health claims  
containing both Part A and Part B services  
this code identifies the total charge amount  
for the Part A visits (based on revenue  
center codes 042X, 043X, 044X, 055X, 056X,  
& 057X). Code created internally in the  
CWFMQA system (eff. 10/31/01 with HHPPS).

XY = Total Charge Amount for all Part B visits  
on RIC 'U' claims - for Home Health claims  
containing both Part A and Part B services  
this code identifies the total charge amount  
for the Part B visits (based on revenue  
center codes 042X, 043X, 044X, 055X, 056X,  
& 057X). Code created internally in the  
CWFMQA system (eff. 10/31/01 with HHPPS).

XZ = Total Charge Amount for all Part B non-  
visit charges on the RIC 'U' claims - for  
Home Health claims containing both Part A  
& Part B services, this code identifies the  
total charge amount for the Part B non-visit  
charges. Code created internally in the  
CWFMQA system (eff. 10/31/01 with HHPPS).

Y1 = Part A demo payment - Portion of the  
payment designated as reimbursement for  
Part A services under the demonstration.  
This amount is instead of the traditional

prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included in this amount.

Y2 = Part B demo payment - Portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.

Y3 = Part B coinsurance - Amount of Part B coinsurance applied by the intermediary to this demo claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).

Y4 = Conventional Provider Payment Amount for Non-Demonstration Claims - This is the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operating IME and DSH.

Y5 = Part B deductible, applicable for a Model 4 demonstration 64 claims

CLM\_VBP\_PRTCPNT\_IND\_TB

Claim VBP Participant Indicator Table

Y = Participating in Hospital Value Based Purchasing

N = Not participating in Hospital Value Based Purchasing

Blank = same as 'N'

CLM\_WC\_IND\_TB

Workers' Compensation Indicator Table

Y = The diagnosis codes on the claims are related to the diagnosis codes on the MSP auxiliary file in CWF.

Spaces

- 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 Facilities (IDTFs -- eff. 4/1/03)
- 75 = Other medical care (GPPP) (not to assigned after 5/92)
- 76 = Peripheral vascular disease (eff 5/92)
- 77 = Vascular surgery (eff 5/92)
- 78 = Cardiac surgery (eff 5/92)
- 79 = Addiction medicine (eff 5/92)
- 80 = Licensed clinical social worker
- 81 = Critical care (intensivists) (eff 5/92)
- 82 = Hematology (eff 5/92)
- 83 = Hematology/oncology (eff 5/92)
- 84 = Preventive medicine (eff 5/92)
- 85 = Maxillofacial surgery (eff 5/92)
- 86 = Neuropsychiatry (eff 5/92)
- 87 = All other suppliers (e.g. drug and department stores) (note: DMERC used 87 to mean department store from 10/93 through 9/94; recoded eff 10/94 to A7; NCH cross-walked DMERC reported 87 to A7.
- 88 = Unknown supplier/provider specialty (note: DMERC used 87 to mean grocery store from 10/93 - 9/94; recoded eff 10/94 to A8; NCH cross-walked DMERC reported 88 to A8.
- 89 = Certified clinical nurse specialist



90 = Medical oncology (eff 5/92)  
 91 = Surgical oncology (eff 5/92)  
 92 = Radiation oncology (eff 5/92)  
 93 = Emergency medicine (eff 5/92)  
 94 = Interventional radiology (eff 5/92)  
 95 = Competative Acquisition Program (CAP)  
     Vendor (eff. 07/01/06). Prior to  
     07/01/06, known as Independent  
     physiological laboratory (eff. 5/92)  
 96 = Optician (eff 10/93)  
 97 = Physician assistant (eff 5/92)  
 98 = Gynecologist/oncologist (eff 10/94)  
 99 = Unknown physician specialty  
 A0 = Hospital (eff 10/93) (DMERCs only)  
 A1 = SNF (eff 10/93) (DMERCs only)  
 A2 = Intermediate care nursing facility  
     (eff 10/93) (DMERCs only)  
 A3 = Nursing facility, other (eff 10/93)  
     (DMERCs only)  
 A4 = HHA (eff 10/93) (DMERCs only)  
 A5 = Pharmacy (eff 10/93) (DMERCs only)  
 A6 = Medical supply company with respiratory  
     therapist (eff 10/93) (DMERCs only)  
 A7 = Department store (for DMERC use:  
     eff 10/94, but cross-walked from  
     code 87 eff 10/93)  
 A8 = Grocery store (for DMERC use:  
     eff 10/94, but cross-walked from  
     code 88 eff 10/93)  
 A9 = Indian Health Service (IHS), tribe and  
     tribal organizations (non-hospital or  
     non-hospital based facilities. DMERCs shall  
     process claims submitted by IHS, tribe and  
     non-tribal organizations for DMEPOS and drugs  
     covered by the DMERCs. (eff. 1/2005)  
 B1 = Supplier of oxygen and/or oxygen related  
     equipment (eff. 10/2/07)  
 B2 = Pedorthic Personnel (eff. 10/2/07)  
 B3 = Medical Supply Company with Pedorthic Personnel  
     (eff. 10/2/07)  
 B4 = Rehabilitation Agency (eff. 10/2/07)  
 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 = Opioid Treatment Program (eff. 1/2020)

CTGRY\_EQTBL\_BENE\_IDENT\_TB

Category Equatable Beneficiary Identification Code (BIC) Table

NCH BIC

SSA Categories

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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)

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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

## DRG\_OUTLIER\_STAY\_TB

## Diagnosis Related Group Outlier Patient Stay Table

0 = No outlier

1 = Day outlier (condition code 60)

2 = Cost outlier, (condition code 61)

\*\*\* Non-PPS Only \*\*\*

6 = Valid diagnosis related groups (DRG)  
received from the intermediary

7 = CMS developed DRG

8 = CMS developed DRG using patient status  
code

9 = Not groupable

## END\_REC\_TB

## End of Record Code Table

EOR = End of record/segment

EOC = End of claim

## FI\_CLM\_ACTN\_TB

## Fiscal Intermediary Claim Action Table

1 = Original debit action (includes non-  
adjustment RTI correction items) - it  
will always be a 1 in regular bills.

2 = Cancel by credit adjustment - used  
only in credit/debit pairs (under HHPPS,  
updates the RAP).

3 = Secondary debit adjustment - used only  
in credit/debit pairs (under HHPPS, would  
be the final claim or an adjustment on  
a LUPA).

4 = Cancel only adjustment (under HHPPS,  
RAP/final claim/LUPA).

5 = Secondary debit adjustment

6 = Cancel only adjustment

8 = Benefits refused (for inpatient bills,  
an 'R' nonpayment code must also be  
present

9 = Payment requested (used on bills that  
replace previously-submitted benefits-  
refused bills, action code 8. In such  
cases a debit/credit pair is not re-  
quired. For inpatient bills, a 'P'  
should be entered in the nonpayment  
code.)

## FI\_NUM\_TB

## Fiscal Intermediary Number / Medicare Administrative Contractor Table

00010 = Alabama BC - Alabama (term. 05/2009)  
(replaced with MAC #10101 -- see below)

00011 = Alabama BC - Iowa (term. 10/2007)  
replaced by MAC # 03401 -- see below)

00011 = Cahaba - (RHHI) (term. 06/2011)  
replaced by MAC # 03401 -- see below)

00012 = Iowa (terminated)  
replaced by MAC # 05101 -- see below)

00012 = Arizona - Noridian - J3 A MAC (AZA)  
(term. 05/2008)

00020 = Arkansas BC - Arkansas

00021 = Arkansas BC - Rhode Island  
(term. 05/2009)

00030 = Arizona BC (term. 09/2007)  
(replaced by MAC # 03101 -- see below)

00040 = California BC (term. 11/2000)

00041 = California - Oakland BC (terminated)

00050 = New Mexico BC/CO (term. 06/89)

00050 = Colorado BC (terminated)

00060 = Connecticut BC (term. 06/99)

00070 = Delaware BC - (term. 02/98)

00080 = Florida BC (term. 03/88)

00080 = District of Columbia BC (terminated)

00090 = Florida BC (term. 02/2009)  
(replaced with MAC #09101 -- see below)

00100 = Georgia - Atlantic BC (terminated)

00101 = Georgia BC (term. 05/2009)  
(replaced with MAC #10201 -- see below)

00110 = Idaho BC (terminated)

00121 = Illinois - HCSC (term. 08/98)

00122 = Illinois - BC (terminated)

00123 = Michigan - HCSC (term. 08/98)

00130 = Indiana BC/Administar Federal (term. 7/22/2012)  
(replaced with MAC # 08101 -- see below)

00131 = Illinois - Anthem

00140 = Iowa - Wellmark (term. 05/2000)

00141 = Iowa - Souix City BC (terminated)

00150 = Kansas BC (term. 02/2008)  
(replaced with MAC # 05201 -- see below)

00160 = Kentucky - Anthem (term. 4/30/2011)  
(replaced with MAC # 15101 -- see below)

00170 = Louisiana - Baton Rouge BC (terminated)

00171 = Louisiana - New Orleans BC (terminated)

00180 = Maine BC (term. 05/2009)  
(replaced with MAC #14004 & 14101 -- see below)

00180 = Connecticut, Maine, Massachusetts,  
New Hampshire, Rhode Island (Maine RHHI)  
(term. 05/2009)  
(replaced with MAC #14004 & 14101 -- see below)

00181 = Massachusetts - Maine BC (term. 05/2009)  
 00190 = Carefirst of Maryland (term. 09/2005)  
 00191 = District of Columbia - Maryland BC (terminated)

00200 = Massachusetts BC (term. 7/97)  
 00210 = Michigan BC (term. 9/94)  
 00220 = Minnesota BC (term. 07/99)  
 00230 = Mississippi BC  
 00230 = Trispan Health Services (LA-MS) (term. 09/2009)  
 (previously also MOA)  
 00231 = Mississippi BC - Louisiana (term. 09/1992)  
 00232 = Mississippi BC  
 00233 = Louisiana, Mississippi (J7 Interim)  
 (eff 10/01/2009)  
 00234 = PBSI J7 A TEMP ROLLUP AK,LA,MS  
 (terminated)  
 00240 = Kansas City BC - Missouri (terminated)  
 00241 = Missouri BC (term. 9/92)  
 00242 = Missouri (terminated)  
 (replaced with MAC # 05301 --see below)  
 00242 = BCBS of MS (MOA) (term. 04/2008)  
 (replaced with MAC # 05301 --see below)  
 00250 = Montana BC (term. 11/2006)  
 (replaced by MAC # 03201 -- see below)  
 00260 = Nebraska BC (term. 11/2007)  
 (replaced with MAC # 05401 --see below)  
 00270 = New Hampshire BC - New Hampshire, Vermont  
 (term. 06/2009)  
 (replaced with MAC #14501 -- see below)  
 00280 = New Jersey BC (term. 07/2000)  
 00290 = New Mexico BC - (term. 11/1995)  
 00291 = New Mexico BC - Colorado (terminated)

00300 = New York - Albany BC (terminated)  
 00301 = New York - Buffalo BC (terminated)  
 00302 = New York - Jamestown BC (terminated)  
 00303 = New York - New York City BC (terminated)  
 00304 = New York - Rochester BC (terminated)  
 00305 = New York - Syracuse BC (terminated)  
 00306 = New York - Utica BC (terminated)  
 00307 = New York - Watertown BC (terminated)  
 00308 = Empire BC - New York, Connecticut, Delaware  
 (term. 11/2008)  
 (replaced with MAC # 12101, 13201 & 13101 -- see below)

00310 = North Carolina BC (term. 09/2002)  
 00312 (terminated)  
 00320 = North Dakota BC - North Dakota (term. 12/1/2006)  
 (replaced with MAC # 03301 -- see  
 below)  
 00322 = North Dakota BC - Washington & Alaska  
 00323 = North Dakota BC - Idaho, Oregon & Utah  
 (term. 11/2006)  
 (replaced with MAC # 03501 --see below)

00325 = Noridian - Idaho, Oregon

00326 = J2 Rollup (Merge into a single CICS region)  
 (temporary) (terminated)

00330 NA (terminated)

00331 = Canton BC - Ohio (terminated)

00332 = Administar - Ohio  
 Anthem - Ohio

00333 = Cleveland BC - Ohio (terminated)  
 Ohio-Administar

00334 = Columbus BC - Ohio (terminated)

00335 = Lima BC - Ohio (terminated)

00337 = Toledo BC - Ohio (terminated)

00338 = Youngstown BC - Ohio (terminated)

00340 = Oklahoma BC (term. 02/2008)  
 (replaced with MAC # 04301 -- see below)

00350 = Regence - Oregon, Idaho, Utah  
 (term. 11/2005)

00351 = Oregon BC/ID. (term. 09/88)

00355 = Regence CWF - Oregon (term. 09/2004)

00360 = Allentown BC - Pennsylvania (terminated)

00361 = Harrisburg BC - Pennsylvania (terminated)

00361 = Independence BC - Pennsylvania (terminated)

00362 = Independence BC - terminated 8/97

00363 = Pennsylvania/Highmark - Veritus  
 (term. 07/2008)

00364 = Wilkes Barre BC - Pennsylvania (terminated)

00366 = Highmark (MD & DC) - Part A (eff. 10/2005)  
 (term. 07/2008)

00370 = Rhode Island BC  
 (term. 03/2004)  
 (replaced with MAC #14401 - see below)

00380 = South Carolina BC - South Carolina  
 (term. 01/2011)  
 (replaced with MAC #11004 & 11201 - see below)

00380 = Palmetto GBA - AL, AR, GA, FL, IL, IN, KY,  
 LA, MS, MN, NC, OK, OH, SC, TN, TX  
 (term. 01/2011)

00381 NA (terminated)

00382 = South Carolina BC - North Carolina  
 (term. 10/2010)  
 (replaced with MAC #11501 - see below)

00388 = Palmetto Drugs (terminated)

00390 = Riverbend BC - New Jersey, Tennessee  
 (term. 08/2009)  
 (replaced with MAC # 12001 & 10301 -- see below)

00392 = Memphis BC - Tennessee (terminated)

00400 = Texas BC - Colorado, New Mexico, Texas  
 (term. 05/2008)  
 (replaced with MAC #04101, 04201, 04401 -- see below)

00401 NA (terminated)

00410 = Utah BC (term. 09/2000)

00423 = Trigon - Virginia, West Virginia (term. 07/1999)

00424 = Roanoke BC - Virginia (terminated)

00425 = Virginia BC - West Virginia (term. 08/1992)

00430 = Premera BC - Washington, Alaska  
(term. 09/2004)

00440 = Bluefield BC - West Virginia (terminated)

00441 = West Virginia BC (term. 11/1990)

00443 = Parkersburg BC - West Virginia (terminated)

00444 = Wheeling BC - West Virginia (terminated)

00450 = Wisconsin BC - Wisconsin

00450 = Michigan, Minnesota, New Jersey, New York,  
Wisconsin (RHHI)

00452 = Wisconsin BC - Michigan (term. 7/22/2012)  
(replaced with MAC # 08201 -- see below)

00453 = Wisconsin BC - Virginia & West Virginia  
(term. 05/2011)  
(replaced with MAC #11301 & 11401 - see below)

00454 = Wisconsin BC - California, Hawaii, Nevada (RHHI)  
(term. 08/2008)  
(replaced by MAC #01101, 01201 & 01301 -- see below)

00456 = United Government Services, LLC (CAR)  
(eff 08/15/2008)

00460 = Wyoming BC  
(term. 10/2006)  
(replaced by MAC # 03601 -- see below)

00468 = N Carolina BC/CPRTIVA (terminated)

00470 = Puerto Rico BC (terminated)

  

00993 = BC/BS Assoc.

17120 = Hawaii Medical Service (term. 06/99)

18390 = Inter-County (terminated)

19050 = Kaiser Foundation (terminated)

20330 = New York State Dept of Health (terminated)

21230 = Community Health Association (term. 05/1969)

22400 = Puerto Rico - Cooperative De Saluda  
(term. 01/1970)

50050 = Travelers - Long Beach, California (terminated)

50051 = Travelers - Los Angeles, California (terminated)

50052 = Travelers - Pomona, California (terminated)

50053 = Travelers - San Francisco, California (terminated)

50070 = Travelers - Hartford, Connecticut (terminated)

50072 = Travelers - Hamden, Connecticut (terminated)

50100 = Travelers - Jacksonville, Florida (terminated)

50101 = Travelers - Miama, Florida (terminated)

50102 = Travelers - Tampa, Florida (terminated)

50110 = Travelers - Atlanta, Georgia (terminated)

50333 = Travelers; Connecticut United Healthcare  
(term. 07/2000)

50334 = Travelers; Syracuse, New York (terminated)

50390 = Travelers; Erie, Pennsylvania (terminated)

50391 = Travelers; Pittsburgh, PA (terminated)

50392 = Travelers; Wyomissing, PA (terminated)

50393 = Travelers; Philadelphia, PA (terminated)

50410 = Travelers; Providence, Rhode Island (terminated)

  

51050 = Aetna-Los Angeles - California (terminated)

51051 = Aetna California - terminated 6/97

51070 = Aetna Connecticut - terminated 6/97  
51100 = Aetna Florida - terminated 6/97  
51140 = Aetna Illinois - terminated 6/97  
51220 = Aetna-Worcester - Massachusetts  
51290 = Aetna-Reno, Nevada (terminated)  
51390 = Aetna Pennsylvania - terminated 6/97  
51440 = Aetna-Nashville, Tennessee (terminated)  
51441 = Aetna-Memphis, Tennessee (terminated)  
51490 = Aetna-Newport News - Virginia (terminated)  
51500 = Seattle, Washington (terminated)  
52280 = NE - Mutual of Omaha  
53310 = Prudential-New Jersey (terminated)  
56360 = Nationwide-Ohio (terminated)  
57400 = Puerto Rico - Cooperativa (term.02/2009)  
(replaced with MAC # 09201)  
61000 = Aetna (term. 06/97)  
80883 = Contractor ID for Inpatient & Outpatient  
Risk Adjustment Data (data not sent through  
CWF; but through Palmetto)  
99990 = SSA (terminated)

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#### Medicare Administrative Contractor Numbers

##### JURISDICTION 1 - PART A MACs

01001 = J1 Roll-up  
01101 = California (eff. 8/15/2008)  
(replaces FI #00454)  
01201 = Hawaii (eff. 8/15/2008)  
(replaces FI #00454)  
01301 = Nevada (eff. 8/15/2008)  
(replaces FI #00454)  
01901 = Palmetto GBA J1  
(Mutual of Omaha Legacy)

##### JURISDICTION 2 - Part A MACs

02001 = JF Roll-up(2/3)  
02101 = Alaska (eff 02/01/2012)  
02201 = Idaho (eff 02/01/2012)  
02301 = Oregon (eff 02/01/2012)  
02401 = Washington (eff 02/01/2012)

##### JURISDICTION 3 - Part A MACs

03001 = JF Roll-up(2/3)  
(Orig. J3 term. 09/2007)  
03101 = Arizona (eff. 10/1/2007)  
(replaces FI #00030)  
03201 = Montana (eff. 12/1/2006)  
(replaces FI #00250)  
03301 = N. Dakota (eff. 12/1/2006)  
(replaces FI #00320)



03401 = S. Dakota (eff. 3/1/2007)  
(replaces FI #00011)  
03501 = Utah (eff. 12/1/2006)  
(replaces FI #00323)  
03601 = Wyoming (eff. 11/1/2006)  
(replaces FI #00460)

#### JURISDICTION 4 - Part A MACs

04001 = J4 Roll-up  
04101 = Colorado (eff. 6/1/2008) (terminated)  
(replaces FI #00400)  
04201 = New Mexico (eff. 6/16/2008)  
(replaces FI #00400)  
04301 = Oklahoma (eff. 3/1/2008)  
(replaces FI #00340)  
04401 = Texas (eff. 6/16/2008)  
(replaces FI #00400)  
04901 = Trailblazer Health Enterprises  
(Mutual of Omaha Legacy)

#### JH Roll-up (4/7)

04111 = Colorado (eff. 10/29/2012)  
(CR 7812)  
04211 = New Mexico (eff. 10/29/2012)  
04311 = Oklahoma (eff. 10/29/2012)  
04411 = Texas (eff. 10/29/2012)  
04911 = WPS (Mutual of Omaha Legacy)  
(eff. 10/29/2012)

#### JURISDICTION 5 - Part A MACs

05001 = J5 Roll-up  
05101 = Iowa (eff. 5/1/2008)  
(replaces FI #00012)  
05201 = Kansas (eff. 03/01/2008)  
(replaces FI #00150)  
05301 = W. Missouri (eff. 5/1/2008)  
(replaces FI #00242)  
05392 = E. Missouri (eff. 6/1/2008)  
05402 = Nebraska (eff. 12/1/2007)  
(replaces FI #00260)  
05902 = WPS J5 (Mutual of Omaha Legacy)

06001 = J6 Roll-up  
06004 = (HHH D RHHI)  
06101 = Illinois  
06201 = Minnesota  
06301 = Wisconsin

07001 = JH Roll-up (4/7)  
07101 = Arkansas (eff. 08/20/2012) (CR7812)  
07201 = Louisiana (eff. 08/20/2012)  
07301 = Mississippi (eff. 08/20/2012)

## JURISDICTION 8 - PART A MACs

08001 = J8 Roll-up  
08101 = Indiana, WPS J8 (eff. 07/23/2012)  
(replaces FI #00130)  
08201 = Michigan, WPS J8 (eff. 07/23/2012)  
(replaces FI #00452)

## JURISDICTION 9 - PART A MACs

09001 = J9 Roll-up  
09101 = Florida (eff. 2/13/2009)  
(replaces FI #00090)  
09201 = Puerto Rico (eff. 03/02/2009)  
(replaces FI #57400)  
09301 = Virgin Island (eff. 03/02/2009)  
(replaces FI #57400)

## JURISDICTION 10 - PART A MACs

10001 = J10 Roll-up  
10101 = Alabama (eff. 5/18/2009)  
(replaces FI #00010)  
10201 = Georgia (eff. 05/04/2009)  
(replaces FI #00101)  
10301 = Tennessee (eff. 8/3/2009)  
(replaces FI #00390)

## JURISDICTION 11 - PART A MACs

11001 = J11 Roll-up  
11003 = J11 Roll-up (Shared CICS Region - 11301 & 11401)  
11004 = Region C (HHH C RHHI) (eff. 1/24/2011)  
(replaces FI #00380)  
11201 = South Carolina (eff. 1/24/2011)  
(replaces FI #00380)  
11301 = Virginia (eff. 5/16/2011)  
(replaces FI #00453)  
11401 = West Virginia (eff. 5/16/2011)  
(replaces FI #00453)  
11501 = North Carolina (eff. 10/01/2010)  
(replaces FI #00390)

## JURISDICTION 12 - PART A MACs

12001 = J12 Roll-up  
12101 = Delaware (eff. 11/14/2008)  
(replaces FI # 00308)  
12201 = District of Columbia (eff. 08/01/2008)  
12301 = Maryland (eff. 08/01/2008)  
12401 = New Jersey (eff. 9/1/2008)  
(replaces FI # 00390)  
12501 = Pennsylvania (eff. 08/01/2008)

12901 = Novitas Solutions J12  
(Mutual of Omaha Legacy)

#### JURISDICTION 13 - PART A MACs

13001 = J13 Roll-up  
13101 = Connecticut (eff. 8/1/2008)  
(replaces FI #00308)  
13201 = NGS-New York (eff. 7/18/2008)  
(replaces FI #00308)  
13282 = NGS-New York (eff. 9/1/2008)  
(replaces FI #00308)  
13292 = NGS-New York (eff. 7/18/2008)  
(replaces FI #00308)

#### JURISDICTION 14 - PART A MACs

14001 = J14 Roll-up  
14003 = J11 Roll-up (Shared CICS Region)  
14004 = Region A (HHH A RHHI) (eff.5/15/2009)  
(replaces FI #00180)  
14101 = Maine (eff. 5/15/2009)  
(replaces FI #00180)  
14201 = Massachusetts (eff. 5/15/2009)  
(replaces FI #00181)  
14301 = New Hampshire (eff. 6/15/2009)  
(replaces FI #00270)  
14401 = Rhode Island (eff. 6/1/2009)  
(replaces FI #00370)  
14501 = Vermont (eff. 6/5/2009)  
(replaces FI #00270)

#### JURISDICTION 15 - PART A MACs

15001 = J15 Roll-up  
15004 = CGS Government Services (HHH B RHHI)  
(eff. 06/13/2011)  
15101 = Kentucky (eff. 10/17/2011)  
(replaces FI #00160)  
15201 = Ohio (eff. 10/17/2011)  
(replaces FI #00160)  
52280 = Mutual of Omaha (NT)  
Note: Nebraska - 00260 (NE) & 52280 (NT)

FI\_RQST\_CLM\_CNCL\_RSN\_TB

Claim Cancel Reason Code Table

C = Coverage Transfer  
D = Duplicate Billing  
H = Other or blank  
L = Combining two beneficiary master records  
P = Plan Transfer  
S = Scramble

\*\*\*\*\*For Action Code 4 \*\*\*\*\*

\*\*\*\*\*Effective with HHPPS - 10/00\*\*\*\*\*

A = RAP/Final claim/LUPA is cancelled by Intermediary. Does not delete episode. Do not set cancellation indicator.

B = RAP/Final claim/LUPA is cancelled by Intermediary. Does not delete episode. Set cancellation indicator to 1.

E = RAP/Final claim/LUPA is cancelled by Intermediary. Remove episode.

F = RAP/Final claim/LUPA is cancelled by Provider. Remove episode.

GEO\_SSA\_STATE\_TB

State Table

- 01 = Alabama
- 02 = Alaska
- 03 = Arizona
- 04 = Arkansas
- 05 = California
- 06 = Colorado
- 07 = Connecticut
- 08 = Delaware
- 09 = District of Columbia
- 10 = Florida
- 11 = Georgia
- 12 = Hawaii
- 13 = Idaho
- 14 = Illinois
- 15 = Indiana
- 16 = Iowa
- 17 = Kansas
- 18 = Kentucky
- 19 = Louisiana
- 20 = Maine
- 21 = Maryland
- 22 = Massachusetts
- 23 = Michigan
- 24 = Minnesota
- 25 = Mississippi
- 26 = Missouri
- 27 = Montana
- 28 = Nebraska
- 29 = Nevada
- 30 = New Hampshire
- 31 = New Jersey
- 32 = New Mexico
- 33 = New York
- 34 = North Carolina
- 35 = North Dakota
- 36 = Ohio
- 37 = Oklahoma

38 = Oregon  
39 = Pennsylvania  
40 = Puerto Rico  
41 = Rhode Island  
42 = South Carolina  
43 = South Dakota  
44 = Tennessee  
45 = Texas  
46 = Utah  
47 = Vermont  
48 = Virgin Islands  
49 = Virginia  
50 = Washington  
51 = West Virginia  
52 = Wisconsin  
53 = Wyoming  
54 = Africa  
55 = California  
56 = Canada & Islands  
57 = Central America and West Indies  
58 = Europe  
59 = Mexico  
60 = Oceania  
61 = Philippines  
62 = South America  
63 = U.S. Possessions  
64 = American Samoa  
65 = Guam  
66 = Commonwealth of the Northern Marianas Islands  
67 = Texas  
68 = Florida (eff. 10/2005)  
69 = Florida (eff. 10/2005)  
70 = Kansas (eff. 10/2005)  
71 = Louisiana (eff. 10/2005)  
72 = Ohio (eff. 10/2005)  
73 = Pennsylvania (eff. 10/2005)  
74 = Texas (eff. 10/2005)  
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 = Louisiana (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)

MCO\_OPTN\_TB                      MCO Option Table

\*\*\*\*\*For lock-in beneficiaries\*\*\*\*\*

- A = HCFA to process all provider bills
- B = MCO to process only in-plan
- C = MCO to process all Part A and Part B bills

\*\*\*\*\* For non-lock-in beneficiaries\*\*\*\*\*

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

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

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

NCH\_CLM\_TYPE\_TB                      NCH Claim Type Table

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

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

NCH\_COND\_TRLR\_IND\_TB                      NCH Condition Trailer Indicator Table

C = Condition code trailer present

NCH\_DEMO\_TRLR\_IND\_TB                      NCH Demonstration Trailer Indicator Table

D = Demo trailer present

NCH\_DGNS\_E\_TRLR\_IND\_TB                      NCH Diagnosis E Trailer Indicator Code Table

Valid Value:

W = NCH Diagnosis E Code trailer

NCH\_DGNS\_TRLR\_IND\_TB                      NCH Diagnosis Trailer Indicator Table

Y = Diagnosis code trailer present

NCH\_EDIT\_DISP\_TB                              NCH Edit Disposition Table

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

NCH\_EDIT\_TB                                      NCH EDIT TABLE

A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE  
A000 = (C) REIMB > \$100,000 OR UNITS > 150  
A002 = (C) CLAIM IDENTIFIER (CAN)  
A003 = (C) BENEFICIARY IDENTIFICATION (BIC)  
A004 = (C) PATIENT SURNAME BLANK  
A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC  
A006 = (C) DATE OF BIRTH IS NOT NUMERIC  
A007 = (C) INVALID GENDER (0, 1, 2)  
A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)  
A009 = (C) TYPE OF BILL RECEIVED IS 41A, 41B, OR 41D  
A010 = (C) DISPOSITION CODE VS. ACTION/ENTRY CODE  
A023 = (C) PORTABLE X-RAY WITHOUT MODIFIER

A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73  
 A031 = (C) HOSPITAL CLAIMS--CLAIM SHOWS SERVICES WERE PAID  
 BY AN HMO AND CODITION CODE '04' IS NOT PRESENT.  
 (TOB '11' & '12')  
 A041 = (C) HHA CLAIMS--TOB 32X OR 33X WITH >4 VISITS; DATE  
 OF SERVICE > 9/30/00 AND LUPA IND IS PRESENT.  
 BYPASS FOR NON-PAYMENT CODE B, C, Q, T-Y.  
 A1X1 = (C) PERCENT ALLOWED INDICATOR  
 A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589  
 A1X3 = (C) DT>96365,DIAG=V725  
 A1X4 = (C) INVALID DIAGNOSTIC CODES  
 C050 = (U) HOSPICE - SPELL VALUE INVALID  
 D102 = (C) DME DATE OF BIRTH INVALID  
 D2X2 = (C) DME SCREEN SAVINGS INVALID  
 D2X3 = (C) DME SCREEN RESULT INVALID  
 D2X4 = (C) DME DECISION IND INVALID  
 D2X5 = (C) DME WAIVER OF PROV LIAB INVALID  
 D3X1 = (C) DME NATIONAL DRUG CODE INVALID  
 D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID  
 D4X2 = (C) DME OUT OF DMERC SERVICE AREA  
 D4X3 = (C) DME STATE CODE INVALID  
 D5X1 = (C) TOS INVALID FOR DME HCPCS  
 D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING  
 D5X3 = (C) DME INVALID USE OF MS MODIFIER  
 D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED  
 D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS  
 D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID  
 D5X7 = (C) ANTI-EMETIC/ANTI-CANCER DRUG W/O CANCER  
 DIAGNOSIS  
 D5X8 = (C) TWO ANTI-EMETIC DRUGS PRESENT ON SAME CLAIM  
 WITH IDENTICAL DATES OF SERVICE.  
 D6X1 = (C) DME SUPPLIER NUMBER MISSING  
 D7X1 = (C) DME PURCHASE ALLOWABLE INVALID  
 D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1  
 D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6  
 D922 = (C) THERAPEUTIC SHOE CODES 'A5505-A5501'  
 W/MODIFIER 'LT' OR 'RT' MUST HAVE  
 UNITS = '001'  
 XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE  
 Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1  
 Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1  
 Y003 = (C) HCPCS R0075/UNITS=SERVICES  
 Y010 = (C) TOB=13X/14X AND T.C.>\$7,500  
 Y011 = (C) INP CLAIM/REIM > \$350,000  
 Z001 = (C) RVNU 820-859 REQ COND CODE 71-76  
 Z002 = (C) CC M2 PRESENT/REIMB > \$150,000  
 Z003 = (C) CC M2 PRESENT/UNITS > 150  
 Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX  
 Z005 = (C) REIMB>99999 AND REIMB<150000  
 Z006 = (C) UNITS>99 AND UNITS<150  
 Z007 = (C) TOB VS TOTAL CHARGE  
 Z008 = (C) TOB VS TOTAL CHARGE W/O 20/21  
 CONDITION CODE  
 Z237 = (E) HOSPICE OVERLAP - DATE ZERO



0011 = (C) ACTION CODE INVALID  
 0012 = (C) IME/GME CLAIM -- '04' OR '69'  
     CONDITION CODE  
 0013 = (C) CABG/PCOE/MPPD AND INVALID ADMIT DATE  
 0014 = (C) DEMO NUM INVALID  
 0015 = (C) ESRD PLAN VS DEMO NUM  
 0016 = (C) INVALID VA CLAIM  
 0017 = (C) DEMO=38 W/O CONTRACTOR #80881/80882  
 0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5  
 0019 = (C) DEMO 07/08 WITH CONDITION CODE B1  
 0020 = (C) CANCEL ONLY CODE INVALID  
 0021 = (C) DEMO COUNT > 1  
 0022 = (C) TOB '32X' OR '33X' W/DATES OF SERVICE >9/30/00  
     AND HAS CANCEL ONLY CODE OTHER THAN A,B,E,F  
 0023 = (C) DEMO '46' AND HCPCS INCONSISTENT  
 0301 = (C) INVALID HI CLAIM NUMBER  
 0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK  
 04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)  
 04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC  
 0401 = (C) BILL TYPE/PROVIDER INVALID  
 0402 = (C) BILL TYPE/REV CODE/PROVR RANGE  
 0403 = (C) TOB '41X'/PRVDR # 1990-1999) OR TOB '51X'/  
     PRVDR #6990-6999, TRANS CODE SHOULD BE  
     '0' OR '3'  
 0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092 OR SEX NOT F  
 0407 = (C) RESPITE CARE BILL TYPE NOT 34X,NO REV 66  
 0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974  
 041A = (C) TOB '11A' OR '11D' AND DEMO #'07' OR '08'  
     NOT PRESENT  
 0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636  
 0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES  
 0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS  
 0414 = (C) VALU CD 61,MSA AMOUNT MISSING  
 0415 = (C) HOME HEALTH INCORRECT ALPHA RIC  
 0416 = (C) REVENUE CENTER '0022', TOB MUST BE  
     '18X' OR '21X'  
 0417 = (C) REVENUE CENTER '0023', TOB MUST BE '32X'  
     OR '33X'  
 0418 = (C) HHA--TOB '3X5' AND DATES OF SERVICE  
     >9/30/00  
 0419 = (C) HHA--RIC 'W' MUST HAVE VALUE CODE '63'/  
     RIC 'V' MUST HAVE VALUE CODE '62' AND  
     RIC 'U' MUST HAVE VALUE CODES '62' AND  
     '63' PRESENT FOR DATES OF SERVICE >  
     9/30/00.  
 0420 = (C) HHA W/O REVENUE CODE '0023'  
 0421 = (C) START DATE MISSING  
 0422 = (C) COB VS. OVERRIDE CODE  
 05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE  
 05X5 = (C) UPIN REQUIRED FOR DME  
 0501 = (C) REFERRING UPIN REQUIRED FOR CLINICAL LAB  
 0502 = (C) REFERRING UPIN INVALID  
 0601 = (C) GENDER INVALID  
 0701 = (C) CONTRACTOR/POS 1-2 PROVIDER NUM INVALID

0702 = (C) PROVIDER NUMBER VS. TOB  
 0703 = (C) MAMMOGRAPHY FOR NOT FEMALE  
 0704 = (C) INVALID CONT FOR CABG DEMO  
 0705 = (C) INVALID CONT FOR PCOE DEMO  
 0706 = (C) REVENUE CENTER CODE MAMMOGRAPHY AND  
       BENEFICIARY <35  
 0901 = (C) INVALID DISP CODE OF 02  
 0902 = (C) INVALID DISP CODE OF SPACES  
 0903 = (C) INVALID DISP CODE  
 1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE  
 13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE  
 1301 = (C) LINE COUNT NOT NUMERIC OR > 13  
 1302 = (C) RECORD LENGTH INVALID  
 1401 = (C) INVALID MEDICARE STATUS CODE  
 1501 = (C) ADMIT DATE/START DATE/ENTRY CODE INVALID  
 1502 = (C) ADMIT DATE/START CARE DATE > STAY FROM DATE  
 1503 = (C) ADMIT DATE INVALID WITH THRU DATE  
 1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE  
 1505 = (C) HCPCS W SERVICE DATES > 09-30-94  
 1601 = (C) INVESTIGATION IND INVALID  
 1701 = (C) SPLIT IND INVALID  
 1801 = (C) PAY-DENY CODE INVALID  
 1802 = (C) HEADER AMT/LINE ITEMS DENIED  
 1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME  
 1901 = (C) AB CROSSOVER IND INVALID  
 2001 = (C) HOSPICE OVERRIDE INVALID  
 2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID  
 2102 = (C) PATIENT STATUS VS. TOB  
 2103 = (C) HIPPS RATE/CMG CODE VS. PATIENT STATUS  
 2201 = (C) FROM DATE/HCPCS YR INVALID  
 2202 = (C) STAY-FROM DATE > THRU-DATE  
 2203 = (C) THRU DATE INVALID  
 2204 = (C) FROM DATE BEFORE EFFECTIVE DATE  
 2205 = (C) DATE YEARS DIFFERENT ON OUTPAT  
 2207 = (C) MAMMOGRAPHY BEFORE 1991  
 2208 = (C) TOB '21X', REV CODE 0022 FROM DATE  
       < 06-03-98  
 2209 = (C) HHA WITH OVERLAPPING DATES JUNE/JULY,  
       SEPT/OCT  
 2210 = (C) TOB 41X, SERVICE DATES 6/30/00,  
       EXCEP/NONEXCEP IND = 1,2  
 2212 = (C) TOB 51X WITH SERVICE DATES >6/30/00  
 2213 = (C) TOB 32X OR 33X, SERVICE >9/30/00 DAYS  
       CAN NOT = 60  
 2215 = (C) DEMO 37 WITH VALUE CODES 'A2', 'B2', 'C2'  
 2216 = (C) DEMO 37 OR CONDITION CODE 78 AND CHARGES  
       SUB TO DED > 0  
 2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID  
 2302 = (C) COVERED DAYS INVALID OR INCONSIST  
 2303 = (C) COST REPORT DAYS > ACCOMIDATION  
 2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL  
 2305 = (C) LATE CHARGE BILL WITH DATA FIELD PRESENT  
 2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT  
 2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09

2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO  
 2401 = (C) NON-UTIL DAYS INVALID  
 2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL  
 2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE  
 2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN  
 2504 = (C) COINSURANCE AMOUNT EXCESSIVE  
 2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT  
 2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST  
 2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR  
 2508 = (C) COINSURANCE DAYS INVALID FOR TRAN  
 2601 = (C) CLAIM PAID DT INVALID OR LIFE RES  
 2602 = (C) LR-DAYS, NO VAL 08,10/PD/DEN>CUR+27  
 2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR  
 2604 = (C) PPS BILL, NO DAY OUTLIER  
 2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.  
 28XA = (C) UTIL DAYS > FROM TO BENEF EXH  
 28XB = (C) BENEFITS EXH DATE > FROM DATE  
 28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE  
 28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP  
 28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)  
 28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)  
 28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS  
 28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE  
 28XN = (C) INVALID OCC CODE  
 28XO = (C) AN 'N' NO-PAY CODE IS PRESENT AND OCCURRENCE  
 CODE '23' OR '42' IS NOT PRESENT AND THE  
 DATE ASSOCIATED WITH CODE IS MISSING OR NOT  
 EQUAL TO THRU DATE.  
 28XP = (C) THE OCCURRENCE CODE 23 DATE DOES NOT EQUAL THE  
 THRU DATE  
 28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES  
 28X1 = (C) OCCUR DATE INVALID  
 28X2 = (C) OCCUR = 20 AND TRANS = 4  
 28X3 = (C) OCCUR 20 DATE < ADMIT DATE  
 28X4 = (C) OCCUR 20 DATE > ADMIT + 12  
 28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM  
 28X6 = (C) OCCUR 20 DATE < BENE EXH DATE  
 28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE  
 28X8 = (C) OCCUR 22 DATE < FROM OR > THRU  
 28X9 = (C) UTIL > FROM - THRU LESS NCOV  
 33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)  
 33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)  
 33X3 = (C) QS DAYS/ADMISSION ARE INVALID  
 33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)  
 33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE  
 33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091  
 33X7 = (C) TOB<>18/21/28/51,COND=WO  
 33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001  
 33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT  
 33#A = (C) MULTIPLE PET SCANS  
 33#B = (C) MULTIPLE PET SCANS W/O MODIFIER 26  
 OR TC  
 3401 = (C) DEMO ID = 04 AND RIC NOT = 1 OR 2  
 34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN

34#3 = (C) CONDITION CODE = W0 AND DEMO NOT = 04  
 35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS  
 35X2 = (C) COND = 60 OR 61 AND NO VALU 17  
 35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0  
 35#3 = (C) (SECOND CONDITION) CONDITION CODE = C3  
 REQUIRES SPAN CODE 76 OR 77  
 35#4 = (C) CONDITION CODE = 69 AND TOB NOT 11X  
 36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU  
 36#1 = (C) SURGICAL DATE = ZEROES OR < FROM OR >  
 THRU DATES  
 3701 = (C) ASSIGN CODE INVALID  
 3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA  
 3706 = (C) INVALID IDE NUMBER-NOT IN FILE  
 3710 = (C) NUM OF IDE# > REV 0624  
 3715 = (C) NUM OF IDE# < REV 0624  
 3720 = (C) IDE AND LINE ITEM NUMBER > 2  
 3801 = (C) AMT BENE PD INVALID  
 3XA/ = (C) COLORECTAL/PROSTATE SCREENING BILLED  
 MULTIPLE TIMES  
 4001 = (C) BLOOD PINTS FURNISHED INVALID  
 4002 = (C) BLOOD FURNISHED/REPLACED INVALID  
 4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT  
 4201 = (C) BLOOD PINTS UNREPLACED INVALID  
 4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED  
 4203 = (C) INVALID CPO PROVIDER NUMBER  
 4301 = (C) BLOOD DEDUCTABLE INVALID  
 4302 = (C) BLOOD DEDUCT/FURNISHED PINTS  
 4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD  
 4304 = (C) BLOOD DEDUCT > 3 - REPLACED  
 4501 = (C) PRIMARY DIAGNOSIS INVALID  
 4502 = (C) SERVICE DATES > CURRENT DATE  
 46#A = (C) MSP VET AND VET AT MEDICARE  
 46#B = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)  
 46#C = (C) COIN VALUE (A2,B2,C2) ON INP/SNF  
 46#G = (C) VALU CODE 20 INVALID  
 46#L = (C) BLOOD FURNISHED < BLOOD REPLACED  
 46#N = (C) VALUE CODE 37,38,39 INVALID  
 46#O = (C) VALUE CDE 37,38,39 AMOUNT NOT > 00  
 46#P = (C) BLD UNREP VS REV CDS AND/OR UNITS  
 46#Q = (C) VALUE CDE 37=39 AND 38 IS PRESENT  
 46#R = (C) BLD FIELDS VS REV CDE 380,381,382  
 46#S = (C) VALU CODE 39, AND 37 IS NOT PRESENT  
 46#T = (C) CABG/PCOE/MPPD,VC<>Y1,Y2,Y3,Y4,VA NOT>0  
 46#U = (C) MSP VALUES ON CABG/PCOE/MPPD (INP)  
 TOB '32X'/'33X' MUST HAVE VALUE 62/64  
 OR 63/65 (HHA)  
 46#V = (C) TOB '32X'/'33X' VISITS IN 62/63 NOT =  
 REVENUE CODE 42X-44X, 55X-57X  
 46#W = (C) CONDITION CODE =30/78 AND WITH VALUE  
 CODE = A1, B1, C1  
 46#1 = (C) VALUE AMOUNT INVALID  
 46#2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO  
 46#3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)  
 46#4 = (C) VALU (A1,B1,C1): AMT > DEDUCT

46#5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL  
 46#6 = (C) VALU 17 AND NO COND CODE 60 OR 61  
 46#7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16  
 46#8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)  
 46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN  
 4600 = (C) CAPITAL TOTAL NOT = CAP VALUES  
 4601 = (C) CABG/PCOE, MSP CODE PRESENT  
 4603 = (C) DEMO ID = 03 AND RIC NOT=6,7  
 4604 = (C) DEMO = 03 WITH DATES OF SERVICE  
     > 09/31/01  
 4901 = (C) PCOE/CABG,DEN CD NOT D  
 4902 = (C) PCOE/CABG BUT DME  
 50#1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85  
 50#2 = (C) REV CD=054X,MOD NOT = QM,QN  
 5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS  
 5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD  
 5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER  
 51#A = (C) HCPCS EYEWARE & REV CODE NOT 274  
 51#C = (C) HCPCS REQUIRES DIAG CODE OF CANCER  
 51#D = (C) HCPCS REQUIRES UNITS > ZERO  
 51#E = (C) HCPCS REQUIRES REVENUE CODE 636/294  
 51#F = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS  
 51#G = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A  
 51#H = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044  
 51#I = (C) TOB 21X/P82<>2/3/4;REV CD>8999<9045  
 51#J = (C) TOB 21X/REV CD: SVC-FROM DT INVALID  
 51#K = (C) TOB 21X/P82=2/3/4,REV CD = NNX  
 51#L = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83  
 51#M = (C) 21X,RC>9041/<9045,RC<>4/234  
 51#N = (C) 21X,RC>9032/<9042,RC<>4/234  
 51#O = (C) TWO ANTI-EMETIC/ANTI-CANCER DRUGS  
     ON SAME CLAIM  
 51#P = (C) HHA/OUTPATIENT RC DATE OF SRVC MISSING  
 51#Q = (C) NO RC 0636 OR DTE INVALID  
 51#R = (C) DEMO ID=01,RIC NOT=2  
 51#S = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21  
 51#V = (C) TOB 72X W HCPCS 'J1955' MISSING REVENUE  
     CENTER 636  
 51#W = (C) TOB 12X, 13X, 22X, 23X, 34X, 74X, 75X,  
     83X, HCPCS '97504', '97116', PRESENT  
     ON SAME DAY  
 51#X = (C) TOB '32X-34X' REQUIRE HCPCS FOR REVENUE  
     CODE '29X', '60X', '636'  
 51X0 = (C) REV CENTER CODE INVALID  
 51X1 = (C) REV CODE CHECK  
 51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE  
 51X3 = (C) UNITS MUST BE > 0  
 51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR  
 51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE  
 51X6 = (C) REV TOTAL CHARGES EQUAL ZERO  
 51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85  
 51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID  
 51X9 = (C) HCPCS/REV CODE/BILL TYPE  
 5100 = (U) TRANSITION SPELL / SNF

5160 = (U) LATE CHG HSP BILL STAY DAYS > 0  
 5166 = (U) PROVIDER NE TO 1ST WORK PRVDR  
 5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT  
 5168 = (E) CLAIM IN HOSPICE WITH 2ND START DATE  
         PRESENT  
 5169 = (U) PROVIDER NE TO WORK PROVIDER  
 5170 = (E) OCCURRENCE CODE = 42 AND < DOLBA  
 5177 = (U) PROVIDER NE TO WORK PROVIDER  
 5178 = (U) HOSPICE BILL THRU < DOLBA  
 5181 = (U) HOSP BILL OCCR 27 DISCREPANCY  
 5200 = (E) ENTITLEMENT EFFECTIVE DATE  
 5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90  
 5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE  
 5202 = (U) HOSPICE TRAILER ERROR  
 5203 = (E) ENTITLEMENT HOSPICE PERIODS  
 5203 = (U) HOSPICE START DATE ERROR  
 5204 = (U) HOSPICE DATE DIFFERENCE NE 90  
 5205 = (U) HOSPICE DATE DISCREPANCY  
 5206 = (U) HOSPICE DATE DISCREPANCY  
 5207 = (U) HOSPICE THRU > TERM DATE 2ND  
 5208 = (U) HOSPICE PERIOD NUMBER BLANK  
 5209 = (U) HOSPICE DATE DISCREPANCY  
 5210 = (E) ENTITLEMENT FRM/TRU/END DATES  
 5211 = (E) ENTITLEMENT DATE DEATH/THRU  
 5212 = (E) ENTITLEMENT DATE DEATH/THRU  
 5213 = (E) ENTITLEMENT DATE DEATH MBR  
 5220 = (E) ENTITLEMENT FROM/EFF DATES  
 5225 = (E) ENT INP PPS SPAN 70 DATES  
 5232 = (E) ENTL HMO NO HMO OVERRIDE CDE  
 5233 = (E) ENTITLEMENT HMO PERIODS  
 5234 = (E) ENTITLEMENT HMO NUMBER NEEDED  
 5235 = (E) ENTITLEMENT HMO HOSP+NO CC07  
 5236 = (E) ENTITLEMENT HMO HOSP + CC07  
 5237 = (E) ENTITLEMENT HOSP OVERLAP  
 5238 = (U) HOSPICE CLAIM OVERLAP > 90  
 5239 = (U) HOSPICE CLAIM OVERLAP > 60  
 524Z = (E) HOSP OVERLAP NO OVD NO DEMO  
 5240 = (U) HOSPICE DAYS STAY+USED > 90  
 5241 = (U) HOSPICE DAYS STAY+USED > 60  
 5242 = (C) INVALID CARRIER FOR RRB  
 5243 = (C) HMO=90091,INVALID SERVICE DTE  
 5244 = (E) DEMO CABG/PCOE MISSING ENTL  
 5245 = (C) INVALID CARRIER FOR NON RRB  
 525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO  
 5250 = (U) HOSPICE DOEBA/DOLBA  
 5255 = (U) HOSPICE DAYS USED  
 5256 = (U) HOSPICE DAYS USED > 999  
 526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0  
 526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0  
 5270 = (C) CONDITION CODE = 30 AND HMO REQUIRES  
         MODIFIER = 'QV' OR 'KZ'/DED IND  
 5271 = (C) RISK HMO NOT PRESENT AND MOD 'KZ'/  
         OR CONDITION CODE 78 PRESENT  
 527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0

527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0  
 5299 = (U) HOSPICE PERIOD NUMBER ERROR  
 52#K = (C) HCPCS VS DIAGNOSIS  
 52#L = (C) HCPCS VS MODIFIER  
 52#M = (C) HCPCS VS DATES OF SERVICE  
 52#N = (C) TOB '71X' OR '73X' WITH REVENUE  
 CENTER CODE 0403 MISSING REVENUE  
 CENTER CODE 0521  
 52#O = (C) REVENUE CENTER CODE 0022/0024 WITH  
 CHARGES >0  
 52#P = (C) REVENUE CENTER CODE 010X-021X MINUS  
 18X <> 0022  
 52#Q = (C) REVENUE CENTER CODE 0022 AND HIPPS  
 MISSING  
 52#R = (C) REVENUE CENTER CODE 0022 MISSING DATE  
 OF SERVICE  
 52#T = (C) REVENUE CENTER CODE 0022 MISSING REVENUE  
 CENTER CODE 042X-044X  
 5320 = (U) BILL > DOEBA AND IND-1 = 2  
 5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY  
 5355 = (U) HOSPICE DAYS USED SECONDARY  
 5362 = (C) MAMMOGRAPHY AND BENE <35  
 5378 = (C) SERVICE DATE < AGE 50  
 5379 = (C) HCPCS 'G0160' PRESENT MORE THAN  
 ONCE  
 5381 = (C) HCPCS 'G0161' PRESENT MORE THAN  
 ONCE  
 5382 = (C) HCPCS 'G0102-03' AND BENE <50  
 538Q = (C) SERVICE DATES WITHIN ALIEN RECORD  
 5397 = (C) DEMO '37' AND NOT CAT 74  
 5398 = (C) HCPCS 'G9001-G9005 & G9009-G9011 >1  
 OR 2 ARE PRESENT  
 5399 = (U) HOSPICE PERIOD NUM MATCH  
 539A = (C) HCPCS 'G9008' PRESENT MORE THAN ONCE  
 539C = (C) HCPCS 'G9013-G9015' PRESENT MORE THAN  
 ONCE OR 2 PRESENT  
 5410 = (U) INPAT DEDUCTABLE  
 5425 = (U) PART B DEDUCTABLE CHECK  
 5430 = (U) PART B DEDUCTABLE CHECK  
 5450 = (U) PART B COMPARE MED EXPENSE  
 5460 = (U) PART B COMPARE MED EXPENSE  
 5499 = (U) MED EXPENSE TRAILER MISSING  
 5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS  
 5510 = (U) COIN DAYS/SNF COIN DAYS  
 5515 = (U) FULL DAYS/COIN DAYS  
 5516 = (U) SNF FULL DAYS/SNF COIN DAYS  
 5520 = (U) LIFE RESERVE DAYS  
 5530 = (U) UTIL DAYS/LIFE PSYCH DAYS  
 5540 = (U) HH VISITS NE AFT PT B TRLR  
 5550 = (E) SNF LESS THAN PT A EFF DATE  
 5600 = (D) LOGICAL DUPE, COVERED  
 5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123  
 5602 = (D) LOGICAL DUPE, PANDE C, E OR I  
 5603 = (D) LOGICAL DUPE, COVERED

5604 = (D) LOGICAL DUPE, DATES  
 5605 = (D) POSS DUPE, OUTPAT REIMB  
 5606 = (D) POSS DUPE, HOME HEALTH COVERED U  
 5623 = (U) NON-PAY CODE IS P  
 57X1 = (C) PROVIDER SPECIALITY CODE INVALID  
 57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL  
 57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND  
 57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID  
 57X5 = (C) HCPCS 98940-2 MODIFIER NOT = 'AT'  
 5700 = (U) LINKED TO THREE SPELLS  
 5701 = (C) DEMO ID=02, RIC NOT = 5  
 5702 = (C) DEMO ID=02, INVALID PROVIDER NUM  
 58X1 = (C) PROVIDER TYPE INVALID  
 58X9 = (C) TYPE OF SERVICE INVALID  
 5802 = (C) REIMB > \$150,000  
 5803 = (C) UNITS/VISITS > 150  
 5804 = (C) UNITS/VISITS > 99  
 5805 = (C) OUTPATIENT CHARGE > \$150,000  
 5806 = (C) REVENUE CENTER CODE '042X-044X'  
 WITHOUT MODIFIER 'GN-GP'  
 58#4 = (C) REVENUE CENTER CODE MISSING REQUIRED  
 HCPCS OR MODIFIER  
 59XA = (C) PROST ORTH HCPCS/FROM DATE  
 59XB = (C) HCPCS/FROM DATE/TYPE P OR I  
 59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE  
 59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE  
 59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS  
 59XG = (C) INVALID TOS FOR DME  
 59XH = (C) HCPCS E0620/TYPE/DATE  
 59XI = (C) HCPCS E0627-9/ DATE < 1991  
 59XJ = (C) GLOBAL HCPCS TOS MUST = 2  
 59XK = (C) HCPCS PEN PUMP AND TOS <>9  
 59XL = (C) HCPCS 00104 - TOS/POS  
 59X1 = (C) INVALID HCPCS/TOS COMBINATION  
 59X2 = (C) ASC IND/TYPE OF SERVICE INVALID  
 59X3 = (C) TOS INVALID TO MODIFIER  
 59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB  
 59X5 = (C) MAMMOGRAPHY FOR MALE  
 59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS  
 59X7 = (C) CAPPED-HCPCS/FROM DATE  
 59X8 = (C) FREQUENTLY MAINTAINED HCPCS  
 59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R  
 5901 = (U) ERROR CODE OF Q  
 5A#1 = (C) DEMO=37, UNITS >1 FOR 'G9001-05'  
 'G9007-11', G9013-G9015'  
 60X1 = (C) ASSIGN IND INVALID  
 6000 = (U) ADJUSTMENT BILL SPELL DATA  
 6020 = (U) CURRENT SPELL DOEBA < 1990  
 6030 = (U) ADJUSTMENT BILL SPELL DATA  
 6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA  
 61X1 = (C) PAY PROCESS IND INVALID  
 61X2 = (C) DENIED CLAIM/NO DENIED LINE  
 61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES  
 61X4 = (C) RATE MISSING OR NON-NUMERIC



61#E = (C) PROVIDER PAYMENT INCONSISTENCIES  
 61#F = (C) BENEFICIARY PAYMENT INCONSISTENCIES  
 61#G = (C) PATIENT RESPONSIBILITY INCONSISTENCIES  
 61#H = (C) MEDICARE PAYMENT INCONSISTENCIES  
 61#I = (C) LINE DATE OF SERVICE < FROM DATE  
     > THRU DATE  
 61#J = (C) DUPLICATE HCPCS CODE '55873'  
 61#K = (C) HCPCS 'G0117-8' >2 OR BOTH PRESENT  
 61#L = (C) REVENUE CENTER CODE 0024 > 2  
 61#M = (C) REVENUE CENTER CODE 0024 VS PROVIDER  
     NUMBER  
 61#N = (C) REVENUE CENTER CODE 0024 REQUIRES  
     VALID HIPPS RATE CMG CODE  
 61#R = (C) HCPCS/TOB/REVENUE CENTER CODE  
 61#S = (C) HCPCS 'G0247' REQUIRES 'G0245-6' TO  
     BE COVERED  
 61#T = (C) HCPCS CODE '0245-0246' PRESENT MULTIPLE  
     TIMES  
 61#0 = (C) REVENUE CENTER CODE VS SPAN CODE '74'  
 61#6 = (C) PAYMENT METHOD INVALID  
 61#7 = (C) ANSI CODE MISSING  
 61#8 = (C) BLOOD CASH DEDUCTIBLE INCONSISTENCIES  
 61#9 = (C) CASH DEDUCTIBLE INCONSISTENCIES  
 6100 = (C) REV 0001 NOT PRESENT ON CLAIM  
 6101 = (C) REV COMPUTED CHARGES NOT=TOTAL  
 6102 = (C) REV COMPUTED NON-COVERED/NON-COV  
 6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER  
 6105 = (C) REVE CODE 0001 > 1  
 6106 = TOB 3X2 REVENUE CENTER CODE 0023 NOT =  
     TOTAL CHARGE  
 6109 = (C) REIMBURSEMENT > 4 OR 6 TIMES  
 62XA = (C) PSYC OT PT/REIM/TYPE  
 62XC = (C) DEMO 37 WITH REIMBURSEMENT/DED IND  
     <>1  
 62X1 = (C) DME/DATE/100% OR INVAL REIMB IND  
 62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED  
 62X8 = (C) KIDNEY DONO/TYPE/100%  
 62X9 = (C) PNEUM VACCINE/TYPE/100%  
 6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV  
 6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE  
 6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA  
 6260 = (U) HOSPICE ADJUSTMENT STAY DAYS  
 6261 = (U) HOSPICE ADJUSTMENT DAYS USED  
 6265 = (U) HOSPICE ADJUSTMENT DAYS USED  
 6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)  
 63X1 = (C) DEDUCT IND INVALID  
 63X2 = (C) DED/HCFA COINS IN PCOE/CABG  
 6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS  
 6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)  
 64X1 = (C) PROVIDER IND INVALID  
 6430 = (U) PART B DEDUCTABLE CHECK  
 65X1 = (C) PAYSCREEN IND INVALID  
 66?? = (D) POSS DUPE, CR/DB, DOC-ID  
 66XX = (D) POSS DUPE, CR/DB, DOC-ID

66X1 = (C) UNITS AMOUNT INVALID  
66X2 = (C) UNITS IND > 0; AMT NOT VALID  
66X3 = (C) UNITS IND = 0; AMT > 0  
66X4 = (C) MT INDICATOR/AMOUNT  
66X7 = (C) DEMO 37/HCPCS/UNITS  
6600 = (U) ADJUSTMENT BILL FULL DAYS  
6610 = (U) ADJUSTMENT BILL COIN DAYS  
6620 = (U) ADJUSTMENT BILL LIFE RESERVE  
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS  
67X1 = (C) UNITS INDICATOR INVALID  
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0  
67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2  
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1  
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST  
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD  
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN  
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS  
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS  
68XA = (C) HCPCS G0117-8 >1 OR BOTH PRESENT  
68XB = (C) HCPCS CODE G0245-46 > 1  
68X1 = (C) INVALID HCPCS CODE  
68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092  
68X3 = (C) TYPE OF SERVICE = G /PROC CODE  
68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE  
68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC  
68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC  
68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.  
68X8 = (C) ANTI-EMETIC WITHOUT ANTI-CANCER DRUG  
6812 = (C) DEMO 37 WITH PRIMARY PAYER CODE  
69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL  
69XB = (C) HCPCS CODE 97504/97116 PRESENT ON  
SAME DAY  
69XC = (C) HCPCS CODE VS PAY PROCESS INDICATOR  
69X3 = (C) PROC CODE MOD = LL / TYPE = R  
69X6 = (C) PROC CODE MOD/NOT CAPPED  
69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL  
69X9 = (C) NURSE PRACTITIONER, MOD INVALID  
6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO  
6902 = (C) KRON IND AND NO-PAY CODE B OR N  
6903 = (C) KRON IND AND INPATIENT DEDUCT = 0  
6904 = (C) KRON IND AND TRANS CODE IS 4  
6910 = (C) REV CODES ON HOME HEALTH  
6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY  
6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO  
6913 = (C) REV CODE INVAL FOR OXYGEN  
6914 = (C) REV CODE INVAL FOR DME  
6915 = (C) PURCHASE OF RENT DME INVAL ON DATES  
6916 = (C) PURCHASE OF RENT DME INVAL ON DATES  
6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000  
6918 = (C) HCPCS INVALID ON DATE RANGES  
6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89  
6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33  
6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X  
6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274

6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291  
 6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL  
 6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X  
 6929 = (U) ADJUSTMENT BILL LIFE RESERVE  
 6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS  
 7000 = (U) INVALID DOEBA/DOLBA  
 7002 = (U) LESS THAN 60/61 BETWEEN SPELLS  
 7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD  
 71X1 = (C) SUBMITTED CHARGES INVALID  
 71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG  
 71X3 = (C) HCPCS 76092 PAY INDICATOR <> A,R,S  
     & 76085 PAY INDICATOR A,R,S  
 72X1 = (C) ALLOWED CHGS INVALID  
 72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYP  
 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/TYP  
 77X4 = (C) ASC/TYP/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/TYP/100%  
 78X7 = (C) LAB EDIT/TYP/100%/FROM DATE  
 79X1 = (C) THRU DATE IMPOSSIBLE  
 79X2 = (C) THRU DATE > CURRENT DATE  
 79X3 = (C) THRU DATE>RECD DATE/NOT DENIED  
 79X4 = (C) THRU DATE>PAID DATE/NOT DENIED  
 8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90  
 8028 = (E) NO ENTITLEMENT  
 8029 = (U) HH BEFORE PERIOD NOT PRESENT  
 8030 = (U) HH BILL VISITS > PT A REMAINING  
 8031 = (U) HH PT A REMAINING > 0  
 8032 = (U) HH DOLBA+59 NOT GT FROM-DATE  
 8050 = (U) HH QUALIFYING INDICATOR = 1  
 8051 = (U) HH # VISITS NE AFT PT B APPLIED  
 8052 = (U) HH # VISITS NE AFT TRAILER  
 8053 = (U) HH BENEFIT PERIOD NOT PRESENT  
 8054 = (U) HH DOEBA/DOLBA NOT > 0  
 8060 = (U) HH QUALIFYING INDICATOR NE 1  
 8061 = (U) HH DATE NE DOLBA IN AFT TRLR  
 8062 = (U) HH NE PT-A VISITS REMAINING

81X1 = (C) NUM OF SERVICES INVALID  
83X1 = (C) DIAGNOSIS INVALID  
8301 = (C) HCPCS/GENDER DIAGNOSIS  
8302 = (C) HCPCS G0101 V-CODE/SEX CODE  
8303 = (C) HCPCS/GENDER  
8304 = (C) BILL TYPE INVALID FOR G0123/4  
8305 = (C) HCPCS/SERVICE DATES/GENDER  
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC  
84X2 = (C) INVALID DME START DATE  
84X3 = (C) INVALID DME START DATE W/HCPCS  
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE  
84X5 = (C) HCPCS CODE WITH INV DIAG CODE  
84X6 = (C) HCPCS/GENDER  
84X7 = (C) HCPCS/SERVICE DATES/GENDER  
84X8 = (C) DUPLICATE HCPCS  
86X1 = (C) CLINICAL LAB HCPCS W/O CLINICAL  
LAB ID  
86X2 = (C) NON-WAIVER HCPCS/PAY DENIAL CODE/  
MODIFIER  
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS  
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD  
9000 = (U) DOEBA/DOLBA CALC  
9005 = (U) FULL/COINS HOSP DAYS CALC  
9010 = (U) FULL/COINS SNF DAYS CALC  
9015 = (U) LIFE RESERVE DAYS CALC  
9020 = (U) LIFE PSYCH DAYS CALC  
9030 = (U) INPAT DEDUCTABLE CALC  
9040 = (U) DATA INDICATOR 1 SET  
9050 = (U) DATA INDICATOR 2 SET  
91X1 = (C) PATIENT REIMB/PAY-DENY CODE  
92X1 = (C) PATIENT REIMB INVALID  
92X2 = (C) PROVIDER REIMB INVALID  
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB  
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES  
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT  
92X7 = (C) REIMB/PAY-DENY INCONSISTANT  
9201 = (C) UPIN REF NAME OR INITIAL MISSING  
9202 = (C) UPIN REF FIRST 3 CHAR INVALID  
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC  
93X1 = (C) CASH DEDUCTABLE INVALID  
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE  
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE  
93X4 = (C) FROM DATE/CASH DEDUCTIBLE  
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS  
9300 = (C) UPIN OTHER, NOT PRESENT  
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM  
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC  
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED  
9351 = (C) OTHER UPIN PRESENT/MISSING OTHER FIELDS  
9352 = (C) OTHER UPIN INVALID  
9353 = (C) OTHER UPIN INVALID  
94A1 = (C) NON-COVERED FROM DATE INVALID  
94A2 = (C) NON-COVERED FROM > THRU DATE  
94A3 = (C) NON-COVERED THRU DATE INVALID

94A4 = (C) NON-COVERED THRU DATE > ADMIT  
 94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE  
 94C1 = (C) PR-PSYCH DAYS INVALID  
 94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT  
 94F1 = (C) REIMBURSEMENT AMOUNT INVALID  
 94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID  
 94G1 = (C) NO-PAY CODE INVALID  
 94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL  
 94G3 = (C) NO-PAY/PROVIDER INCONSISTANT  
 94G4 = (C) NO PAY CODE = R & REIMB PRESENT  
 94X1 = (C) BLOOD LIMIT INVALID  
 94X2 = (C) TYPE/BLOOD DEDUCTIBLE  
 94X3 = (C) TYPE/DATE/LIMIT AMOUNT  
 94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES  
 94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX  
 9401 = (C) BLOOD DEDUCTIBLE AMT > 3  
 9402 = (C) BLOOD FURNISHED > DEDUCTIBLE  
 9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY  
 9404 = (C) INVALID GENDER CODE ON PRO-PAY  
 9407 = (C) INVALID DIAGNOSIS  
 9408 = (C) INVALID DRG NUMBER (GLOBAL)  
 9409 = (C) HCFA DRG<>DRG ON BILL  
 940X = (C) INVALID DRG  
 9410 = (C) CABG/PCOE,INVALID DRG  
 95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87  
 95X2 = (C) MSP AMOUNT APPLIED INVALID  
 95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES  
 95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE  
 95X5 = (C) MSP CODE = G/DATE BEFORE 1987  
 95X6 = (C) MSP CODE = X AND NOT AVOIDED  
 95X7 = (C) MSP CODE VALID, CABG/PCOE  
 96X1 = (C) OTHER AMOUNTS INVALID  
 96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB  
 97X1 = (C) OTHER AMOUNTS INDICATOR INVALID  
 97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0  
 98X1 = (C) COINSURANCE INVALID  
 98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH  
 98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI  
 98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP  
 9801 = (C) REV CENTER CODE 0910 WITH SERVICE  
 DATE > 10/15/2004  
 99XX = (D) POSS DUPE, PART B DOC-ID  
 9901 = (C) REV CODE INVALID OR TRAILER CNT=0  
 9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE  
 9903 = (C) NO CLINIC VISITS FOR RHC  
 9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE  
 991X = (C) NO DATE OF SERVICE  
 9910 = (C) BLOOD DEDUCTIBLE NON NUMERIC  
 9911 = (C) BLOOD DEDUCTIBLE PRESENT WITHOUT  
 BLOOD FURNISHED  
 9920 = (C) CASH DEDUCTIBLE INVALID  
 9930 = (C) COINSURANCE INVALID  
 9931 = (C) OUTPAT COINSURANCE VALUES  
 9933 = (C) RATE EXCEEDS MAMMOGRAPHY LIMIT

9934 = (C) HCPCS 76092 NON COVERED/76085 COVERED  
 9940 = (C) PROVIDER PAYMENT INVALID  
 9941 = (C) REIMBURSEMENT AMOUNT/COND/NON-PAYMENT/  
 PRIMARY PAYER  
 9942 = (C) PATIENT DISTRIBUTION INVALID  
 9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612  
 9945 = (C) HCPCS INVALID FOR SERVICE DATES  
 9946 = (C) TOB INVALID FOR HCPCS  
 9947 = (C) INVALID DATE FOR HCPCS  
 9948 = (C) STAY FROM>96365,DIAG=V725  
 9960 = (C) MED CHOICE BUT HMO DATA MISSING  
 9965 = (C) HMO PRESENT BUT MED CHOICE MISSING  
 9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER  
 9999 = (U) MAIN SPELL TRAILER NUMBER DOES NOT MATCH SPELL

NCH\_EDIT\_TRLR\_IND\_TB

NCH Edit Trailer Indicator Table

E = Edit code trailer present

NCH\_IP\_PRO\_APRVL\_TYPE\_TB

NCH Inpatient Peer Review Organization Approval Type Table

- 1 = Approved by the PRO as billed - Code indicates that the claim has been reviewed by the PRO and has been fully approved including any day or cost outliers.
- 2 = Automatic approval - Does not apply to Medicare claim.
- 3 = Partial approval - Code indicates the bill has been reviewed by the PRO, and some portion (days or services) has been denied. The from/thru dates of the approved portion of the stay, excluding grace days and any period at a noncovered level of care are shown on the bill.
- 4 = Admission denied - Code indicates the patient's need for inpatient services was reviewed upon admission and the PRO found that the stay was not medically necessary.
- 5 = Post payment review - Code indicates that any medical review will be completed after the claim is paid. The bill may be a day outlier, part of the sample review, or may not be reviewed.
- 6 = Pre-admission authorization - Pre-admission authorization obtained, but services not reviewed by the PRO.

7 THRU 9 = Reserved.

NCH\_MCO\_TRLR\_IND\_TB

NCH Managed Care Organization (MCO) Trailer Indicator Table

M = MCO trailer present

NCH\_MQA\_QUERY\_PATCH\_TB

NCH MQA Query Patch Table

Y = MQA changed bill query code on a action  
code 6 (force action code 2)  
bill to a zero. (Eff. 10/12/93)

Z = MQA changed bill query code on a action  
code 4 (cancel only adjustment)  
bill to zero. (Eff. 5/16/94)

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 HHPSS and HHA A/B split. (effective 10/00)
- M = Part B DMEPOS claim record (processed by DME Regional Carrier) (effective 10/93)

NCH\_OCRNC\_TRLR\_IND\_TB

NCH Occurrence Trailer Indicator Table

O = Occurrence code trailer present

NCH\_PATCH\_TB

NCH Patch Table

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



- routine to claims with NCH weekly process date prior to 4/22/94. Prior to Version 'H' patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 4.
- 05 = Wrong century bene birth date corrected (all claim types) -- applied during Nearline 'H' conversion to all history where century greater than 1700 and less than 1850; if century less than 1700, zeroes moved.
- 06 = Inconsistent CWF bene medicare status code made consistent with age (all claim types) -- applied during Nearline 'H' conversion to all history and patched ongoing. Bene age is calculated to determine the correct value; if greater than 64, 1st position MSC ='1'; if less than 65, 1st position MSC = '2'.
- 07 = Missing CWF bene medicare status code derived (all claim types) -- applied during Nearline 'H' conversion to all history and patched ongoing, except claims with unknown DOB and/or Claim From Date='0' (left blank). Bene age is calculated to determine missing value; if greater than 64, MSC='10'; if less than 65, MSC = '20'.
- 08 = Invalid NCH primary payer code set to blanks (Instnl) -- applied during Version 'H' conversion to claims with NCH weekly process date 10/1/93-10/30/95, where MSP values = invalid '0', '1', '2', '3' or '4' (caused by erroneous logic in HCFA program code, which was corrected on 11/1/95).
- 09 = Zero CWF claim accretion date replaced with NCH weekly process date (all claim types) -- applied during Version 'H' conversion to Instnl and DMERC claims; applied during Version 'G' conversion to non-institutional (non-DMERC) claims. Prior to Version 'H', patch indicator stored in redefined claim edit group, 3rd occurrence, position 1.
- 10 = Multiple Revenue Center 0001 (Outpatient, HHA and Hospice) -- patch applied to 1998 & 1999 Nearline and SAFs to delete any revenue codes that followed the first '0001' revenue center code. The edit was applied across all institutional claim types, including Inpatient/SNF (the problem was only found with OP/HHA/Hospice claims). The problem was corrected 6/25/99.
- 11 = Truncated claim total charge amount in the fixed portion replaced with the total charge amount in the revenue center 0001 amount field -- service years 1998 & 1999 patched during quarterly merge. The 1998 & 1999 SAFs were corrected when finalized in 7/99. The patch

was done for records with NCH Daily Process  
Date 1/4/99 - 5/14/99.

- 12 = Missing claim-level HHA Total Visit Count -- service years 1998, 1999 & 2000 patch applied during Version 'I' conversion of both the Nearline and SAFs. Problem occurs in those claims recovered during the missing claims effort.
- 13 = Inconsistent Claim MCO Paid Switch made consistent with criteria used to identify an inpatient encounter claim -- if MCO paid switch equal to blank or '0' and ALL conditions are met to indicate an inpatient encounter claim (bene enrolled in a risk MCO during the service period), change the switch to a '1'. The patch was applied during the Version 'I' conversion, for claims back to 7/1/97 service thru date.
- 14 = SNF claims incorrectly identified as Inpatient Encounter claims -- SNF claims matching the Inpatient encounter data criteria were incorrectly identified as Inpatient encounter claims (claim type code = '61' instead of '20' or '30'). NOTE: if the SNF claims were identified the MCO paid switch was set to '1'. The patch was applied to correctly identify these claims as a '20' or '30'. The MCO paid switch will be set to '0' as there is no way to recover the original value. The problem occurred in claims with an NCH Weekly Process Date ranging from 7/7/2000 - 1/26/2001. The patch applied date is 03/30/2001.
- 15 = HHA Part A claims with overlaid revenue center lines - During the Version 'I' conversion, NCH made each segment of a claim contains a maximum of 45 revenue lines. During the month of June 2000 our CWFMQA had to be ready to except the new expanded format, but the NCH was not ready. CWFMQA converted these 'I' claims back to Version 'H', a typo in the code caused the additional revenue lines to overlay some of the revenue lines on the base/initial record/segment. The problem occurred in claims with NCH Weekly Process dates from 6/16/00, 6/23/00, 6/30/00 and 7/7/00 (both Version 'H' & 'I' files).

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

The patch applied date is 06/29/2001.

P = Patch code trailer present

NCH\_POA\_DGNS\_E\_TRLR\_IND\_TB            NCH POA Diagnosis Trailer E Indicator Code Table

Valid Value:

B = NCH POA Diagnosis E Code Trailer

NCH\_POA\_DGNS\_TRLR\_IND\_TB            NCH POA Diagnosis Trailer Indicator Code Table

Valid Value:

A = NCH POA Diagnosis Code trailer

NCH\_PRCDR\_TRLR\_IND\_TB            NCH Procedure Trailer Indicator Table

Z = Procedure code trailer present

NCH\_PTNT\_STUS\_IND\_TB            NCH Patient Status Indicator Table

A = Discharged

B = Died

C = Still patient

NCH\_REV\_TRLR\_IND\_TB            NCH Revenue Center Trailer Indicator Table

R = Revenue code trailer present

NCH\_SPAN\_TRLR\_IND\_TB            NCH Span Trailer Indicator Table

S = Span code trailer present

NCH\_STATE\_SGMT\_TB            NCH State Segment Table

NCH State Segment    State Codes

-----  
B =            01;02;03;04;06;07;08;09;  
              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

NCH\_VAL\_TRLR\_IND\_TB

NCH Value Trailer Indicator Table

V = Value code trailer present

NG\_ACO\_IND\_TB  
Table

Next Generation (NG) Accountable Care Organization (ACO) Indicator Code

- 0 = Base record (no enhancements)
- 1 = Population Based Payments (PBP)
- 2 = Telehealth
- 3 = Post Discharge Home Health Visits
- 4 = 3-Day SNF Waiver
- 5 = Capitation
- 6 = CEC Telehealth
- 7 = Care Management Home Visits
- 8 = Primary Care Capitation (PCC)

9 = Home Health Benefit Enhancement - eff. 4/2021  
B = Concurrent Care for Beneficiaries that Elect the Medicare  
Hospice Benefit - eff. 4/2021  
C = Kidney Disease Education (KDE) eff. 4/2021  
D = Seriously Ill Population (SIP)  
E = Flat Visit Fee (FVF)  
F = Quarterly Capitation Payment (QCP) eff. 4/2021

#### PMT\_EDIT\_RIC\_TB

#### Payment And Edit Record Identification Code Table

C = Inpatient hospital, SNF  
D = Outpatient  
E = Religious Nonmedical Health Care Institutions (eff. 8/00);  
Christian Science, prior to 7/00  
F = Home Health Agency (HHA)  
G = Discharge notice  
(obsoleted 7/98)  
I = Hospice

#### PRVDR\_NUM\_TB

#### Provider Number Table

- First two positions are the GEO SSA State Code.
- Positions 3 and sometimes 4 are used as a category identifier. The remaining positions are serial numbers. The following blocks of numbers are reserved for the facilities indicated (NOTE: may have different meanings dependent on the Type of Bill (TOB):
- A 'V' in the 5th position identifies a VA demo.

0001-0879 Short-term (general and specialty)  
hospitals where TOB = 11X; ESRD  
clinic where TOB = 72X

0880-0899 Reserved for hospitals participating  
in ORD demonstration projects where  
TOB = 11X; ESRD clinic where TOB =  
72X

0900-0999 Multiple hospital component in a  
medical complex (numbers retired)  
where TOB = 11X; ESRD clinic where  
TOB = 72X

1000-1199 Reserved for future use

1200-1224 Alcohol/drug hospitals (excluded  
from PPS-numbers retired)  
where TOB = 11X; ESRD clinic where  
TOB = 72X

1225-1299 Medical assistance facilities  
(Montana project); ESRD clinic where

TOB = 72X

- 1300-1399 Rural Primary Care Hospital (RCPH) -  
eff. 10/97 changed to Critical Access  
Hospitals (CAH)
- 1400-1499 Continuation of 4900-4999 series (CMHC)
- 1500-1799 Hospices
- 1800-1989 Federally Qualified Health Centers  
(FQHC) where TOB = 73X; SNF (IP PTB)  
where TOB = 22X; HHA where TOB = 32X,  
33X, 34X
- 1990-1999 Christian Science Sanatoria  
(hospital services) - eff. 7/00 changed  
to Religious Nonmedical Health Care  
Institutions (RNHCI)
- 2000-2299 Long-term hospitals
- 2300-2499 Chronic renal disease facilities  
(hospital based)
- 2500-2899 Non-hospital renal disease  
treatment centers
- 2900-2999 Independent special purpose renal  
dialysis facility (1)
- 3000-3024 Formerly tuberculosis hospitals  
(numbers retired)
- 3025-3099 Rehabilitation hospitals
- 3100-3199 Continuation of Subunits of Nonprofit  
and Proprietary Home Health Agencies  
(7300-7399) Series (3) (eff. 4/96)
- 3200-3299 Continuation of 4800-4899 series (CORF)
- 3300-3399 Children's hospitals (excluded from PPS)  
where TOB = 11X; ESRD clinic where TOB =  
72X
- 3400-3499 Continuation of rural health clinics  
(provider-based) (3975-3999)
- 3500-3699 Renal disease treatment centers  
(hospital satellites)
- 3700-3799 Hospital based special purpose renal  
dialysis facility (1)
- 3800-3974 Rural health clinics (free-standing)
- 3975-3999 Rural health clinics (provider-based)
- 4000-4499 Psychiatric hospitals
- 4500-4599 Comprehensive Outpatient  
Rehabilitation Facilities (CORF)
- 4600-4799 Community Mental Health Centers (CMHC);  
9/30/91 - 3/31/97 used for clinic OPT  
where TOB = 74X
- 4800-4899 Continuation of 4500-4599 series (CORF)  
(eff. 10/95)
- 4900-4999 Continuation of 4600-4799 series (CMHC)  
(eff. 10/95); 9/30/91 - 3/31/97 used for  
clinic OPT where TOB = 74X
- 5000-6499 Skilled Nursing Facilities
- 6500-6989 CMHC / Outpatient physical therapy services  
where TOB = 74X; CORF where TOB =  
75X

6990-6999 Christian Science Sanatoria (skilled nursing services) - eff. 7/00 Numbers Reserved (formerly CS)  
7000-7299 Home Health Agencies (HHA) (2)  
7300-7399 Subunits of 'nonprofit' and 'proprietary' Home Health Agencies (3)  
7400-7799 Continuation of 7000-7299 series  
7800-7999 Subunits of state and local governmental Home Health Agencies (3)  
8000-8499 Continuation of 7400-7799 series (HHA)  
8500-8899 Continuation of rural health center (provider based) (3400-3499)  
8900-8999 Continuation of rural health center (free-standing) (3800-3974)  
9000-9799 Continuation of 8000-8499 series (HHA) (eff. 10/95)  
9800-9899 Transplant Centers (eff. 10/1/07)  
9900-9999 Freestanding Opioid Treatment Program (eff. 1/2021)

Exception:

P001-P999 Organ procurement organization

- (1) These facilities (SPRDFS) will be assigned the same provider number whenever they are recertified.
- (2) The 6400-6499 series of provider numbers in Iowa (16), South Dakota (43) and Texas (45) have been used in reducing acute care costs (RACC) experiments.
- (3) In Virginia (49), the series 7100-7299 has been reserved for statewide subunit components of the Virginia state home health agencies.
- (4) Parent agency must have a number in the 7000-7299, 7400-7799 or 8000-8499 series.

NOTE:

There is a special numbering system for units of hospitals that are excluded from prospective payment system (PPS) and hospitals with SNF swing-bed designation. An alpha character in the third position of the provider number identifies the type of unit or swing-bed designation as follows:

M = Psychiatric Unit in Critical Access Hospital  
R = Rehabilitation Unit in Critical Access Hospital

S = Psychiatric unit (excluded from PPS)  
T = Rehabilitation unit (excluded from PPS)  
U = Swing-Bed Hospital Designation for Short-Term Hospitals  
V = Alcohol drug unit (prior to 10/87 only)  
W = Swing-Bed Hospital Designation for Long Term Care Hospitals  
Y = Swing-Bed Hospital Designation for Rehabilitation Hospitals  
Z = Swing Bed Designation for Critical Access Hospitals

There is also a special numbering system for assigning emergency hospital identification numbers (non participating hospitals). The sixth position of the provider number is as follows:

E = Non-federal emergency hospital  
F = Federal emergency hospital

PTNT\_DSCHRG\_STUS\_TB

Patient Discharge Status Table

- 01 = Discharged to home/self care (routine charge).
- 02 = Discharged/transferred to other short term general hospital for inpatient care.
- 03 = Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care -- (For hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF.
- 04 = Discharged/transferred to a facility that provides custodial or supportive care (includes intermediate care facilities (ICF). Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to Assisted Living Facilities.
- 05 = Discharged/transferred to a designated cancer center or children's hospital (eff. 10/09). Prior to 10/1/09, discharged/transferred to another type of institution for inpatient care (including distinct parts). NOTE: Effective 1/2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is '65'.
- 06 = Discharged/transferred to home care of organized home health service organization



- in anticipation of covered skilled care.
- 07 = Left against medical advice or discontinued care.
- 08 = Discharged/transferred to home under care of a home IV drug therapy provider. (discontinued effective 10/1/05)
- 09 = Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
- 20 = Expired
- 21 = Discharged/transferred to Court/Law Enforcement.
- 30 = Still patient.
- 40 = Expired at home (Hospice claims only).
- 41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
- 42 = Expired - place unknown (Hospice claims only)
- 43 = Discharged/transferred to a federal hospital (eff. 10/1/03). Discharges and transfers to a government operated health facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not.
- 50 = Hospice - home (eff. 10/96)
- 51 = Hospice - medical facility (certified) providing hospice level of care
- 61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/01)
- 62 = Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital. (eff. 1/2002)
- 63 = Discharged/transferred to a Medicare certified long term care hospital. (eff. 1/2002)
- 64 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare (eff. 10/2002)
- 65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code). (eff. 1/2005).
- 66 = Discharged/transferred to a Critical Access Hospital (CAH) (eff. 1/1/06)
- 69 = Discharge/transfers to a Designated Disaster Alternative Care site (eff. 10/2013)

- 70 = Discharged/transferred to another type of health care institution not defined elsewhere in code list.
- 71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)
- 72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)
- 81 = Discharged to home or self-care with a planned acute care hospital inpatient (eff. 10/2013)
- 82 = Discharged/transferred to a short term general hospital for inpatient care readmission (eff. 10/2013)
- 83 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare (eff. 10/2013)
- 84 = Discharged/transferred to a facility that provides custodial supportative care with a planned acute care hospital inpatient readmission certification with a planned acute care hospital inpatient readmission (eff. 10/2013)
- 85 = Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission (eff. 10/2013)
- 86 = Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission (eff. 10/2013)
- 87 = Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (eff. 10/2013)
- 88 = Discharged/transferred to a Federal health care facility with a planned acute care hospital inpatient readmission (eff. 10/2013)
- 89 = Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (eff. 10/2013)
- 90 = Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct units of a hospital with a planned acute care hospital inpatient readmission (eff. 10/2013)
- 91 = Discharged/transferred to a Medicare certified Long Term Care Hospital (LTCH) with a planned acute care hospital inpatient readmission (eff. 10/2013)
- 92 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (eff. 10/2013)
- 93 = Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (eff. 10/2013)
- 94 = Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission

(eff. 10/2013)

95 = Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission. (eff. 10/2013)

REV\_CNTR\_ANSI\_TB

Revenue Center ANSI Code Table

\*\*\*\*\*EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES\*\*\*\*\*

\*\*\*\*\*POSITIONS 1 & 2 OF ANSI CODE\*\*\*\*\*

CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals -- this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

OA = Other Adjustments -- this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions -- this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility -- this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

\*\*\*\*\*Claim Adjustment Reason Codes\*\*\*\*\*

\*\*\*\*\*POSITIONS 3 through 5 of ANSI CODE\*\*\*\*\*

1 = Deductible Amount

2 = Coinsurance Amount

3 = Co-pay Amount

4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.

5 = The procedure code/bill type is inconsistent with the place of service.

6 = The procedure code is inconsistent with the patient's age.

7 = The procedure code is inconsistent with the patient's gender.

8 = The procedure code is inconsistent with the provider

type.

9 = The diagnosis is inconsistent with the patient's age.

10 = The diagnosis is inconsistent with the patient's gender.

11 = The diagnosis is inconsistent with the procedure.

12 = The diagnosis is inconsistent with the provider type.

13 = the date of death precedes the date of service.

14 = The date of birth follows the date of service.

15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.

16 = Claim/service lacks information which is needed for adjudication.

17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.

18 = Duplicate claim/service.

19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.

20 = Claim denied because this injury/illness is covered by the liability carrier.

21 = Claim denied because this injury/illness is the liability of the no-fault carrier.

22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.

23 = Claim adjusted because charges have been paid by another payer.

24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.

25 = Payment denied. Your Stop loss deductible has not been met.

26 = Expenses incurred prior to coverage.

27 = Expenses incurred after coverage terminated.

28 = Coverage not in effect at the time the service was provided.

29 = The time limit for filing has expired.

30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.

31 = Claim denied as patient cannot be identified as our insured.

32 = Our records indicate that this dependent is not an eligible dependent as defined.

33 = Claim denied. Insured has no dependent coverage.

34 = Claim denied. Insured has no coverage for newborns.

35 = Benefit maximum has been reached.

36 = Balance does not exceed copayment amount.

37 = Balance does not exceed deductible amount.

38 = Services not provided or authorized by designated (network) providers.

39 = Services denied at the time authorization/pre-certification was requested.

40 = Charges do not meet qualifications for emergency/urgent care.

41 = Discount agreed to in Preferred Provider contract.  
42 = Charges exceed our fee schedule or maximum allowable amount.  
43 = Gramm-Rudman reduction.  
44 = Prompt-pay discount.  
45 = Charges exceed your contracted/legislated fee arrangement.  
46 = This (these) service(s) is(are) not covered.  
47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid.  
48 = This (these) procedure(s) is(are) not covered.  
49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.  
50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.  
51 = These are non-covered services because this a pre-existing condition.  
52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.  
53 = Services by an immediate relative or a member of the same household are not covered.  
54 = Multiple physicians/assistants are not covered in this case.  
55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.  
56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.  
57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.  
58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.  
59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.  
60 = Charges for outpatient services with the proximity to inpatient services are not covered.  
61 = Charges adjusted as penalty for failure to obtain second surgical opinion.  
62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.  
63 = Correction to a prior claim. INACTIVE  
64 = Denial reversed per Medical Review. INACTIVE  
65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE  
66 = Blood Deductible.  
67 = Lifetime reserve days. INACTIVE  
68 = DRG weight. INACTIVE  
69 = Day outlier amount.  
70 = Cost outlier amount.  
71 = Primary Payer amount.

72 = Coinsurance day. INACTIVE  
73 = Administrative days. INACTIVE  
74 = Indirect Medical Education Adjustment.  
75 = Direct Medical Education Adjustment.  
76 = Disproportionate Share Adjustment.  
77 = Covered days. INACTIVE  
78 = Non-covered days/room charge adjustment.  
79 = Cost report days. INACTIVE  
80 = Outlier days. INACTIVE  
81 = Discharges. INACTIVE  
82 = PIP days. INACTIVE  
83 = Total visits. INACTIVE  
84 = Capital adjustments. INACTIVE  
85 = Interest amount. INACTIVE  
86 = Statutory adjustment. INACTIVE  
87 = Transfer amounts.  
88 = Adjustment amount represents collection against  
receivable created in prior overpayment.  
89 = Professional fees removed from charges.  
90 = Ingredient cost adjustment.  
91 = Dispensing fee adjustment.  
92 = Claim paid in full. INACTIVE  
93 = No claim level adjustment. INACTIVE  
94 = Process in excess of charges.  
95 = Benefits adjusted. Plan procedures not followed.  
96 = Non-covered charges.  
97 = Payment is included in allowance for another  
service/procedure.  
98 = The hospital must file the Medicare claim for this  
inpatient non-physician service. INACTIVE  
99 = Medicare Secondary Payer Adjustment Amount. INACTIVE  
100 = Payment made to patient/insured/responsible party.  
101 = Predetermination: anticipated payment upon comple-  
tion of services or claim adjudication.  
102 = Major medical adjustment.  
103 = Provider promotional discount (i.e. Senior citizen  
discount).  
104 = Managed care withholding.  
105 = Tax withholding.  
106 = Patient payment option/election not in effect.  
107 = Claim/service denied because the related or qualifying  
claim/service was not paid or identified on the claim.  
108 = Claim/service reduced because rent/purchase guidelines  
were not met.  
109 = Claim not covered by this payer/contractor. You must  
send the claim to the correct payer/contractor.  
110 = Billing date predates service date.  
111 = Not covered unless the provider accepts assignment.  
112 = Claim/service adjusted as not furnished directly  
to the patient and/or not documented.  
113 = Claim denied because service/procedure was provided  
outside the United States or as a result of war.  
114 = Procedure/PRODUCT not approved by the Food and Drug  
Administration.

115 = Claim/service adjusted as procedure postponed or canceled.  
116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.  
117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.  
118 = Charges reduced for ESRD network support.  
119 = Benefit maximum for this time period has been reached.  
120 = Patient is covered by a managed care plan. INACTIVE  
121 = Indemnification adjustment.  
122 = Psychiatric reduction.  
123 = Payer refund due to overpayment. INACTIVE  
124 = Payer refund amount - not our patient. INACTIVE  
125 = Claim/service adjusted due to a submission/billing error(s).  
126 = Deductible - Major Medical.  
127 = Coinsurance - Major Medical.  
128 = Newborn's services are covered in the mother's allowance.  
129 = Claim denied - prior processing information appears incorrect.  
130 = Paper claim submission fee.  
131 = Claim specific negotiated discount.  
132 = Prearranged demonstration project adjustment.  
133 = The disposition of this claim/service is pending further review.  
134 = Technical fees removed from charges.  
135 = Claim denied. Interim bills cannot be processed.  
136 = Claim adjusted. Plan procedures of a prior payer were not followed.  
137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.  
138 = Claim/service denied. Appeal procedures not followed or time limits not met.  
139 = Contracted funding agreement - subscriber is employed by the provider of services.  
140 = Patient/Insured health identification number and name do not match.  
141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.  
142 = Claim adjusted by the monthly Medicaid patient liability amount.  
A0 = Patient refund amount  
A1 = Claim denied charges.  
A2 = Contractual adjustment.  
A3 = Medicare Secondary Payer liability met. INACTIVE  
A4 = Medicare Claim PPS Capital Day Outlier Amount.  
A5 = Medicare Claim PPS Capital Cost Outlier Amount.  
A6 = Prior hospitalization or 30 day transfer requirement not met.  
A7 = Presumptive Payment Adjustment.  
A8 = Claim denied; ungroupable DRG.

B1 = Non-covered visits.  
B2 = Covered visits. INACTIVE  
B3 = Covered charges. INACTIVE  
B4 = Late filing penalty.  
B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.  
B6 = This service/procedure is adjusted when performed/ billed by this type of provider, by this type of facility, or by a provider of this specialty.  
B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.  
B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.  
B9 = Services not covered because the patient is enrolled in a Hospice.  
B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.  
B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.  
B12 = Services not documented in patients' medical records.  
B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.  
B14 = Claim/service denied because only one visit or consultation per physician per day is covered.  
B15 = Claim/service adjusted because this procedure/service is not paid separately.  
B16 = Claim/service adjusted because 'New Patient' qualifications were not met.  
B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.  
B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.  
B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE  
B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.  
B21 = The charges were reduced because the service/care was partially furnished by another physician.  
INACTIVE  
B22 = This claim/service is adjusted based on the diagnosis.  
B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.  
W1 = Workers Compensation State Fee Schedule Adjustment.



00 = No composite group assigned  
01 = First composite group on claim  
02 = Second composite group on claim  
NN = nth composite group on claim

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00 = N/A in this case  
01-99 = 1st composite - 99th composite  
A1-A9 = 100th composite - 108th composite  
B1-B9 = 109th composite - 117th composite  
C1-C9 = 118th composite - 126th composite  
D1-D9 = 127th composite - 135th composite  
E1-E9 = 136th composite - 144th composite  
F1-F9 = 145th composite - 153rd composite  
G1-G9 = 154th composite - 162nd composite  
H1-H9 = 163rd composite - 171st composite  
I1-I9 = 172nd composite - 180th composite  
J1-J9 = 181st composite - 189th composite  
K1-K9 = 190th composite - 198th composite  
L1-L9 = 199th composite - 207th composite  
M1-M9 = 208th composite - 216th composite  
N1-N9 = 217th composite - 225th composite  
O1-O9 = 226th composite - 234th composite  
P1-P9 = 235th composite - 243rd composite  
Q1-Q9 = 244th composite - 252nd composite  
R1-R9 = 253rd composite - 261st composite  
S1-S9 = 262nd composite - 270th composite  
T1-T9 = 271st composite - 279th composite  
U1-U9 = 280th composite - 288th composite  
V1-V9 = 289th composite - 297th composite  
W1-W9 = 298th composite - 306th composite  
X1-X9 = 307th composite - 315th composite  
Y1-Y9 = 316th composite - 324th composite  
Z1-Z9 = 325th composite - 333rd composite

AA-AZ = 334th composite - 359th composite  
BA-BZ = 360th composite - 385th composite  
CA-CZ = 386th composite - 411th composite  
DA-DZ = 412th composite - 437th composite  
EA-EZ = 438th composite - 463rd composite  
FA-FZ = 464th composite - 489th composite  
GA-GZ = 490th composite - 515th composite  
HA-HZ = 516th composite - 541st composite  
IA-IZ = 542nd composite - 567th composite  
JA-JZ = 568th composite - 593rd composite  
KA-KZ = 594th composite - 619th composite  
LA-LZ = 620th composite - 645th composite  
MA-MZ = 646th composite - 671st composite  
NA-NZ = 672nd composite - 697th composite  
OA-OZ = 698th composite - 723rd composite

PA-PZ = 724th composite - 749th composite  
QA-QZ = 750th composite - 775th composite  
RA-RZ = 776th composite - 801st composite  
SA-SZ = 802nd composite - 827th composite  
TA-TZ = 828th composite - 853rd composite  
UA-UZ = 854th composite - 879th composite  
VA-VZ = 880th composite - 905th composite  
WA-WZ = 906th composite - 931st composite  
XA-XZ = 932nd composite - 957th composite  
ZA-ZZ = 958th composite - 983rd composite

REV\_CNTR\_APC\_TB

Revenue Center Ambulatory Payment Classification (APC)

0000 = Code used when Payment Method Indicator equals 'N9'  
0001 = Photochemotherapy  
0002 = Fine needle Biopsy/Aspiration  
0003 = Bone Marrow Biopsy/Aspiration  
0004 = Level I Needle Biopsy/ Aspiration Except Bone Marrow  
0005 = Level II Needle Biopsy /Aspiration Except Bone Marrow  
0006 = Level I Incision & Drainage  
0007 = Level II Incision & Drainage  
0008 = Level III Incision & Drainage  
0009 = Nail Procedures  
0010 = Level I Destruction of Lesion  
0011 = Level II Destruction of Lesion  
0012 = Level I Debridement & Destruction  
0013 = Level II Debridement & Destruction  
0014 = Level III Debridement & Destruction  
0015 = Level IV Debridement & Destruction  
0016 = Level V Debridement & Destruction  
0017 = Level VI Debridement & Destruction  
0018 = Biopsy Skin, Subcutaneous Tissue or Mucous Membrane  
0019 = Level I Excision/ Biopsy  
0020 = Level II Excision/ Biopsy  
0021 = Level III Excision/ Biopsy  
0022 = Level IV Excision/ Biopsy  
0023 = Exploration Penetrating Wound  
0024 = Level I Skin Repair  
0025 = Level II Skin Repair  
0026 = Level III Skin Repair  
0027 = Level IV Skin Repair  
0028 = Level I Incision/Excision Breast  
0029 = Incision/Excision Breast (obsolete 12/00);  
Level II Incision/Excision Breast (effective 1/01)  
0030 = Breast Reconstruction/Mastectomy  
0031 = Hyperbaric Oxygen (obsolete 1/01)  
0032 = Placement Transvenous Catheters/Arterial Cutdown  
0033 = Partial Hospitalization  
0040 = Arthrocentesis & Ligament/Tendon Injection

0041 = Arthroscopy  
0042 = Arthroscopically-Aided Procedures  
0043 = Closed Treatment Fracture Finger/Toe/Trunk  
0044 = Closed Treatment Fracture/Dislocation Except  
Finger/Toe/Trunk  
0045 = Bone/Joint Manipulation Under Anesthesia  
0046 = Open/Percutaneous Treatment Fracture or Dislocation  
0047 = Arthroplasty without Prosthesis  
0048 = Arthroplasty with Prosthesis  
0049 = Level I Musculoskeletal Procedures Except Hand  
and Foot  
0050 = Level II Musculoskeletal Procedures Except Hand  
and Foot  
0051 = Level III Musculoskeletal Procedures Except Hand  
and Foot  
0052 = Level IV Musculoskeletal Procedures Except Hand  
and Foot  
0053 = Level I Hand Musculoskeletal Procedures  
0054 = Level II Hand Musculoskeletal Procedures  
0055 = Level I Foot Musculoskeletal Procedures  
0056 = Level II Foot Musculoskeletal Procedures  
0057 = Bunion Procedures  
0058 = Level I Strapping and Cast Application  
0059 = Level II Strapping and Cast Application  
0060 = Manipulation Therapy  
0070 = Thoracentesis/Lavage Procedures  
0071 = Level I Endoscopy Upper Airway  
0072 = Level II Endoscopy Upper Airway  
0073 = Level III Endoscopy Upper Airway  
0074 = Level IV Endoscopy Upper Airway  
0075 = Level V Endoscopy Upper Airway  
0076 = Endoscopy Lower Airway  
0077 = Level I Pulmonary Treatment  
0078 = Level II Pulmonary Treatment  
0079 = Ventilation Initiation and Management  
0080 = Diagnostic Cardiac Catheterization  
0081 = Non-Coronary Angioplasty or Atherectomy  
0082 = Coronary Atherectomy  
0083 = Coronary Angioplasty  
0084 = Level I Electrophysiologic Evaluation  
0085 = Level II Electrophysiologic Evaluation  
0086 = Ablate Heart Dysrhythm Focus  
0087 = Cardiac Electrophysiologic Recording/Mapping  
0088 = Thrombectomy  
0089 = Level I Implantation/Removal/Revision of  
Pacemaker, AICD Vascular Device (obsolete 12/00);  
Insertion/Replacement of Permanent Pacemaker and  
Electrodes (eff. 1/01)  
0090 = Level II Implantation/Removal/Revision of  
Pacemaker AICD Vascular Device (obsolete 12/00);  
Insertion/Replacement of Permanent Pacemaker  
and Pulse Generator  
0091 = Level I Vascular Ligation  
0092 = Level II Vascular Ligation

0093 = Vascular Repair/Fistula Construction  
0094 = Resuscitation and Cardioversion  
0095 = Cardiac Rehabilitation  
0096 = Non-Invasive Vascular Studies  
0097 = Cardiovascular Stress Test (obsolete 12/00);  
Cardiac Monitoring for 30 days (eff. 1/01)  
0098 = Injection of Sclerosing Solution  
0099 = Continuous Cardiac Monitoring (obsolete 12/00);  
Electrocardiograms (eff. 1/01)  
0100 = Stress test and continuous ECG  
0101 = Tilt Table Evaluation  
0102 = Electronic Analysis of Pacemakers/other Devices  
0103 = Miscellaneous Vascular Procedures (eff. 1/01)  
0104 = Transcatheter Placement of Intracoronary Stents  
(eff. 1/01)  
0105 = Revision/Removal of Pacemakers, AICD or Vascular  
(eff. 1/01)  
0106 = Insertion/Replacement/Repair of Pacemaker  
Electrode (eff. 1/01)  
0107 = Insertion of Cardioverter-Defibrillator  
(eff. 1/01)  
0108 = Insertion/Replacement/Repair of Cardioverter-  
Defibrillator Leads (eff. 1/01)  
0109 = Bone Marrow Harvesting and Bone Marrow/Stem Cell  
Transplant (obsolete 12/00); Removal of Implanted  
Devices (eff. 1/01)  
0110 = Transfusion  
0111 = Blood PRODUCT Exchange  
0112 = Extracorporeal Photopheresis  
0113 = Excision Lymphatic System  
0114 = Thyroid/Lymphadenectomy Procedures  
0115 = Cannula/Access Device Procedures  
(eff. 1/01)  
0116 = Chemotherapy Administration by Other Technique  
Except Infusion  
0117 = Chemotherapy Administration by Infusion Only  
0118 = Chemotherapy Administration by Both Infusion and  
Other Technique  
0119 = Implantation of Devices (eff. 1/01)  
0120 = Infusion Therapy Except Chemotherapy  
0121 = Level I Tube changes and Repositioning  
0122 = Level II Tube changes and Repositioning  
0123 = Bone Marrow Harvesting and Bone Marrow/Stem  
Cell Transplant  
0124 = Revision of Implanted Infusion Pump  
(eff. 1/01)  
0130 = Level I Laparoscopy  
0131 = Level II Laparoscopy  
0132 = Level III Laparoscopy  
0140 = Esophageal Dilation without Endoscopy  
0141 = Upper GI Procedures  
0142 = Small Intestine Endoscopy  
0143 = Lower GI Endoscopy  
0144 = Diagnostic Anoscopy

0145 = Therapeutic Anoscopy  
0146 = Level I Sigmoidoscopy  
0147 = Level II Sigmoidoscopy  
0148 = Level I Anal/Rectal Procedure  
0149 = Level II Anal/Rectal Procedure  
0150 = Level III Anal/Rectal Procedure  
0151 = Endoscopic Retrograde Cholangio-Pancreatography (ERCP)  
0152 = Percutaneous Biliary Endoscopic Procedures  
0153 = Peritoneal and Abdominal Procedures  
0154 = Hernia/Hydrocele Procedures  
0157 = Colorectal Cancer Screening: Barium Enema  
(Not subject to National coinsurance)  
0158 = Colorectal Cancer Screening: Colonoscopy  
Not subject to National coinsurance. Minimum  
unadjusted coinsurance is 25% of the payment rate.  
Payment rate is lower of the HOPD payment rate or  
the Ambulatory Surgical Center payment.  
0159 = Colorectal Cancer Screening: Flexible Sigmoidoscopy  
Not subject to National coinsurance. Minimum  
unadjusted coinsurance is 25% of the payment rate.  
Payment rate is lower of the HOPD payment rate or  
the Ambulatory Surgical Center payment.  
0160 = Level I Cystourethroscopy and other Genitourinary  
Procedures  
0161 = Level II Cystourethroscopy and other Genitourinary  
Procedures  
0162 = Level III Cystourethroscopy and other Genitourinary  
Procedures  
0163 = Level IV Cystourethroscopy and other Genitourinary  
Procedures  
0164 = Level I Urinary and Anal Procedures  
0165 = Level II Urinary and Anal Procedures  
0166 = Level I Urethral Procedures  
0167 = Level II Urethral Procedures  
0168 = Level III Urethral Procedures  
0169 = Lithotripsy  
0170 = Dialysis for Other Than ESRD Patients  
0180 = Circumcision  
0181 = Penile Procedures  
0182 = Insertion of Penile Prosthesis  
0183 = Testes/Epididymis Procedures  
0184 = Prostate Biopsy  
0190 = Surgical Hysteroscopy  
0191 = Level I Female RePRODuctive Procedures  
0192 = Level II Female RePRODuctive Procedures  
0193 = Level III Female RePRODuctive Procedures  
0194 = Level IV Female RePRODuctive Procedures  
0195 = Level V Female RePRODuctive Procedures  
0196 = Dilatation & Curettage  
0197 = Infertility Procedures  
0198 = Pregnancy and Neonatal Care Procedures  
0199 = Vaginal Delivery  
0200 = Therapeutic Abortion  
0201 = Spontaneous Abortion

0210 = Spinal Tap  
0211 = Level I Nervous System Injections  
0212 = Level II Nervous System Injections  
0213 = Extended EEG Studies and Sleep Studies  
0214 = Electroencephalogram  
0215 = Level I Nerve and Muscle Tests  
0216 = Level II Nerve and Muscle Tests  
0217 = Level III Nerve and Muscle Tests  
0220 = Level I Nerve Procedures  
0221 = Level II Nerve Procedures  
0222 = Implantation of Neurological Device  
0223 = Level I Revision/Removal Neurological Device  
(obsolete 12/00); Implantation of Pain  
Management Device (eff. 1/01)  
0224 = Level II Revision/Removal Neurological Device  
(obsolete 12/00); Implantation of Reservoir/  
Pump/Shunt (eff. 1/01)  
0225 = Implantation of Neurostimulator Electrodes  
0226 = Implantation of Drug Infusion Reservoir  
(eff. 1/01)  
0227 = Implantation of Drug Infusion Device  
(eff. 1/01)  
0228 = Creation of Lumbar Subarachnoid Shunt  
(eff. 1/01)  
0229 = Transcatheter Placement of Intravascular Shunts  
(eff. 1/01)  
0230 = Level I Eye Tests  
0231 = Level II Eye Tests  
0232 = Level I Anterior Segment Eye  
0233 = Level II Anterior Segment Eye  
0234 = Level III Anterior Segment Eye Procedures  
0235 = Level I Posterior Segment Eye Procedures  
0236 = Level II Posterior Segment Eye Procedures  
0237 = Level III Posterior Segment Eye Procedures  
0238 = Level I Repair and Plastic Eye Procedures  
0239 = Level II Repair and Plastic Eye Procedures  
0240 = Level III Repair and Plastic Eye Procedures  
0241 = Level IV Repair and Plastic Eye Procedures  
0242 = Level V Repair and Plastic Eye Procedures  
0243 = Strabismus/Muscle Procedures  
0244 = Corneal Transplant  
0245 = Cataract Procedures without IOL Insert  
0246 = Cataract Procedures with IOL Insert  
0247 = Laser Eye Procedures Except Retinal  
0248 = Laser Retinal Procedures  
0250 = Nasal Cauterization/Packing  
0251 = Level I ENT Procedures  
0252 = Level II ENT Procedures  
0253 = Level III ENT Procedures  
0254 = Level IV ENT Procedures  
0256 = Level V ENT Procedures  
0257 = Implantation of Cochlear Device (obsolete 1/01)  
0258 = Tonsil and Adenoid Procedures  
0260 = Level I Plain Film Except Teeth

0261 = Level II Plain Film Except Teeth Including Bone  
Density Measurement  
0262 = Plain Film of Teeth  
0263 = Level I Miscellaneous Radiology Procedures  
0264 = Level II Miscellaneous Radiology Procedures  
0265 = Level I Diagnostic Ultrasound Except Vascular  
0266 = Level II Diagnostic Ultrasound Except Vascular  
0267 = Vascular Ultrasound  
0268 = Guidance Under Ultrasound  
0269 = Echocardiogram Except Transesophageal  
0270 = Transesophageal Echocardiogram  
0271 = Mammography  
0272 = Level I Fluoroscopy  
0273 = Level II Fluoroscopy  
0274 = Myelography  
0275 = Arthrography  
0276 = Level I Digestive Radiology  
0277 = Level II Digestive Radiology  
0278 = Diagnostic Urography  
0279 = Level I Diagnostic Angiography and Venography  
Except Extremity  
0280 = Level II Diagnostic Angiography and Venography  
Except Extremity  
0281 = Venography of Extremity  
0282 = Level I Computerized Axial Tomography  
0283 = Level II Computerized Axial Tomography  
0284 = Magnetic Resonance Imaging  
0285 = Positron Emission Tomography (PET)  
0286 = Myocardial Scans  
0290 = Standard Non-Imaging Nuclear Medicine  
0291 = Level I Diagnostic Nuclear Medicine Excluding  
Myocardial Scans  
0292 = Level II Diagnostic Nuclear Medicine Excluding  
Myocardial Scans  
0294 = Level I Therapeutic Nuclear Medicine  
0295 = Level II Therapeutic Nuclear Medicine  
0296 = Level I Therapeutic Radiologic Procedures  
0297 = Level II Therapeutic Radiologic Procedures  
0300 = Level I Radiation Therapy  
0301 = Level II Radiation Therapy  
0302 = Level III Radiation Therapy  
0303 = Treatment Device Construction  
0304 = Level I Therapeutic Radiation Treatment  
Preparation  
0305 = Level II Therapeutic Radiation Treatment  
Preparation  
0310 = Level III Therapeutic Radiation Treatment  
Preparation  
0311 = Radiation Physics Services  
0312 = Radioelement Applications  
0313 = Brachytherapy  
0314 = Hyperthermic Therapies  
0320 = Electroconvulsive Therapy  
0321 = Biofeedback and Other Training

0322 = Brief Individual Psychotherapy  
0323 = Extended Individual Psychotherapy  
0324 = Family Psychotherapy  
0325 = Group Psychotherapy  
0330 = Dental Procedures  
0340 = Minor Ancillary Procedures  
0341 = Immunology Tests  
0342 = Level I Pathology  
0343 = Level II Pathology  
0344 = Level III Pathology  
0345 = Transfusion Laboratory Procedures Level I  
(eff. 1/01)  
0346 = Transfusion Laboratory Procedures Level II  
(eff. 1/01)  
0347 = Transfusion Laboratory Procedures Level III  
(eff. 1/01)  
0348 = Fertility Laboratory Procedures  
(eff. 1/01)  
0349 = Miscellaneous Laboratory Procedures  
(eff. 1/01)  
0354 = Administration of Influenza Vaccine (Not  
subject to national coinsurance)  
0355 = Level I Immunizations  
0356 = Level II Immunizations  
0357 = Level III Immunizations (obsolete 1/01)  
0358 = Level IV Immunizations (obsolete 1/01)  
0359 = Injections  
0360 = Level I Alimentary Tests  
0361 = Level II Alimentary Tests  
0362 = Fitting of Vision Aids  
0363 = Otorhinolaryngologic Function Tests  
0364 = Level I Audiometry  
0365 = Level II Audiometry  
0366 = Electrocardiogram (ECG) (obsolete 1/01)  
0367 = Level I Pulmonary Test  
0368 = Level II Pulmonary Test  
0369 = Level III Pulmonary Test  
0370 = Allergy Tests  
0371 = Allergy Injections  
0372 = Therapeutic Phlebotomy  
0373 = Neuropsychological Testing  
0374 = Monitoring Psychiatric Drugs  
0600 = Low Level Clinic Visits  
0601 = Mid Level Clinic Visits  
0602 = High Level Clinic Visits  
0603 = Interdisciplinary Team Conference (obsolete 1/01)  
0610 = Low Level Emergency Visits  
0611 = Mid Level Emergency Visits  
0612 = High Level Emergency Visits  
0620 = Critical Care  
0701 = Strontium (eligible for pass-through payments)  
(obsolete 12/00); SR 89 chloride, per mCi  
(eff. 1/01)  
0702 = Samarium (eligible for pass-through payments)



(obsolete 12/00); SM 153 lexidronam, 50 mCi  
(eff. 1/01)  
0704 = IN 111 Satumomab Pendetide (eligible for pass-through payments)  
0705 = Tc99 Tetrofosmin (eligible for pass-through payments)  
0725 = Leucovorin Calcium (eligible for pass-through payments)  
0726 = Dexrazoxane Hydrochloride (eligible for pass-through payments)  
0727 = Injection, Etidronate Disodium (eligible for pass-through payments)  
0728 = Filgrastim (G-CSF) (eligible for pass-through payments)  
0730 = Pamidronate Disodium (eligible for pass-through payments)  
0731 = Sargramostim (GM-CSF) (eligible for pass-through payments)  
0732 = Mesna (eligible for pass-through payments)  
0733 = Non-ESRD Epoetin Alpha (eligible for pass-through payments)  
0750 = Dolasetron Mesylate 10 mg (eligible for pass-through payments)  
0754 = Metoclopramide HCL (eligible for pass-through payments)  
0755 = Thiethylperazine Maleate (eligible for pass-through payments)  
0761 = Oral Substitute for IV Antiemetic (eligible for pass-through payments)  
0762 = Dronabinol (eligible for pass-through payments)  
0763 = Dolasetron Mesylate 100 mg Oral (eligible for pass-through payments)  
0764 = Granisetron HCL, 100 mcg (eligible for pass-through payments)  
0765 = Granisetron HCL, 1mg Oral (eligible for pass-through payments)  
0768 = Ondansetron Hydrochloride per 1 mg Injection (eligible for pass-through payments)  
0769 = Ondansetron Hydrochloride 8 mg oral (eligible for pass-through payments)  
0800 = Leuprolide Acetate per 3.75 mg (eligible for pass-through payments)  
0801 = Cyclophosphamide (eligible for pass-through payments)  
0802 = Etoposide (eligible for pass-through payments)  
0803 = Melphalan (eligible for pass-through payments)  
0807 = Aldesleukin single use vial (eligible for pass-through payments)  
0809 = BCG (Intravesical) one vial (eligible for pass-through payments)  
0810 = Goserelin Acetate Implant, per 3.6 mg (eligible for pass-through payments)  
0811 = Carboplatin 50 mg (eligible for pass-through payments)

0812 = Carmustine 100 mg (eligible for pass-through payments)  
0813 = Cisplatin 10 mg (eligible for pass-through payments)  
0814 = Asparaginase, 10,000 units (eligible for pass-through payments)  
0815 = Cyclophosphamide 100 mg (eligible for pass-through payments)  
0816 = Cyclophosphamide, Lyophilized 100 mg (eligible for pass-through payments)  
0817 = Cytrabine 100 mg (eligible for pass-through payments)  
0818 = Dactinomycin 0.5 mg (eligible for pass-through payments)  
0819 = Dacarbazine 100 mg (eligible for pass-through payments)  
0820 = Daunorubicin HCl 10 mg (eligible for pass-through payments)  
0821 = Daunorubicin Citrate, Liposomal Formulation, 10 mg (eligible for pass-through payments)  
0822 = Diethylstilbestrol Diphosphate 250 mg (eligible for pass-through payments)  
0823 = Docetaxel 20 mg (eligible for pass-through payments)  
0824 = Etoposide 10 mg (eligible for pass-through payments)  
0826 = Methotrexate Oral 2.5 mg (eligible for pass-through payments)  
0827 = Floxuridine injection 500mg  
0828 = Gemcitabine HCL 200 mg (eligible for pass-through payments)  
0830 = Irinotecan 20 mg (eligible for pass-through payments)  
0831 = Ifosfamide injection 1 gm (eligible for pass-through payments)  
0832 = Idarubicin HCL injection 5 mg (eligible for pass-through payments)  
0833 = Interferon Alfacon-1, 1 mcg (eligible for pass-through payments)  
0834 = Interferon, Alfa-2A, Recombinant 3 million units (eligible for pass-through payments)  
0836 = Interferon, Alfa-2B, Recombinant, 1 million units (eligible for pass-through payments)  
0838 = Interferon, Gamma 1-B injection, 3 million units (eligible for pass-through payments)  
0839 = Mechlorethamine HCL injection 10 mg (eligible for pass-through payments)  
0840 = Melphalan HCL 50 mg (eligible for pass-through payments)  
0841 = Methotrexate sodium injection 5 mg (eligible for pass-through payments)  
0842 = Fludarabine Phosphate injection 50 mg (eligible for pass-through payments)  
0843 = Pegaspargase, single dose vial (eligible for

pass-through payments)  
0844 = Pentostatin injection, 10 mg (eligible for pass-through payments)  
0847 = Doxorubicin HCL 10 mg (eligible for pass-through payments)  
0849 = Rituximab, 100 mg (eligible for pass-through payments)  
0850 = Streptozocin injection, 1 gm (eligible for pass-through payments)  
0851 = Thiotepa injection, 15 mg (eligible for pass-through payments)  
0852 = Topotecan 4 mg (eligible for pass-through payments)  
0853 = Vinblastine Sulfate injection, 1 mg (eligible for pass-through payments)  
0854 = Vincristine Sulfate 1 mg (eligible for pass-through payments)  
0855 = Vinorelbine Tartrate per 10 mg (eligible for pass-through payments)  
0856 = Porfimer Sodium 75 mg (eligible for pass-through payments)  
0857 = Bleomycin Sulfate injection 15 units (eligible for pass-through payments)  
0858 = Cladribine, 1mg (eligible for pass-through payments)  
0859 = Fluorouracil injection 500 mg  
0860 = Plicamycin (mithramycin) injection, 2.5 mg  
0861 = Leuprolide Acetate 1 mg (eligible for pass-through payments)  
0862 = Mitomycin, 5mg (eligible for pass-through payments)  
0863 = Paclitaxel, 30mg (eligible for pass-through payments)  
0864 = Mitoxantrone HCl, per 5mg (eligible for pass-through payments)  
0865 = Interferon alfa-N3, 250,000 IU (eligible for pass-through payments)  
0884 = Rho (D) Immune Globulin, Human one dose pack (eligible for pass-through payments)  
0886 = Azathioprine, 50 mg oral  
(Not subject to national coinsurance)  
0887 = Azathioprine, Parenteral 100 mg, 20 ml each injection  
(Not subject to national coinsurance)  
0888 = Cyclosporine, Oral 100 mg  
(Not subject to national coinsurance)  
0889 = Cyclosporine, Parenteral  
(Not subject to national coinsurance)  
0890 = Lymphocyte Immune Globulin 250 mg  
(Not subject to national coinsurance)  
0891 = Tacrolimus per 1 mg oral  
(Not subject to national coinsurance)  
0892 = Daclizumab, Parenteral, 25 mg (obsolete 1/01)  
(eligible for pass-through payments)  
0900 = Injection, Alglucerase per 10 units  
(eligible for pass-through payments)  
0901 = Alpha I, Proteinase Inhibitor, Human per 10mg  
(eligible for pass-through payments)  
0902 = Botulinum Toxin, Type A per unit

(eligible for pass-through payments)  
0903 = CMV Immune Globulin (obsolete 12/00);  
Cytomegalovirus imm IV, vial  
(eligible for pass-through payments) (eff. 1/01)  
0905 = Immune Globulin per 500 mg  
(eligible for pass-through payments)  
0906 = RSV-ivig 50 mg  
(eligible for pass-through payments)  
0907 = Ganciclovir Sodium 500 mg injection  
(Not subject to national coinsurance)  
0908 = Tetanus Immune Globulin, injection up to 250 units  
(Not subject to national coinsurance)  
0909 = Interferon Beta - 1a 33 mcg (eligible for pass-through payments)  
0910 = Interferon Beta - 1b 0.25 mg (eligible for pass-through payments)  
0911 = Streptokinase per 250,000 iu  
(Not subject to national coinsurance)  
0913 = Ganciclovir long act implant 4.5 mg (eligible for pass-through payments)  
0914 = Reteplase, 37.6 mg  
(Not subject to national coinsurance)  
0915 = Alteplase injection, recombinant, 10mg  
(Not subject to national coinsurance)  
0916 = Imiglucerase per unit (eligible for pass-through payments)  
0917 = Dipyridamole, 10mg / Adenosine 6MG  
(Not subject to national coinsurance) (obsolete 1/01)  
Pharmacologic stresses (eff. 1/01)  
0918 = Brachytherapy Seeds, Any type, Each (eligible for pass-through payments) (obsolete 4/01)  
0925 = Factor VIII (Antihemophilic Factor, Human) per iu (eligible for pass-through payments)  
0926 = Factor VIII (Antihemophilic Factor, Porcine) per iu (eligible for pass-through payments)  
0927 = Factor VIII (Antihemophilic Factor, Recombinant) per iu (eligible for pass-through payments)  
0928 = Factor IX, Complex (eligible for pass-through payments)  
0929 = Other Hemophilia Clotting Factors per iu (eligible for pass-through payments) (obsolete 1/01)  
Anti-inhibitor per iu (eff. 1/01)  
0930 = Antithrombin III (Human) per iu (eligible for pass-through payments)  
0931 = Factor IX (Antihemophilic Factor, Purified, Non-Recombinant) (eligible for pass-through payments)  
0932 = Factor IX (Antihemophilic Factor, Recombinant) (eligible for pass-through payments)  
0949 = Plasma, Pooled Multiple Donor, Solvent/Detergent Treated, Frozen (not subject to national coinsurance)  
0950 = Blood (Whole) For Transfusion (not subject to national coinsurance)  
0952 = Cryoprecipitate (not subject to national coinsurance)  
0953 = Fibrinogen Unit (not subject to national coinsurance)

0954 = Leukocyte Poor Blood (not subject to national coinsurance)  
0955 = Plasma, Fresh Frozen (not subject to national coinsurance)  
0956 = Plasma Protein Fraction (not subject to national coinsurance)  
0957 = Platelet Concentrate (not subject to national coinsurance)  
0958 = Platelet Rich Plasma (not subject to national coinsurance)  
0959 = Red Blood Cells (not subject to national coinsurance)  
0960 = Washed Red Blood Cells (not subject to national coinsurance)  
0961 = Infusion, Albumin (Human) 5%, 500 ml (not subject to national coinsurance)  
0962 = Infusion, Albumin (Human) 25%, 50 ml (not subject to national coinsurance)  
0970 = New Technology - Level I (\$0 - \$50) (not subject to national coinsurance)  
0971 = New Technology - Level II (\$50 - \$100) (not subject to national coinsurance)  
0972 = New Technology - Level III (\$100 - \$200) (not subject to national coinsurance)  
0973 = New Technology - Level IV (\$200 - \$300) (not subject to national coinsurance)  
0974 = New Technology - Level V (\$300 - \$500) (not subject to national coinsurance)  
0975 = New Technology - Level VI (\$500 - \$750) (not subject to national coinsurance)  
0976 = New Technology - Level VII (\$750 - \$1000) (not subject to national coinsurance)  
0977 = New Technology - Level VIII (\$1000 - \$1250) (not subject to national coinsurance)  
0978 = New Technology - Level IX (\$1250 - \$1500) (not subject to national coinsurance)  
0979 = New Technology - Level X (\$1500 - \$1750) (not subject to national coinsurance)  
0980 = New Technology - Level XI (\$1750 - \$2000) (not subject to national coinsurance)  
0981 = New Technology - Level XII (\$2000 - \$2500) (not subject to national coinsurance)  
0982 = New Technology - Level XIII (\$2500 - \$3500) (not subject to national coinsurance)  
0983 = New Technology - Level XIV (\$3500 - \$5000) (not subject to national coinsurance)  
0984 = New Technology - Level XV (\$5000 - \$6000) (not subject to national coinsurance)  
0987 = New Device Technology - Level I (\$0 - \$250) (eff. 1/01)  
0988 = New Device Technology - Level II (\$250 - \$500) (eff. 1/01)  
0989 = New Device Technology - Level III (\$500 - \$750) (eff. 1/01)  
0990 = New Device Technology - Level IV (\$750 - \$1000)

(eff. 1/01)  
0991 = New Device Technology - Level V (\$1000 - \$1500)  
(eff. 1/01)  
0992 = New Device Technology - Level VI (\$1500 - \$2000)  
(eff. 1/01)  
0993 = New Device Technology - Level VII (\$2000 - \$3000)  
(eff. 1/01)  
0994 = New Device Technology - Level VIII (\$3000 - \$4000)  
(eff. 1/01)  
0995 = New Device Technology - Level IX (\$4000 - \$5000)  
(eff. 1/01)  
0996 = New Device Technology - Level X (\$5000 - \$7000)  
(eff. 1/01)  
0997 = New Device Technology - Level XI (\$7000 - \$9000)  
(eff. 1/01)  
1000 = Perclose Closer Prostar Arterial Vascular  
Closure (eff. 1/01)  
1001 = AcuNav-diagnostic ultrasound ca (eff. 1/01)  
1002 = Cochlear Implant System (eff. 1/01)  
1003 = Cath, ablation, livewire TC (eff. 1/01)  
1004 = Fast-Cath, Swartz, SAFL, CSTA (eff. 1/01)  
1006 = ARRAY post chamb IOL (eff. 1/01)  
1007 = Ams 700 penile prosthesis (eff. 1/01)  
1008 = Urolume-implant urethral stent (eff. 1/01)  
1009 = Plasma, cryoprecipitate-reduced, unit  
(eff. 1/01)  
1010 = Blood, L/R CMV-neg (eff. 1/01)  
1011 = Platelets, L/R, CMV-neg (eff. 1/01)  
1012 = Platelet concentrate, L/R, irradiated, unit  
(eff. 1/01)  
1013 = Platelet concentrate, L/R, unit (eff. 1/01)  
1014 = Platelets, aph/pher, L/R, unit (eff. 1/01)  
1016 = Blood, L/R, froz/deglycerol/washed (eff. 1/01)  
1017 = Platelets, aph/pher, L/R CMV-neg, unit  
(eff. 1/01)  
1018 = Blood, L/R, irradiated (eff. 1/01)  
1019 = Platelets, aph/pher, L/R, irradiated, unit  
(eff. 1/01)  
1024 = Quinupristin 150 mg/dalfopriston 350 mg  
(eff. 1/01)  
1025 = Marindr CS catheter (eff. 1/01)  
1026 = RF Perfrmr cath 5F RF Marindr (eff. 1/01)  
1027 = Magic x/short, radius 14m (eff. 1/01)  
1028 = Precis Twst trnsvg anch sys (eff. 1/01)  
1029 = CRE guided balloon dil cath (eff. 1/01)  
1030 = Cthtr:Mrshal, Blu Max Utr Dmnd (eff. 1/01)  
1033 = Sonicath mdl 37-410 (eff. 1/01)  
1034 = SURPASS, Long30 SURPASS-cath (eff. 1/01)  
1035 = Cath, Ultra ICE (eff. 1/01)  
1036 = R port/reservior impl dev (eff. 1/01)  
1037 = Vaxcelchronic dialysis cath (eff. 1/01)  
1038 = UltraCross Imaging Cath (eff. 1/01)  
1039 = Wallstent/RP:Trach (eff. 1/01)  
1040 = Wallstent/RP TIPS -- 20/40/60 (eff. 1/01)

1042 = Wallstent, UltraFlex: Bil (eff. 1/01)  
1045 = I-131 MIBG (ioben-sulfate) 0.5mCi  
(eff. 1/01)  
1047 = Navi-Star, Noga-Star cath (eff. 1/01)  
1048 = NeuroCyberneticPros: gen (eff. 1/01)  
1051 = Oasis Thrombectomy Cath (eff. 1/01)  
1053 = EnSite 3000 catheter (eff. 1/01)  
1054 = Hydrolyser Thromb Cath 6/7F (eff. 1/01)  
1055 = Transesoph 210, 210-S Cath (eff. 1/01)  
1056 = Thermachoice II Cath (eff. 1/01)  
1057 = Micromark Tissue Marker (eff. 1/01)  
1059 = Carticel, auto cult-chndr cyte (eff. 1/01)  
1060 = ACS multi-link tristor stent (eff. 1/01)  
1061 = ACS Viking Guiding cath (eff. 1/01)  
1063 = EndoTak Endurance EZ,RX leads (eff. 1/01)  
1067 = Megalink biliary stent (eff. 1/01)  
1068 = Pulsar DDD pmkr (eff. 1/01)  
1069 = Discovery DR, pmaker  
1071 = Pulsar Max, Pulsar SR pmkr (eff. 1/01)  
1072 = Guidant: bln dil cath (eff. 1/01)  
1073 = Gynecare Morcellator (eff. 1/01)  
1074 = RX/OTW Viatrac-peri dil cath (eff. 1/01)  
1075 = Guidant: lead (eff. 1/01)  
1076 = Ventak minisc defib (eff. 1/01)  
1077 = Ventak VR Prizm VR, sc defib (eff. 1/01)  
1078 = Ventak: Prizm, AVIIIDR defib  
1079 = CO 57/58 0.5 mCi (eff. 1/01)  
1084 = Denileukin diftitox, 300 mcg (eff. 1/01)  
1086 = Temozolomide, 5 mg (eff. 1/01)  
1087 = I-123 per uCi capsule (eff. 1/01)  
1089 = CO 57, 0.5 mCi (eff. 1/01)  
1090 = IN 111 Chloride, per mCi (eff. 1/01)  
1091 = IN 111 Oxyquinoline, per 5 mCi (eff. 1/01)  
1092 = IN 111 Pentetate, per 1.5 mCi (eff. 1/01)  
1094 = TC 99M Albumin aggr, per vial  
1095 = TC 99M Depreotide, per vial (eff. 1/01)  
1096 = TC 99M Exametazime, per dose (eff. 1/01)  
1097 = TC 99M Mebrofenin, per vial (eff. 1/01)  
1098 = TC 99M Pentetate, per vial (eff. 1/01)  
1099 = TC 99M Pyrophosphate, per vial (eff. 1/01)  
1100 = Medtronic AVE GT1 guidewire (eff. 1/01)  
1101 = Medtronic AVE, AVE Z2 cath (eff. 1/01)  
1102 = Synergy Neurostim Genrtr (eff. 1/01)  
1103 = Micro Jewell Defibrillator (eff. 1/01)  
1104 = RF ConductorAblative Cath (eff. 1/01)  
1105 = Sigman 300VDD pacmkr (eff. 1/01)  
1106 = SynergyEZ Pt Progmr (eff. 1/01)  
1107 = Torqr, Solist cath (eff. 1/01)  
1108 = Reveal Cardiac Recorder (eff. 1/01)  
1109 = Implantable anchor: Ethicon (eff. 1/01)  
1110 = Stable Mapper, cath electrd (eff. 1/01)  
1111 = AneuRxAort-Uni-llicstnt & cath (eff. 1/01)  
1112 = AneuRx Stent graft/del cath (eff. 1/01)  
1113 = Tlnt Endo Sprng Stnt Grft Sys (eff. 1/01)

1114 = TalntSprgStnt + Graf endo pros (eff. 1/01)  
1115 = 5038S, 5038, 5038L pace lead (eff. 1/01)  
1116 = CapSureSP pacing lead (eff. 1/01)  
1117 = Ancure Endograft Del Sys (eff. 1/01)  
1118 = Sigma300DR LegIIDR, pacemkr (eff. 1/01)  
1119 = Sprint6932, 6943 defib lead (eff. 1/01)  
1120 = Sprint6942, 6945 defi lead (eff. 1/01)  
1121 = Gem defibrillator (eff. 1/01)  
1122 = TC 99M arcitumomab per dose (eff. 1/01)  
1123 = Gem II VR defibrillator (eff. 1/01)  
1124 = InterStim Test Stim Kit (eff. 1/01)  
1125 = Kappa 400SR, Ttopaz II SR pmkr (eff. 1/01)  
1126 = Kappa 700 DR pacemkr (eff. 1/01)  
1127 = Kappa 700SR, pmkr sgl chamber (eff. 1/01)  
1128 = Kappa 700D, Ruby IID pmkr (eff. 1/01)  
1129 = Kappa 700VDD, pacmkr (eff. 1/01)  
1130 = Sigma 200D, LGCY IID sc pmkr (eff. 1/01)  
1131 = Sigma 200DR pmker (eff. 1/01)  
1132 = Sigma 200SR Leg II:sc pac (eff. 1/01)  
1133 = Sigma SR, Vita SR, pmaker (eff. 1/01)  
1134 = Sigma 300D pmker (eff. 1/01)  
1135 = Entity DR 5326L/R, DC, pmkr (eff. 1/01)  
1136 = Affinity DR 5330L/R, DC, pmkr (eff. 1/01)  
1137 = CardioSEAL implant syst (eff. 1/01)  
1143 = AddVent mod 2060BL, VDD (eff. 1/01)  
1144 = Afnty SP 5130, Integrity SR, pmkr (eff. 1/01)  
1145 = Angio-Seal 6fr, 8fr (eff. 1/01)  
1147 = AV Plus DX 1368: lead (eff. 1/01)  
1148 = Contour MD sc defib (eff. 1/01)  
1149 = Entity DC 5226R-pmker (eff. 1/01)  
1151 = Passiveplus DXlead, 10mdls (eff. 1/01)  
1152 = LifeSite Access System (eff. 1/01)  
1153 = Regency SC+ 2402L pmkr (eff. 1/01)  
1154 = SPL:SPOI, 0204- defib lead (eff. 1/01)  
1155 = Repliform 8 sq cm (eff. 1/01)  
1156 = Tr 1102TrSR+ 2260L, 2264L, 5131 (eff. 1/01)  
1157 = Trilogy DCT 23/8L pmkr (eff. 1/01)  
1158 = TVL lead SV01, SV02, SV04 (eff. 1/01)  
1159 = TVL RV02, RV06, RV07: lead (eff. 1/01)  
1160 = TVL-ADX 1559: lead (eff. 1/01)  
1161 = Tendril DX, 1338 pacing lead (eff. 1/01)  
1162 = TempoDr, TrilogyDR+ DC pmkr (eff. 1/01)  
1163 = Tendril SDX, 1488T pacing lead (eff. 1/01)  
1164 = Iodine-125 brachytx seed (eff. 1/01)  
1166 = Cytarabine liposomal, 10 mg (eff. 1/01)  
1167 = Epirubicin hcl, 2 mg (eff. 1/01)  
1171 = Autosuture site marker stple (eff. 1/01)  
1172 = Spacemaker dissect ballon (eff. 1/01)  
1173 = Cor stntS540, S670, o-wire stn (eff. 1/01)  
1174 = Bard brachytx needle (eff. 1/01)  
1178 = Busulfan IV, 6 mg (eff. 1/01)  
1180 = Vigor SR, SC, pmkr (eff. 1/01)  
1181 = Meridian SSI, SC pmkr (eff. 1/01)  
1182 = Pulsar SSI, SC, pmkr (eff. 1/01)



1183 = Jade IIS, Sigma 300S, SC, pmkr (eff. 1/01)  
1184 = Sigma 200S, SC, pmkr (eff. 1/01)  
1188 = I 131, per mCi (eff. 1/01)  
1200 = TC 99M Sodium Clucoheptonate, per vial  
(eff. 1/01)  
1201 = TC 99M succimer, per vial (eff. 1/01)  
1202 = TC 99M Sulfur Colloid, per dose (eff. 1/01)  
1203 = Verteporfin for Injection (eff. 1/01)  
1205 = TC 99M Disofenin, per vial (eff. 1/01)  
1207 = Octreotide acetate depot 1 mg (eff. 1/01)  
1302 = SQ01:lead (eff. 1/01)  
1303 = CapSure Fix 6940/4068-110, lead (eff. 1/01)  
1304 = Sonicath mdl 37-416,-418 (eff. 1/01)  
1305 = Apligraf (eff. 1/01)  
1306 = NeuroCyberneticsPros: lead (eff. 1/01)  
1311 = Trilogy DR + DAO pmkr (eff. 1/01)  
1312 = Magic WALLSTENT stent-mini (eff. 1/01)  
1313 = Magic medium, radius 31mm (eff. 1/01)  
1314 = Magic WALLSTENT stent-Long (eff. 1/01)  
1315 = Vigor DR, Meridian DR pmkr (eff. 1/01)  
1316 = Meridian DDD pmkr (eff. 1/01)  
1317 = Discovery SR, pmkr (eff. 1/01)  
1318 = Meridian SR pmkr (eff. 1/01)  
1319 = Wallstent/RP Enteral--60mm (eff. 1/01)  
1320 = Wallstent/RP Iliac Del Sys (eff. 1/01)  
1325 = Pallidium - 103 seed (eff. 1/01)  
1326 = Angio-jet rheolytic thromb cath (eff. 1/01)  
1328 = ANS Renew NS trnsmt (eff. 1/01)  
1333 = PALMZA Corinthian bill stent (eff. 1/01)  
1334 = Crown, Mini-crown,CrossLC (eff. 1/01)  
1335 = Mesh, Prolene (eff. 1/01)  
1336 = Constant Flow Imp Pump (eff. 1/01)  
1337 = IsoMed 8472-20/35/60 (eff. 1/01)  
1348 = I 131 per mCi solution (eff. 1/01)  
1350 = Prosta/OncoSeed, RAPID strand, I-125 (eff. 1/01)  
1351 = CapSure (Fix) pacing lead (eff. 1/01)  
1352 = Gem II defib (eff. 1/01)  
1353 = Itrel Interstm neurostim + ext (eff. 1/01)  
1354 = Kappa 400DR, Diamond II 820 DR (eff. 1/01)  
1355 = Kappa 600 DR, Vita DR (eff. 1/01)  
1356 = Profile MD V-186HV3 sc defib (eff. 1/01)  
1357 = Angstrom MD V-190HV3 sc defib (eff. 1/01)  
1358 = Affinity DC 5230R-Pacemaker (eff. 1/01)  
1359 = Pulsar, Pulsar Max DR, pmkr (eff. 1/01)  
1363 = Gem DR, DC, defib (eff. 1/01)  
1364 = Photon DR V-230HV3 DC defib (eff. 1/01)  
1365 = Guidewire, Hi-Torque 14/18/35 (eff. 1/01)  
1366 = Guidewire, PTCA, Hi-Torque (eff. 1/01)  
1367 = Guidewire, Hi-Torque Crosslt (eff. 1/01)  
1369 = ANS Renew Stim Sys recvr (eff. 1/01)  
1370 = Tension-Free Vaginal Tape (eff. 1/01)  
1371 = Symp Nitinol Transhep Bil Sys (eff. 1/01)  
1372 = Cordis Nitinol bil Stent (eff. 1/01)  
1375 = Stent, coronary, NIR (eff. 1/01)

1376 = ANS Renew Stim Sys lead (eff. 1/01)  
1377 = Specify 3988 neuro lead (eff. 1/01)  
1378 = InterStim Tx 3080/3886 lead (eff. 1/01)  
1379 = Pisces-Quad 3887 lead (eff. 1/01)  
1400 = Diphenhydramine hcl 50 mg (eff. 1/01)  
1401 = Prochlorperazine maleate 5 mg (eff. 1/01)  
1402 = Promethazine hcl 12.5 mg oral (eff. 1/01)  
1403 = Chlorpromazine hcl 10mg oral (eff. 1/01)  
1404 = Trimethobenzamide hcl 250mg (eff. 1/01)  
1405 = Thiethylperazine maleate 10 mg (eff. 1/01)  
1406 = Perphenazine 4 mg oral (eff. 1/01)  
1407 = Hydroxyzine pamoate 25 mg (eff. 1/01)  
1409 = Factor via recombinant, per 1.2 mg (eff. 1/01)  
1410 = Prosorba column (eff. 1/01)  
1411 = Herculink, OTW SDS bil stent (eff. 1/01)  
1420 = StapleTac2 Bone w/Dermis (eff. 1/01)  
1421 = StapleTac2 Bone w/o Dermis (eff. 1/01)  
1450 = Orthosphere Arthroplasty (eff. 1/01)  
1451 = Orthosphere Arthroplasty Kity (eff. 1/01)  
1500 = Atherectomy sys, peripheral (eff. 1/01)  
1600 = TC 99M sestamibi, per syringe (eff. 1/01)  
1601 = TC 99M medronate, per dose (eff. 1/01)  
1602 = TC 99M apcitide, per vial (eff. 1/01)  
1603 = TL 201, mCi (eff. 1/01)  
1604 = IN 111 capromab pendetide, per dose (eff. 1/01)  
1605 = Abciximab injection, 10 mg (eff. 1/01)  
1606 = Anistreplase, 30 u (eff. 1/01)  
1607 = Eptifibatide injection, 5 mg (eff. 1/01)  
1608 = Etanercept injection, 25 mg (eff. 1/01)  
1609 = Rho(D) Immune globulin h, sd 100 iu (eff. 1/01)  
1611 = Hylan G-F 20 injection, 16 mg (eff. 1/01)  
1612 = Daclizumab, parenteral, 25 mg (eff. 1/01)  
1613 = Trastuzumab, 10 mg (eff. 1/01)  
1614 = Valrubicin, 200 mg (eff. 1/01)  
1615 = Basiliximab, 20 mg (eff. 1/01)  
1616 = Histrelin Acetate, 0.5 mg (eff. 1/01)  
1617 = Lepirdin, 50 mg (eff. 1/01)  
1618 = Von Willebrand factor, per iu (eff. 1/01)  
1619 = Ga 67, per mCi (eff. 1/01)  
1620 = TC 99M Bicisate, per vial (eff. 1/01)  
1621 = Xe 133, per mCi (eff. 1/01)  
1622 = TC 99M Mertiatide, per vial (eff. 1/01)  
1623 = TC 99M Gluceptate (eff. 1/01)  
1624 = P32 sodium, per mCi (eff. 1/01)  
1625 = IN 111 Pentetreotide, per mCi (eff. 1/01)  
1626 = TC 99M Oxidronate, per vial (eff. 1/01)  
1627 = TC-99 labeled red blood cell, per test (eff. 1/01)  
1628 = P32 phosphate chromic, per mCi (eff. 1/01)  
1700 = Authen Mick TP brachy needle (eff. 1/01)  
(obsolete 4/01)  
1701 = Medtec MT-BT-5201-25 ndl (eff. 1/01)  
(obsolete 4/01)  
1702 = WWMT brachytx needle (eff. 1/01)  
(obsolete 4/01)

1703 = Mentor Prostate Brachy (eff. 1/01)  
(obsolete 4/01)  
1704 = MT-BT-5001-25/5051-25 (eff. 1/01)  
(obsolete 4/01)  
1705 = Best Flexi Brachy Needle (eff. 1/01)  
(obsolete 4/01)  
1706 = Indigo Prostate Seeding Ndl (eff. 1/01)  
(obsolete 4/01)  
1707 = Varisource Implt Ndl (eff. 1/01)  
(obsolete 4/01)  
1708 = UroMed Prostate Seed Ndl (eff. 1/01)  
(obsolete 4/01)  
1709 = Remington Brachytx Needle (eff. 1/01)  
(obsolete 4/01)  
1710 = US Biopsy Prostate Needle (eff. 1/01)  
(obsolete 4/01)  
1711 = MD Tech brachytx needle (eff. 1/01)  
(obsolete 4/01)  
1712 = Imagyn brachytx needle (eff. 1/01)  
(obsolete 4/01)  
1713 = Anchor/screw bn/bn,tis/bn (eff. 4/01)  
1714 = Cath, trans atherectomy, dir (eff. 4/01)  
1715 = Brachytherapy needle (eff. 4/01)  
1716 = Brachytx seed, Gold 198 (eff. 4/01)  
1717 = Brachytx seed, HDR Ir-192 (eff. 4/01)  
1718 = Brachytx seed, Iodine 125 (eff. 4/01)  
1719 = Brachytx seed, Non-HDR Ir-192 (eff. 4/01)  
1720 = Brachytx, Palladium 103 (eff. 4/01)  
1721 = AICD, dual chamber (eff. 4/01)  
1722 = AICD, single chamber (eff. 4/01)  
1723 = Cath, ablation, non-cardiac (eff. 4/01)  
1724 = Cath, trans atherec, rotation (eff. 4/01)  
1725 = Cath, translumin non-laser (eff. 4/01)  
1726 = Cath, bal dil, non-vascular (eff. 4/01)  
1727 = Cath, bal tis, dis, nonvas (eff. 4/01)  
1728 = Cath, brachytx seed adm (eff. 4/01)  
1729 = Cath, drainage, biliary (eff. 4/01)  
1730 = Cath, EP, 19 or fewer elect (eff. 4/01)  
1731 = Cath, EP, 20 or more elect (eff. 4/01)  
1732 = Cath, EP, diag/abl, 3D/vect (eff. 4/01)  
1733 = Cath, EP, other than temp (eff. 4/01)  
1750 = Cath, hemodialysis, long-term (eff. 4/01)  
1751 = Cath, inf pr/cent/midline (eff. 4/01)  
1752 = Cath, hemodialysis, short-term (eff. 4/01)  
1753 = Cath, intravas ultrasound (eff. 4/01)  
1754 = Catheter, intradiscal (eff. 4/01)  
1755 = Catheter, intraspinal (eff. 4/01)  
1756 = Cath, pacing, transesoph (eff. 4/01)  
1757 = Cath, thrombectomy/embolect (eff. 4/01)  
1758 = Cath, ureteral (eff. 4/01)  
1759 = Cath, intra echocardiography (eff. 4/01)  
1760 = Closure dev, vasc, imp/insert (eff. 4/01)  
1762 = Conn tiss, human (inc fascia) (eff. 4/01)  
1763 = Conn tiss, non-human (eff. 4/01)

1764 = Event recorder, cardiac (eff. 4/01)  
1767 = Generator, neurostim, imp (eff. 4/01)  
1768 = Graft, vascular (eff. 4/01)  
1769 = Guide wire (eff. 4/01)  
1770 = Imaging coil, MR insertable (eff. 4/01)  
1771 = Rep dev, urinary , w/sling (eff. 4/01)  
1772 = Infusion pump, programmable (eff. 4/01)  
1773 = Retrieval dev, insert (eff. 4/01)  
1776 = Joint device (implantable) (eff. 4/01)  
1777 = Lead, AICD, endo single coil (eff. 4/01)  
1778 = Lead, neurostimulator (eff. 4/01)  
1779 = Lead, pmkr, transvenous VDD (eff. 4/01)  
1780 = Lens, intraocular (eff. 4/01)  
1781 = Mesh (implantable) (eff. 4/01)  
1782 = Morcellator (eff. 4/01)  
1784 = Ocular dev, intraop, det ret (eff. 4/01)  
1785 = Pmkr, dual, rate- resp (eff. 4/01)  
1786 = Pmkr, single, rate- resp (eff. 4/01)  
1787 = Patient progr, neurostim (eff. 4/01)  
1788 = Port, indwelling, imp (eff. 4/01)  
1789 = Prosthesis, breast, imp. (eff. 4/01)  
1790 = Iridium 192 HDR (eff. 1/01)  
(obsolete 4/01)  
1791 = OncoSeed, Rapid Strand I-125 (eff. 1/01)  
(obsolete 4/01)  
1792 = UroMed I-125 Brachy seed (eff. 1/01)  
(obsolete 4/01)  
1793 = Bard InterSource P-103 seed (eff. 1/01)  
(obsolete 4/01)  
1794 = Bard IsoSeed P-103 seed (eff. 1/01)  
(obsolete 4/01)  
1795 = Bard BrachySource I-125 (eff. 1/01)  
(obsolete 4/01)  
1796 = Source Tech Med I-125 (eff. 1/01)  
(obsolete 4/01)  
1797 = Draximage I-125 seed (eff. 1/01)  
(obsolete 4/01)  
1798 = Syncor I-125 PharmaSeed (eff. 1/01)  
(obsolete 4/01)  
1799 = I-Plant I-125 Brachytx seed (eff. 1/01)  
(obsolete 4/01)  
1800 = Pd-103 brachytx seed (eff. 1/01)  
(obsolete 4/01)  
1801 = IoGold I-125 brachytx seed (eff. 1/01)  
(obsolete 4/01)  
1802 = Iridium 192 brachytx seed (eff. 1/01)  
(obsolete 4/01)  
1803 = Best Iodine 125 brachytx seeds (eff. 1/01)  
(obsolete 4/01)  
1804 = Best Palladium 103 seeds (eff. 1/01)  
(obsolete 4/01)  
1805 = IsoStar Iodine-125 seeds (eff. 1/01)  
(obsolete 4/01)  
1806 = Gold 198 (eff. 1/01)

(obsolete 4/01)  
1810 = D114S Dilatation Cath (eff. 1/01)  
(obsolete 4/01)  
1811 = Surgical Dynamics Anchors (eff. 1/01)  
(obsolete 4/01)  
1812 = OBL Anchors (eff. 1/01)  
(obsolete 4/01)  
1813 = Prosthesis, penile, inflatab (eff. 4/01)  
1815 = Pros, urinary sph, imp (eff. 4/01)  
1816 = Receiver/transmitter, neuro (eff. 4/01)  
1817 = Septal defect imp sys (eff. 4/01)  
1850 = Repliform 14/21 sq cm (eff. 1/01)  
(obsolete 4/01)  
1851 = Repliform 24/28 sq cm (eff. 1/01)  
(obsolete 4/01)  
1852 = TransCyte, per 247 sq cm (eff. 1/01)  
(obsolete 4/01)  
1853 = Suspend, per 8/14 sq cm (eff. 1/01)  
(obsolete 4/01)  
1854 = Suspend, per 24/28 sq cm (eff. 1/01)  
(obsolete 4/01)  
1855 = Suspend, per 36 sq cm (eff. 1/01)  
(obsolete 4/01)  
1856 = Suspend, per 48 sq cm (eff. 1/01)  
(obsolete 4/01)  
1857 = Suspend, per 84 sq cm (eff. 1/01)  
(obsolete 4/01)  
1858 = DuraDerm, per 8/14 sq cm (eff. 1/01)  
(obsolete 4/01)  
1859 = DuraDerm, per 21/24 sq cm (eff. 1/01)  
(obsolete 4/01)  
1860 = DuraDerm, per 48 sq cm (eff. 1/01)  
(obsolete 4/01)  
1861 = DuraDerm, per 36 sq cm (eff. 1/01)  
(obsolete 4/01)  
1862 = DuraDerm, per 72 sq cm (eff. 1/01)  
(obsolete 4/01)  
1863 = DuraDerm, per 84 sq cm (eff. 1/01)  
(obsolete 4/01)  
1864 = SpermaTex, per 13/44 sq cm (eff. 1/01)  
(obsolete 4/01)  
1865 = FasLata, per 8/14 sq cm (eff. 1/01)  
(obsolete 4/01)  
1866 = FasLata, per 24/28 sq cm (eff. 1/01)  
(obsolete 4/01)  
1867 = FasLata, per 36/48 sq cm (eff. 1/01)  
(obsolete 4/01)  
1868 = FasLata, per 96 sq cm (eff. 1/01)  
(obsolete 4/01)  
1869 = Gore Thyroplasty Dev (eff. 1/01)  
(obsolete 4/01)  
1870 = DermMatrix, per 16 sq cm (eff. 1/01)  
(obsolete 4/01)  
1871 = DermMatrix, 32 or 64 sq cm (eff. 1/01)

(obsolete 4/01)  
1872 = Dermagraft, per 37.5 sq cm (eff. 1/01)  
(obsolete 4/01)  
1873 = Bard 3DMax Mesh (eff. 1/01)  
(obsolete 4/01)  
1874 = Stent, coated/cov w/del sys (eff. 4/01)  
1875 = Stent, coated/cov w/o del sys (eff. 4/01)  
1876 = Stent, non-coated/no-cov w/del (eff. 4/01)  
1877 = Stent, non-coated/cov w/o del (eff. 4/01)  
1878 = Martl for vocal cord (eff. 4/01)  
1879 = Tissue marker, imp (eff. 4/01)  
1880 = Vena cava filter (eff. 4/01)  
1881 = Dialysis access system (eff. 4/01)  
1882 = AICD, other than sing/dual (eff. 4/01)  
1883 = Adapt/ext, pacing/neuro lead (eff. 4/01)  
1885 = Cath, translumin angio laser (eff. 4/01)  
1887 = Catheter, guiding (eff. 4/01)  
1891 = Infusion pump, non-prog, perm (eff. 4/01)  
1892 = Intro/sheath , fixed, peel-away (eff. 4/01)  
1893 = Intro/sheath, fixed, non-peel (eff. 4/01)  
1894 = Intro/sheath, non-laser (eff. 4/01)  
1895 = Lead, AICD, endo dual coil (eff. 4/01)  
1896 = Lead, AICD, non sing/dual (eff. 4/01)  
1897 = Lead, neurostim test kit (eff. 4/01)  
1898 = Lead, pmkr, other than trans (eff. 4/01)  
1899 = Lead, pmkr/AICD combination (eff. 4/01)  
1929 = Maverick PTCA Cath (eff. 1/01) (obsolete 4/01)  
1930 = Coyote Dil Cath, 20/30/40mm (eff. 1/01)  
(obsolete 4/01)  
1931 = Talon Dil Cath (eff. 1/01) (obsolete 4/01)  
1932 = Scimed remedy Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1933 = Opti-Plast XL/Centurion Cath (eff. 1/01)  
(obsolete 4/01)  
1934 = Ultraverse 3.5F Bal Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1935 = Workhorse PTA Bal Cath (eff. 1/01)  
(obsolete 4/01)  
1936 = Uromax Ultra Bal Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1937 = Synergy Balloon Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1938 = Uroforce Bal Dil Cath (eff. 1/01) (obsolete 4/01)  
1939 = Raptur, Ninja PTCA Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1940 = PowerFlex, OPTA 5/LP Bal Cath (eff. 1/01)  
(obsolete 4/01)  
1941 = Jupiter PTA Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1942 = Cordis Maxi LD PTA Bal Cath (eff. 1/01)  
(obsolete 4/01)  
1943 = RXCrossSail OTW OpenSail (eff. 1/01)  
(obsolete 4/01)  
1944 = Rapid Exchange Bil Dil Cath (eff. 1/01)

(obsolete 4/01)  
1945 = Savvy PTA Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1946 = R1s Rapid Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1947 = Gazelle Bal Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1948 = Pursuit Balloon Cath (eff. 1/01)  
(obsolete 4/01)  
1949 = Oracle Megasonics Cath (eff. 1/01)  
(obsolete 4/01)  
1979 = Visions PV/Avanar US Cath (eff. 1/01)  
(obsolete 4/01)  
1980 = Atlantis SR Coronary Cath (eff. 1/01)  
(obsolete 4/01)  
1981 = PTCA Catheters (eff. 1/01)  
(obsolete 4/01)  
2000 = Orbiter ST Steerable Cath (eff. 1/01)  
(obsolete 4/01)  
2001 = Constellation Diag Cath (eff. 1/01)  
(obsolete 4/01)  
2002 = Irvine 5F Inquiry Diag EP Cath (eff. 1/01)  
(obsolete 4/01)  
2003 = Irvine 6F Inquiry Diag EP Cath (eff. 1/01)  
(obsolete 4/01)  
2004 = Biosense EP Cath -- Octapolar (eff. 1/01)  
(obsolete 4/01)  
2005 = Biosense EP Cath -- Hexapolar (eff. 1/01)  
(obsolete 4/01)  
2006 = Biosense EP Cath -- Decapolar (eff. 1/01)  
(obsolete 4/01)  
2007 = Irvine 6F Luma-Cath EP Cath (eff. 1/01)  
(obsolete 4/01)  
2008 = 7F Luma-Cath EP Cath 81910-15 (eff. 1/01)  
(obsolete 4/01)  
2009 = Irvine 7F Luma-Cath EP Cath (eff. 1/01)  
(obsolete 4/01)  
2010 = Fixed Curve EP Cath (eff. 1/01)  
(obsolete 4/01)  
2011 = Deflectable Tip Cath--Quad (eff. 1/01)  
(obsolete 4/01)  
2012 = Celsius Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2013 = Celsius Large Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2014 = Celsius II Asym Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2015 = Celsius II Sym Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2016 = Navi-Star DS, Navi-Star Ther (eff. 1/01)  
(obsolete 4/01)  
2017 = Navi-Star Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2018 = Polaris T Ablation Cath (eff. 1/01)

(obsolete 4/01)  
2019 = EP Deflectable Cath (eff. 1/01)  
(obsolete 4/01)  
2020 = Blazer II XP Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2021 = SilverFlex EP Cath (eff. 1/01)  
(obsolete 4/01)  
2022 = CP Chilli Cooled Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2023 = Chilli Cld AblnCath-std, lg (eff. 1/01)  
(obsolete 4/01)  
2100 = CP CS Reference Cath (eff. 1/01)  
(obsolete 4/01)  
2102 = CP Radii 7F EP Cath (eff. 1/01)  
(obsolete 4/01)  
2103 = CP Radii 7F EP Cath w/Track (eff. 1/01)  
(obsolete 4/01)  
2104 = Lasso Deflectable Cath (eff. 1/01)  
(obsolete 4/01)  
2151 = Veripath Guiding Cath (eff. 1/01)  
(obsolete 4/01)  
2152 = Cordis Vista Brite Tip Cath (eff. 1/01)  
(obsolete 4/01)  
2153 = Bard Viking Cath (eff. 1/01)  
(obsolete 4/01)  
2200 = Arrow-Trerotola PTD Cath (eff. 1/01)  
(obsolete 4/01)  
2300 = Varisource Stnd Catheters (eff. 1/01)  
(obsolete 4/01)  
2597 = Clinicath/kit 16/18 sgl/dbl (eff. 1/01)  
(obsolete 4/01)  
2598 = Clinicath 18/20/24-G single (eff. 1/01)  
(obsolete 4/01)  
2599 = Clinicath 16/18-G-double (eff. 1/01)  
(obsolete 4/01)  
2601 = Bard DL Ureteral Cath (eff. 1/01)  
(obsolete 4/01)  
2602 = Vitesse Laser Cath 1.4/1.7mm (eff. 1/01)  
(obsolete 4/01)  
2603 = Vitesse Laser Cath 2.0mm (eff. 1/01)  
(obsolete 4/01)  
2604 = Vitesse E Laser Cath 2.0mm (eff. 1/01)  
(obsolete 4/01)  
2605 = Extreme Laser Catheter (eff. 1/01)  
(obsolete 4/01)  
2606 = SpineCath XL Catheter (eff. 1/01)  
(obsolete 4/01)  
2607 = SpineCath Intradiscal Cath (eff. 1/01)  
(obsolete 4/01)  
2608 = Scimed 6F Wiseguide Cath (eff. 1/01)  
(obsolete 4/01)  
2609 = Flexima Bil Draingage Cath (eff. 1/01)  
(obsolete 4/01)  
2610 = FlexTipPlus Intraspinal Cath (eff. 1/01)



(obsolete 4/01)  
2611 = AlgoLine Intraspinal Cath (eff. 1/01)  
(obsolete 4/01)  
2612 = InDura Catheter (eff. 1/01)  
(obsolete 4/01)  
2615 = Sealant, pulmonary, liquid (eff. 4/01)  
2616 = Brachytx seed, Yttrium-90 (eff. 4/01)  
2617 = Stent, non-cor, tem w/o del (eff. 4/01)  
2618 = Probe, cryoablation (eff. 4/01)  
2619 = Pmkr, dual, non rate-resp (eff. 4/01)  
2620 = Pmkr, single, non rate-resp (eff. 4/01)  
2621 = Pmkr, other than single/dual (eff. 4/01)  
2622 = Prosthesis, penile, non-inf (eff. 4/01)  
2625 = Stent, non-cor , tem w/del sys (eff. 4/01)  
2626 = Infusion pump, non-prog, temp (eff. 4/01)  
2627 = Cath, suprapubic/cystoscopic (eff. 4/01)  
2628 = Catheter, occlusion (eff. 4/01)  
2629 = Intro/sheath, laser (eff. 4/01)  
2630 = Cath, EP, temp-controlled (eff. 4/01)  
2631 = Rep dev, urinary, w/o sling (eff. 4/01)  
2700 = MycroPhylax Plus CS defib (eff. 1/01)  
(obsolete 4/01)  
2701 = Phylax XM SC defib (eff. 1/01)  
(obsolete 4/01)  
2702 = Ventak Prizm 2VR Defib (eff. 1/01)  
(obsolete 4/01)  
2703 = Ventak Prizm VR HE Defib (eff. 1/01)  
(obsolete 4/01)  
2704 = Ventak Mini IV + Defib (eff. 1/01)  
(obsolete 4/01)  
2801 = Defender IV DR 612 DC defib (eff. 1/01)  
(obsolete 4/01)  
2802 = Phylax AV DC defib (eff. 1/01)  
(obsolete 4/01)  
2803 = Ventak Prizm DR HE Defib (eff. 1/01)  
(obsolete 4/01)  
2804 = Ventak Prizm 2 DR Defib (eff. 1/01)  
(obsolete 4/01)  
2805 = Jewel AF 7250 Defib (eff. 1/01)  
(obsolete 4/01)  
2806 = GEM VR 7227 Defib (eff. 1/01)  
(obsolete 4/01)  
2807 = Contak CD 1823 (eff. 1/01)  
(obsolete 4/01)  
2808 = Contak TR 1241 (eff. 1/01)  
(obsolete 4/01)  
3001 = Kainox SL/RV defib lead (eff. 1/01)  
(obsolete 4/01)  
3002 = EasyTrak Defib Lead (eff. 1/01)  
(obsolete 4/01)  
3003 = Endotak SQ Array XP lead (eff. 1/01)  
(obsolete 4/01)  
3004 = Intervene Defib lead (eff. 1/01)  
(obsolete 4/01)

3400 = Siltex Spectrum, Contour Prof (eff. 1/01)  
(obsolete 4/01)  
3401 = Saline-Filled Spectrum (eff. 1/01)  
(obsolete 4/01)  
3500 = Mentor alpha I Inf Penile Pros (eff. 1/01)  
(obsolete 4/01)  
3510 = AMS 800 Urinary Pros (eff. 1/01)  
(obsolete 4/01)  
3551 = Choice/PT Graphix/Luge/Trooper (eff. 1/01)  
(obsolete 4/01)  
3552 = Hi-Torque Whisper (eff. 1/01)  
(obsolete 4/01)  
3553 = Cordis guidewires (eff. 1/01)  
(obsolete 4/01)  
3554 = Jindo guidewire (eff. 1/01)  
(obsolete 4/01)  
3555 = Wholey Hi-Torque Plus GW (eff. 1/01)  
(obsolete 4/01)  
3556 = Wave/FlowWire Guidewire (eff. 1/01)  
(obsolete 4/01)  
3557 = HyTek guidewire (eff. 1/01)  
(obsolete 4/01)  
3800 = SynchroMed EL infusion pump (eff. 1/01)  
(obsolete 4/01)  
3801 = Arrow/Microject PCAQ Sys (eff. 1/01)  
(obsolete 4/01)  
3851 = Elastic UV IOL AA-4203T/TF/TL (eff. 1/01)  
(obsolete 4/01)  
4000 = Opus G 4621, 4624 SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4001 = Opus S 4121/4124 SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4002 = Talent 113 SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4003 = Kairos SR SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4004 = Actros SR, Actros SLR SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4005 = Philos SR/SR-B SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4006 = Pulsar Max II SR pmkr (eff. 1/01)  
(obsolete 4/01)  
4007 = Marathon SR pmkr (eff. 1/01)  
(obsolete 4/01)  
4008 = Discovery II SSI pmkr (eff. 1/01)  
(obsolete 4/01)  
4009 = Discovery II SR pmkr (eff. 1/01)  
(obsolete 4/01)  
4300 = Integrity AFx DR 5342 pmkr (eff. 1/01)  
(obsolete 4/01)  
4301 = Integrity AFx DR 5346 pmkr (eff. 1/01)  
(obsolete 4/01)  
4302 = Affinity VDR 5430 DR (eff. 1/01)  
(obsolete 4/01)

4303 = Brio 112 DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4304 = Brio 212, Talent 213/223 DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4305 = Brio 222 DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4306 = Brio 220 DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4307 = Kairos DR DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4308 = Inos2, Inos2+ DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4309 = Actros DR,D,DR-A, SLR DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4310 = Actros DR-B DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4311 = Philos DR/DR-B/SLR DC (eff. 1/01)  
(obsolete 4/01)  
4312 = Pulsar Max II DR pmkr (eff. 1/01)  
(obsolete 4/01)  
4313 = Marathon DR pmkr (eff. 1/01)  
(obsolete 4/01)  
4314 = Momentum DR pmkr (eff. 1/01)  
(obsolete 4/01)  
4315 = Selection AFm pmkr (eff. 1/01)  
(obsolete 4/01)  
4316 = Discovery II DR (eff. 1/01)  
(obsolete 4/01)  
4317 = Discovery II DDD (eff. 1/01)  
(obsolete 4/01)  
4600 = Snynox, Polyrox, Elox, Retrox (eff. 1/01)  
(obsolete 4/01)  
4602 = Tendril SDX, 1488K pmkr lead (eff. 1/01)  
(obsolete 4/01)  
4603 = Oscor/Flexion pmkr lead (eff. 1/01)  
(obsolete 4/01)  
4604 = CrystallineActFix, CapsureFix (eff. 1/01)  
(obsolete 4/01)  
4605 = CapSure Epi pmkr lead (eff. 1/01)  
(obsolete 4/01)  
4606 = Flexextend pmkr lead (eff. 1/01)  
(obsolete 4/01)  
4607 = FinelineII/EZ, ThinlineII/EZ (eff. 1/01)  
(obsolete 4/01)  
5000 = BX Velocity w/Hepacoat (eff. 1/01)  
(obsolete 4/01)  
5001 = Memotherm Bil Stent, sm, med (eff. 1/01)  
(obsolete 4/01)  
5002 = Memotherm Bil Stent, large (eff. 1/01)  
(obsolete 4/01)  
5003 = Memotherm Bil Stent, x-large (eff. 1/01)  
(obsolete 4/01)  
5004 = PalmazCorinthian IQ Bil Stent (eff. 1/01)  
(obsolete 4/01)

5005 = PalmazCorinthian IQ Trans/Bil (eff. 1/01)  
(obsolete 4/01)  
5006 = PalmazTran Bil Stent Sys-Med (eff. 1/01)  
(obsolete 4/01)  
5007 = PalmazTran XL Bil Stent--40mm (eff. 1/01)  
(obsolete 4/01)  
5008 = PalmazTran XL Bil Stent--50mm (eff. 1/01)  
(obsolete 4/01)  
5009 = VistaFlex Biliary Stent (eff. 1/01)  
(obsolete 4/01)  
5010 = Rapid Exchange Bil Stent Sys (eff. 1/01)  
(obsolete 4/01)  
5011 = IntraStent, IntraStent LP (eff. 1/01)  
(obsolete 4/01)  
5012 = IntraStent DoubleStrut LD (eff. 1/01)  
(obsolete 4/01)  
5013 = IntraStent DoubleStrut XS (eff. 1/01)  
(obsolete 4/01)  
5014 = AVE Bridge Stent Sys-10/17/28 (eff. 1/01)  
(obsolete 4/01)  
5015 = AVE/X3 Bridge Sys, 40-100 (eff. 1/010)  
(obsolete 4/01)  
5016 = Biliary stent single use cov (eff. 1/01)  
(obsolete 4/01)  
5017 = WallstentRP Bil--20/40/60/68mm (eff. 1/01)  
(obsolete 4/01)  
5018 = WallstentRP Bil--80/94mm (eff. 1/01)  
(obsolete 4/01)  
5019 = Flexima Bil Stent Sys (eff. 1/01)  
(obsolete 4/01)  
5020 = Smart Nitinol Stent--20mm (eff. 1/01)  
(obsolete 4/01)  
5021 = Smart Nitinol Stent--40/60mm (eff. 1/01)  
(obsolete 4/01)  
5022 = Smart Nitinol Stent--80mm (eff. 1/01)  
(obsolete 4/01)  
5023 = BX Velocity Stent--8/13mm (eff. 1/01)  
(obsolete 4/01)  
5024 = BX Velocity Stent 18mm (eff. 1/01)  
(obsolete 4/01)  
5025 = BX Velocity Stent 23 mm (eff. 1/01)  
(obsolete 4/01)  
5026 = BX Velocity Stent 28/33mm (eff. 1/01)  
(obsolete 4/01)  
5027 = BX Velocity Stent w/Hep--8/13mm (eff. 1/01)  
(obsolete 4/01)  
5028 = BX Velocity Stent w/Hep--18mm (eff. 1/01)  
(obsolete 4/01)  
5029 = BX Velocity Stent w/Hep--23mm (eff. 1/01)  
(obsolete 4/01)  
5030 = Stent, coronary, S660 9/12mm (eff. 1/01)  
(obsolete 4/01)  
5031 = Stent, coronary, S660 15/18mm (eff. 1/01)  
(obsolete 4/01)

5032 = Stent, coronary, S660 24/30mm (eff. 1/01)  
(obsolete 4/01)  
5033 = Niroyal Stent Sys, 9mm (eff. 1/01)  
(obsolete 4/01)  
5034 = Niroyal Stent Sys, 12/15mm (eff. 1/01)  
(obsolete 4/01)  
5035 = Niroyal Stent Sys, 18mm (eff. 1/01)  
(obsolete 4/01)  
5036 = Niroyal Stent Sys, 25mm (eff. 1/01)  
(obsolete 4/01)  
5037 = Niroyal Stent Sys, 31mm (eff. 1/01)  
(obsolete 4/01)  
5038 = BX Velocity Stent w/Raptor (eff. 1/01)  
(obsolete 4/01)  
5039 = IntraCoil Periph Stent--40mm (eff. 1/01)  
(obsolete 4/01)  
5040 = IntraCoil Periph Stent--60mm (eff. 1/01)  
(obsolete 4/01)  
5041 = BeStent Over-the-Wire 24/30mm (eff. 1/01)  
(obsolete 4/01)  
5042 = BeStent Over-the-Wire 18mm (eff. 1/01)  
(obsolete 4/01)  
5043 = BeStent Over-the-Wire 15mm (eff. 1/01)  
(obsolete 4/01)  
5044 = BeStent Over-the-Wire 9/12mm (eff. 1/01)  
(obsolete 4/01)  
5045 = Multilink Tetra Cor Stent Sys (eff. 1/01)  
(obsolete 4/01)  
5046 = Radius 20mm cor stent (eff. 1/01)  
(obsolete 4/01)  
5047 = Niroyal Elite Cor Stent Sys (eff. 1/01)  
(obsolete 4/01)  
5048 = GR II Coronary Stent (eff. 1/01)  
(obsolete 4/01)  
5130 = Wilson-Cook Colonic Z-Stent (eff. 1/01)  
(obsolete 4/01)  
5131 = Bard Colorectal Stent-60mm (eff. 1/01)  
(obsolete 4/01)  
5132 = Bard Colorectal Stent-80mm (eff. 1/01)  
(obsolete 4/01)  
5133 = Bard Colorectal Stent-100mm (eff. 1/01)  
(obsolete 4/01)  
5134 = Enteral Wallstent-90mm (eff. 1/01)  
(obsolete 4/01)  
5279 = Contour/Percuflex Stent (eff. 1/01)  
(obsolete 4/01)  
5280 = Inlay Dbl Ureteral Stent (eff. 1/01)  
(obsolete 4/01)  
5281 = Wallgraft Trach Sys 70mm (eff. 1/01)  
(obsolete 4/01)  
5282 = Wallgraft Trach Sys 20/30/50 (eff. 1/01)  
(obsolete 4/01)  
5283 = Wallstent/RP TIPS--80mm (eff. 1/01)  
(obsolete 4/01)

5284 = Wallstent TrachUltraFlex (eff. 1/01)  
(obsolete 4/01)  
5600 = Closure dev, VasoSeal ES (eff. 1/01)  
(obsolete 4/01)  
5601 = VasoSeal Model 1000 (eff. 1/01)  
(obsolete 4/01)  
6001 = Composix Mesh 8/21 in (eff. 1/01)  
(obsolete 4/01)  
6002 = Composix Mesh 32 in (eff. 1/01)  
(obsolete 4/01)  
6003 = Composix Mesh 48 in (eff. 1/01)  
(obsolete 4/01)  
6004 = Composix Mesh 80 in (eff. 1/01)  
(obsolete 4/01)  
6005 = Composix Mesh 140 in (eff. 1/01)  
(obsolete 4/01)  
6006 = Composix Mesh 144 in (eff. 1/01)  
(obsolete 4/01)  
6012 = Pelvicol Collagen 8/14 sq cm (eff. 1/01)  
(obsolete 4/01)  
6013 = Pelvicol Collagen 21/24/28 sq cm (eff. 1/01)  
(obsolete 4/01)  
6014 = Pelvicol Collagen 36 sq cm (eff. 1/01)  
(obsolete 4/01)  
6015 = Pelvicol Collagen 48 sq cm (eff. 1/01)  
(obsolete 4/01)  
6016 = Pelvicol Collagen 96 sq cm (eff. 1/01)  
(obsolete 4/01)  
6017 = Gore-Tex DualMesh 75/96 sq cm (eff. 1/01)  
(obsolete 4/01)  
6018 = Gore-Tex DualMesh 150 sq cm (eff. 1/01)  
(obsolete 4/01)  
6019 = Gore-Tex DualMesh 285 sq cm (eff. 1/01)  
(obsolete 4/01)  
6020 = Gore-Tex DualMesh 432 sq cm (eff. 1/01)  
(obsolete 4/01)  
6021 = Gore-Tex DualMesh 600 sq cm (eff. 1/01)  
(obsolete 4/01)  
6022 = Gore-Tex DualMesh 884 sq cm (eff. 1/01)  
(obsolete 4/01)  
6023 = Gore-TexPlus 1mm, 75/96 sq cm (eff. 1/01)  
(obsolete 4/01)  
6024 = Gore-TexPlus 1mm, 150 sq cm (eff. 1/01)  
(obsolete 4/01)  
6025 = Gore-TexPlus 1mm, 285 sq cm (eff. 1/01)  
(obsolete 4/01)  
6026 = Gore-TexPlus 1mm, 432 sq cm (eff. 1/01)  
(obsolete 4/01)  
6027 = Gore-TexPlus 1mm, 600 sq cm (eff. 1/01)  
(obsolete 4/01)  
6028 = Gore-TexPlus 1mm, 884 sq cm (eff. 1/01)  
(obsolete 4/01)  
6029 = Gore-TexPlus 2mm, 150 sq cm (eff. 1/01)  
(obsolete 4/01)

6030 = Gore-TexPlus 2mm, 285 sq cm (eff. 1/01)  
(obsolete 4/01)  
6031 = Gore-TexPlus 2mm, 432 sq cm (eff. 1/01)  
(obsolete 4/01)  
6032 = Gore-TexPlus 2mm, 600 sq cm (eff. 1/01)  
(obsolete 4/01)  
6033 = Gore-TexPlus 2mm, 884 sq cm (eff. 1/01)  
(obsolete 4/01)  
6034 = Bard ePTFE: 150 sq cm-2mm  
(obsolete 4/01)  
6035 = Bard ePTFE: 150sqcm-1mm,75-2mm (eff. 1/01)  
(obsolete 4/01)  
6036 = Bard ePTFE: 50/75sqcm-1,2mm (eff. 1/01)  
(obsolete 4/01)  
6037 = Bard ePTFE: 300 sq cm-1,2mm (eff. 1/01)  
(obsolete 4/01)  
6038 = Bard ePTFE: 600 sq cm-1mm (eff. 1/01)  
(obsolete 4/01)  
6039 = Bard ePTFE: 884sq cm-1mm (eff. 1/01)  
(obsolete 4/01)  
6040 = Bard ePTFE: 600sq cm-2mm (eff. 1/01)  
(obsolete 4/01)  
6041 = Bard ePTFE: 884sq cm -2mm (eff. 1/01)  
(obsolete 4/01)  
6050 = Female Sling Sys w/wo Matrl (eff. 1/01)  
(obsolete 4/01)  
6051 = Stratasis Sling, 20/40 cm (eff. 1/01)  
(obsolete 4/01)  
6052 = Stratasis Sling, 60 cm (eff. 1/01)  
(obsolete 4/01)  
6053 = Surgisis Soft Graft (eff. 1/01)  
(obsolete 4/01)  
6054 = Surgisis Enhanced Graft (eff. 1/01)  
(obsolete 4/01)  
6055 = Surgisis Enhanced Tissue (eff. 1/01)  
(obsolete 4/01)  
6056 = Surgisis Soft Tissue Graft (eff. 1/01)  
(obsolete 4/01)  
6057 = Surgisis Hernia Graft (eff. 1/01)  
(obsolete 4/01)  
6058 = SurgiPro Hernia Plug, med/lg (eff. 1/01)  
(obsolete 4/01)  
6080 = Male Sling Sys w/wo Matrial (eff. 1/01)  
(obsolete 4/01)  
6200 = Exxcel Soft ePTFE vas graft (ef. 1/01)  
(obsolete 4/01)  
6201 = Impra Venaflo--10/20cm (eff. 1/01)  
(obsolete 4/01)  
6202 = Impra Venaflo--30/40 cm (eff. 1/01)  
(obsolete 4/01)  
6203 = Impra Venaflo--50 cm, vt45 (eff. 1/01)  
(obsolete 4/01)  
6204 = Impra Venaflo--stepped (eff. 1/01)  
(obsolete 4/01)

6205 = Impra Carboflo--10cm (eff. 1/01)  
(obsolete 4/01)  
6206 = Impra Carboflo--20 cm (eff. 1/01)  
(obsolete 4/01)  
6207 = Impra Carboflo--30/35/40cm (eff. 1/01)  
(obsolete 4/01)  
6208 = Impra Carboflo--40/50cm (eff. 1/01)  
(obsolete 4/01)  
6209 = Impra Carboflo--ctrflex (eff. 1/01)  
(obsolete 4/01)  
6210 = Exxcel ePTFE vas graft (eff. 1/01)  
(obsolete 4/01)  
6300 = Vanguard III Endovas Graft (eff. 1/01)  
(obsolete 4/01)  
6500 = Preface Guiding Sheath (eff. 1/01)  
(obsolete 4/01)  
6501 = Soft Tip Sheaths (eff. 1/01)  
(obsolete 4/01)  
6502 = Perry Exchange Dilator (eff. 1/01)  
(obsolete 4/01)  
6525 = Spectranetics Laser Sheath (eff. 1/01)  
(obsolete 4/01)  
6600 = Micro Litho Flex Probes (eff. 1/01)  
(obsolete 4/01)  
6650 = Fast-Cath Guiding Introducer (eff. 1/01)  
(obsolete 4/01)  
6651 = Seal-Away Guiding Introducer (eff. 1/01)  
(obsolete 4/01)  
6652 = Bard Excalibur Introducer (eff. 1/01)  
(obsolete 4/01)  
6700 = Focal Seal-L (eff. 1/01)  
(obsolete 4/01)  
7000 = Amifostine, 500 mg (eligible for pass-through  
payments)  
7001 = Amphotericin B lipid complex, 50 mg, Inj  
(eligible for pass-through payments)  
7002 = Clonidine, HCl, 1 MG (eligible for pass-  
through payments) (obsolete 1/01)  
7003 = Epoprostenol, 0.5 MG, inj (eligible for pass-  
through payments)  
7004 = Immune globulin intravenous human 5g, inj  
(eligible for pass-through payments)  
7005 = Gonadorelin hcl, 100 mcg (eligible for pass-  
through payments)  
7007 = Milrinone lactate, per 5 ml, inj (not subject  
to national coinsurance)  
7010 = Morphine sulfate concentrate (preservative free)  
per 10 mg (eligible for pass-through payments)  
7011 = Oprelevakin, inj, 5 mg (eligible for pass-through  
payments)  
7012 = Pentamidine isethionate, 300 mg (eligible for  
pass-through payments) (obsolete 1/01)  
7014 = Fentanyl citrate, inj, up to 2 ml (eligible for  
pass-through payments)



7015 = Busulfan, oral 2 mg (eligible for pass-through payments)  
7019 = Aprotinin, 10,000 kiu (eligible for pass-through payments)  
7021 = Baclofen, intrathecal, 50 mcg (eligible for pass-through payments) (obsolete 1/01)  
7022 = Elliotts B Solution, per ml (eligible for pass-through payments)  
7023 = Treatment for bladder calculi, I.e. Renacidin per 500 ml (eligible for pass-through payments)  
7024 = Corticorelin ovine triflutate, 0.1 mg (eligible for pass-through payments)  
7025 = Digoxin immune FAB (Ovine), 10 mg (eligible for pass-through payments)  
7026 = Ethanolamine oleate, 1000 ml (eligible for pass-through payments)  
7027 = Fomepizole, 1.5 G (eligible for pass-through payments)  
7028 = Fosphenytoin, 50 mg (eligible for pass-through payments)  
7029 = Glatiramer acetate, 25 mg (eligible for pass-through payments)  
7030 = Hemin, 1 mg (eligible for pass-through payments)  
7031 = Octreotide Acetate, 500 mcg (eligible for pass-through payments)  
7032 = Sermorelin acetate, 0.5 mg (eligible for pass-through payments)  
7033 = Somatrem, 5 mg (eligible for pass-through payments)  
7034 = Somatropin, 1 mg (eligible for pass-through payments)  
7035 = Teniposide, 50 mg (eligible for pass-through payments)  
7036 = Urokinase, inj, IV, 250,000 I.U. (not subject to national coinsurance)  
7037 = Urofollitropin, 75 I.U. (eligible for pass-through payments)  
7038 = Muromonab-CD3, 5 mg (eligible for pass-through payments)  
7039 = Pegademase bovine inj 25 I.U. (eligible for pass-through payments)  
7040 = Pentastarch 10% inj, 100 ml (eligible for pass-through payments)  
7041 = Tirofiban HCL, 0.5 mg (not subject to national coinsurance)  
7042 = Capecitabine, oral 150 mg (eligible for pass-through payments)  
7043 = Infliximab, 10 MG (eligible for pass-through payments)  
7045 = Trimetrexate Glucoronate (eligible for pass-through payments)  
7046 = Doxorubicin Hcl Liposome (eligible for pass-through payments)

7047 = Droperidol/fentanyl inj (eff. 1/01)  
 7048 = Alteplase, 1 mg (eff. 1/01)  
 7049 = Filgrastim 480 mcg injection (eff. 1/01)  
 7315 = Sodium hyaluronate, 20 mg (eff. 1/01)  
 8099 = Spectranetics Lead Lock Dev (eff. 1/01)  
 (obsolete 4/01)  
 8100 = Adhesion barrier, ADCON-L (eff. 1/01)  
 (obsolete 4/01)  
 8102 = SurgiVision Esoph Coil (eff. 1/01)  
 (obsolete 4/01)  
 9000 = Na chromate Cr51, per 0.25mCi (eff. 1/01)  
 9001 = Linezolid inj, 200mg (eff. 1/01)  
 9002 = Tenecteplase, 50mg/vial (eff. 1/01)  
 9003 = Palivizumab, per 50 mg (eff. 1/01)  
 9004 = Gemtuzumab ozogamicin inj, 5mg (eff. 1/01)  
 9005 = Reteplase inj, half-kit, 18.8 mg/vial (eff. 1/01)  
 9006 = Tacrolimus inj, per 5 mg (1 amp) (eff. 1/01)  
 9007 = Baclofen Intrathecal kit-1amp (eff. 1/01)  
 9008 = Baclofen Refill Kit--500mcg (eff. 1/01)  
 9009 = Baclofen Refill Kit--2000mcg (eff. 1/01)  
 9010 = Baclofen Refill Kit--4000mcg (eff. 1/01)  
 9011 = Caffeine Citrate, inj, 1ml (eff. 1/01)  
 9012 = Arsenic Trioxide, 1mg/kg (eff. 4/01)  
 9013 = Co 57 Cobaltous Cl, 1 ml (eff. 4/01)  
 9100 = Iodinated I-131 Albumin (eff. 1/01)  
 9102 = 51 Na chromate, 50mCi (eff. 1/01)  
 9103 = Na lothalamate I-125, 10uCi (eff. 1/01)  
 9104 = Anti-thymocyte globin, 25 mg (eff. 1/01)  
 9105 = Hep B immun glob, per 1 ml (eff. 1/01)  
 9106 = Sirolimus 1 mg/ml (eff. 1/01)  
 9107 = Tinzaparin sodium, 2ml vial (eff. 1/01)  
 9108 = Thyrotropin Alfa, 1.1 mg (eff. 1/01)  
 9109 = Tirofiban hydrachloride 6.25 mg (eff. 1/01)  
 9217 = Leuprolide acetate for depot suspension,  
 7.5 mg (eff. 1/01)  
 9500 = Platelets, irradi, ea unit (eff. 1/01)  
 9501 = Platelets, pheresis, ea unit (eff. 1/01)  
 9502 = Platelets, pher/irrad, ea unit (eff. 1/01)  
 9503 = Fresh frozen plasma, ea unit (eff. 1/01)  
 9504 = RBC, deglycerolized, ea unit (eff. 1/01)  
 9505 = RBC, irradiated, ea unit (eff. 1/01)  
 9998 = Enoxaparin (eff. 1/01)

REV\_CNTR\_CNSLDTD\_BLG\_TB

Revenue Center Consolidated Billing Table

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

REV\_CNTR\_DDCTBL\_COINSRNC\_TB

Revenue Center Deductible Coinsurance Code

- 0 = Charges are subject to deductible and coinsurance
- 1 = Charges are not subject to deductible
- 2 = Charges are not subject to coinsurance
- 3 = Charges are not subject to deductible or coinsurance
- 4 = No charge or units associated with this revenue center code. (For multiple HCPCS per single revenue center code)

For revenue center code 0001, the following MSP override values may be present:

- M = Override code; EGHP services involved (eff 12/90 for non-institutional claims; 10/93 for institutional claims)
- N = Override code; non-EGHP services involved (eff 12/90 for non-institutional claims; 10/93 for institutional claims)
- X = Override code: MSP cost avoided (eff 12/90 for non-institutional claims; 10/93 for institutional claims)

REV\_CNTR\_DSCNT\_IND\_TB

Revenue Center Discount Indicator Table

\*DISCOUNTING FORMULAS\*

- 1 = 1.0
- 2 =  $(1.0 + D(U - 1)) / U$
- 3 = T/U
- 4 =  $(1 + D) / U$
- 5 = D
- 6 = TD/U
- 7 =  $D(1 + D) / U$
- 8 = 2.0/U

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

- D = Discounting fraction (currently 0.5)
- U = Number of units
- T = Terminated procedure discount (currently 0.5)

REV\_CNTR\_DUP\_CLM\_CHK\_IND\_TB

Revenue Center Duplicate Claim Check Indicator Table

- 1 = Suspect duplicate review performed

REV\_CNTR\_NDC\_QTY\_QLFR\_TB

Revenue Center NDC Qualifier Code Table

Valid Values:

- F2 = International Unit

GR = Gram  
ML = Milliliter  
UN = Unit

## REV\_CNTR\_PACKG\_IND\_TB

## Revenue Center Packaging Indicator Table

- 0 = Not packaged
- 1 = Packaged service (service indicator N)
- 2 = Packaged as part of partial hospitalization per diem or daily mental health service per diem
- 3 = Artificial charges for surgical procedure (eff. 7/2004)

## REV\_CNTR\_PMT\_MTHD\_IND\_TB

## Revenue Center Payment Method Indicator Table

NOTE: Prior to 10/2005, this table contained the valid values for both the payment indicator and status indicator. Effective 10/2005, the payment indicator codes will remain in this table and the status indicator code values will be reflected in the new table: REV\_CNTR\_STUS\_IND\_TB. Both the payment indicator and status indicator values have been expanded to 2-bytes.

- 1 = Paid standard hospital OPPS amount (status indicators K, S,T,V,X)
- 2 = Services not paid under OPPS (status indicator A, or no HCPCS code and not certain revenue center codes)
- 3 = Not paid (status indicator M,W,Y,E) or not paid under OPPS (status indicator B,C & Z)
- 4 = Paid at reasonable cost (status indicator F,L)
- 5 = Additional payment for drug or biological (status indicator G)
- 6 = Additional payment for device (status indicator H)
- 7 = Additional payment for new drug or new biological (status indicator J)
- 8 = Paid partial hospitalization per diem (status indicator P)
- 9 = No additional payment, payment included in line items with APCs (status indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy) or G0177 (partial hospitalization program services))
- A2 = Surgical procedure on ASC list in CY 2007;

payment based on OPPS payment relative weight  
 B5 = Alternative code may be available; no payment made  
 D5 = Deleted/discontinued code; no payment made  
 F4 = Corneal tissue acquisition, hepatitis B vaccine; paid at reasonable cost  
 G2 = Non-office based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight  
 H2 = Brachytherapy source paid separately when provided integral to a surgical procedure on an ASC lists; payment based on OPPS rates  
 J7 = OPPS pass-through device paid when separately provided integral to a surgical procedure on ASC list; payment contractor priced  
 J8 = Device-intensive procedure; paid at adjusted rate  
 K2 = Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate  
 K7 = Unclassified drugs and biologicals; payment contractor priced  
 L1 = Influenza vaccine; pneumococcal vaccine. Packaged item/service, no separate payment made  
 L6 = New Technology Intraocular Lens (NTIOL); special payment  
 N1 = Package service/item; no separate payment made  
 P2 = Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RUVs payment based on OPPS relative payment weight.  
 P3 = Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RUVs payment based on MPFS nonfacility PE RUVs.  
 R2 = Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS non-facility PE RVUs payment based on OPPS relative payment weight.  
 Z2 = Radiology or diagnostic service paid separately when provided integral to a surgical procedure on an ASC list; payment based on OPPS relative payment weight.  
 Z3 = Radiology or diagnostic service paid separately when provided integral to a surgical procedure on an ASC list; payment based on MFPS nonfacility PE RVUs.

\*\*\*\*\*VALUES PRIOR TO 10/3/2005\*\*\*\*\*  
 \*\*\*\*\*Service Indicator\*\*\*\*\*  
 \*\*\*\*\* 1st position \*\*\*\*\*

A = Services not paid under OPPS  
 C = Inpatient procedure pass-through  
 E = Noncovered items or services  
 F = Corneal tissue acquisition  
 G = Current drug or biological pass-through  
 H = Device pass-through

J = New drug or new biological pass-through  
N = Packaged incidental service  
P = Partial hospitalization services  
S = Significant procedure not subject to multiple procedure discounting  
T = Significant procedure subject to multiple procedure discounting  
V = Medical visit to clinic or emergency department  
X = Ancillary service

\*\*\*\*\*Payment Indicator\*\*\*\*\*  
\*\*\*\*\* 2nd position \*\*\*\*\*

1 = Paid standard hospital OPPS amount (service indicators S,T,V,X)  
2 = Services not paid under OPPS (service indicator A, or no HCPCS code and not certain revenue center codes)  
3 = Not paid (service indicators C & E)  
4 = Acquisition cost paid (service indicator F)  
5 = Additional payment for current drug or biological (service indicator G)  
6 = Additional payment for device (service indicator H)  
7 = Additional payment for new drug or new biological (service indicator J)  
8 = Paid partial hospitalization per diem (service indicator P)  
9 = No additional payment, payment included in line items with APCs (service indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization training))

REV\_CNTR\_PRICNG\_IND\_TB

Revenue Center Pricing Indicator Table

A = A valid HCPCS code not subject to a fee schedule payment. Reimbursement is calculated on provider submitted charges.

B = A valid HCPCS code subject to the fee schedule payment. for the provider billed charges. NOTE: There is an exception for Critical Access Hospitals (provider numbers XX1300-XX1399) with reimbursement method 'J' (all-inclusive method) and dates of service on or after 7/1/01. In these situations, reimbursement for professional services (revenue codes 96X, 97X, 98X) is always at the fee schedule amount of logic is not applicable.

C = Unlisted Rehabilitation Carrier Priced HCPCS

D = a valid radiology HCPCS code subject to the Radiology Pricer and the rate is reflected as zeroes on the HCPCS file and cost report. The Radiology Pricer treats this HCPCS as a non-covered service. Reimbursement is calculated on provider submitted charges.

E = A valid ASC HCPCS code subject to the ASC Pricer. The rate is reflected as zeroes on the HCPCS file. The ASC Pricer determines the ASC payment rate and is reported on the cost report.

F = A valid ESRD HCPCS code subject to the parameter rate. Reimbursement is the lesser of provider submitted charges or the fee schedule amount for non-dialysis HCPCS. Reimbursement is calculated on the provider file rates for dialysis HCPCS.

NOTE: The ESRD Pricing Indicator is used when processing the ESRD claim. The non-ESRD pricing indicator is used only for Inpatient claims as follows: valid Hemophilia HCPCS for inpatient claim only and code is summed to parameter rate.

G = A valid HCPCS, code is subject to a fee schedule, but the rate is no longer present on the HCPCS file. Reimbursement is calculated on provider submitted charges.

H = A valid DME HCPCS, code is subject to a fee schedule. The rates are reflected under the DME segment. Reimbursement is calculated either on a fee schedule, provider submitted charges or the lesser of provider submitted, or the fee schedule depending on the category of DME.

I = A valid DME category 5 HCPCS, HCPCS is not found on the DME history record, but a match was found on HIC, category and generic code. Claim must be reviewed by Medical Review before payment can be calculated.

J = A valid DME HCPCS, no DME history is present, and a prescription is required before delivery. Claim must be reviewed by Medical Review.

K = A valid DME HCPCS, prescribed has been reviewed, and fee schedule payment is approved as prescription was present before delivery.

L = A valid TENS HCPCS, rental period is six months or greater and must be reviewed by Medical Review. This code will be automatically set by the system.

M = A valid TENS HCPCS, Medical Review has approved the rental charge in excess of five months. This must be set by Medical Review. This must be set by Medical Review when approved for payment.

N = Paid based on the fee amount for non ESRD TOB's.  
NOTE: Fee amount is paid regardless of charges.

Q = Manual pricing

R = A valid radiology HCPCS code and is subject to APC. The rate is reported on the cost report. Reimbursement is calculated on provider submitted charges.

S = Valid influenza/PPV HCPCS. A fee amount is not applicable. The amount payable is present in the covered charge field. This amount is not subject to the coinsurance and deductible. This charge is subject to the provider's reimbursement rate.

T = Valid HCPCS. A fee amount is present. The amount payable should be the lower of the billed charge or fee amount. The system should compute the fee amount by multiplying the covered units times the rate. The fee amount is not subject to coinsurance and deductible or provider's reimbursement rate.

U = Valid ambulance HCPCS. A fee amount is present. The amount payable is a blended amount based on a percentage of the fee schedule and a percentage of the reasonable cost. The fee amount is subject to coinsurance and deductible.

X = Unclassified drug as subject to manual pricing.

REV\_CNTR\_PRIOR\_AUTHRZTN\_TB

Revenue Center Prior Authorization Indicator Table

A = Part A

B = Part B

D = DME

H = Home Health and Hospice

+ 3 digit number

REV\_CNTR\_PWK\_TB

Revenue Center Paperwork 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

## REV\_CNTR\_STUS\_IND\_TB

## Revenue Center Status Indicator Table

A = Services not paid under OPPTS; paid by MACs under a fee schedule or payment system other than OPPTS  
B = Non-allowed item or service for OPPTS  
C = Inpatient procedure; not paid under OPPTS  
D = Discontinued Codes - not paid under OPPTS or any other Medicare payment system  
E1 = Non-allowed item or service - not paid by Medicare when submitted on outpatient claims (any outpatient bill type)  
E2 = Non-allowed item or service for which pricing information and claims data is not available - not paid by Medicare when submitted on outpatient claims (any outpatient bill type)  
F = Corneal tissue acquisition and certain CRNA services and Hepatitis B vaccines  
G = Drug/biological pass-through  
H = Device pass-through  
J1 = Hospital Part B services paid through a comprehensive APC -- Paid under OPPTS; all covered Part B services on the claim are packaged with the primary "J1" service service for the claim, except services with OPPTS status indicator of "F", "G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; new technology services; self-administered drugs; all preventive services; and certain Part B inpatient services.  
J2 = Hospital Part B services that may be paid through a comprehensize APC - Paid under OPPTS; Addendum B displays APC assignments when services are separately payable  
K = Non pass-through drug/biological, radio-pharmaceutical agent, certain brachytherapy sources. Paid under OPPTS; separate APC payment  
L = Flu/PPV vaccines - Not paid under OPPTS. Paid at reasonable cost; not subject to deductible or coinsurance  
M = Service not billable to MAC; Not paid under OPPTS  
N = Items and services packaged into APC rates Paid under OPPTS; payment is packaged into payment for other services. Therefore, there is no separate APC payment  
P = Partial Hospitalization; Paid under OPPTS; per diem

- APC payment
- Q1 = STV - Packaged Codes - Paid under OPPS; Addendum B displays APC assignments when services are separately payable
- Q2 = T - Packaged Codes - Paid under OPPS; Addendum B displays APC assignments when services are separately payable
- Q3 = Codes that may be paid through a composite APC
- Q4 = Conditionally packaged laboratory tests  
Paid under OPPS or CLFS
- R = Blood and blood products; Paid under OPPS; separate APC payment
- S = Significant procedure not subject to multiple procedure discounting - Paid under OPPS; separate APC payment
- T = Significant procedure subject to multiple procedure discounting; Paid under OPPS; separate APC payment
- U = Brachytherapy Sources - Paid under OPPS; separate APC payment
- V = Medical visit to clinic or emergency department - Paid under OPPS; separate APC payment
- W = Invalid HCPCS or invalid revenue code with blank HCPCS (terminated)
- X = Ancillary service (terminated)
- Y = Non-implantable DME, Therapeutic shoes
- Z = Valid revenue with blank HCPCS and no other SI assigned (terminated)

REV\_CNTR\_TB

Revenue Center Table

- 0001 = Total charge
- 0022 = SNF claim paid under PPS submitted as TOB 21X, effective for cost reporting periods beginning on or after 7/1/98 (dates of service after 6/30/98). NOTE: This code may appear multiple times on a claim to identify different HIPPS Rate Code/assessment periods.
- 0023 = Home Health services paid under PPS submitted as TOB 32X and 33X, effective 10/00. This code may appear multiple times on a claim to identify different HIPPS/Home Health Resource Groups (HRG).
- 0024 = Inpatient Rehabilitation Facility services paid under PPS submitted as TOB 11X, effective for cost reporting periods beginning on or after 1/1/2002 (dates of service after 12/31/01).  
This code may appear only once on a claim.
- 0100 = All inclusive rate-room and board plus ancillary
- 0101 = All inclusive rate-room and board
- 0110 = Private medical or general-general classification
- 0111 = Private medical or general-medical/surgical/GYN
- 0112 = Private medical or general-OB

0113 = Private medical or general-pediatric  
0114 = Private medical or general-psychiatric  
0115 = Private medical or general-hospice  
0116 = Private medical or general-detoxification  
0117 = Private medical or general-oncology  
0118 = Private medical or general-rehabilitation  
0119 = Private medical or general-other  
0120 = Semi-private 2 bed (medical or general)  
general classification  
0121 = Semi-private 2 bed (medical or general)  
medical/surgical/GYN  
0122 = Semi-private 2 bed (medical or general)-OB  
0123 = Semi-private 2 bed (medical or general)-pediatric  
0124 = Semi-private 2 bed (medical or general)-psychiatric  
0125 = Semi-private 2 bed (medical or general)-hospice  
0126 = Semi-private 2 bed (medical or general)  
detoxification  
0127 = Semi-private 2 bed (medical or general)-oncology  
0128 = Semi-private 2 bed (medical or general)  
rehabilitation  
0129 = Semi-private 2 bed (medical or general)-other  
0130 = Semi-private 3 and 4 beds-general classification  
0131 = Semi-private 3 and 4 beds-medical/surgical/GYN  
0132 = Semi-private 3 and 4 beds-OB  
0133 = Semi-private 3 and 4 beds-pediatric  
0134 = Semi-private 3 and 4 beds-psychiatric  
0135 = Semi-private 3 and 4 beds-hospice  
0136 = Semi-private 3 and 4 beds-detoxification  
0137 = Semi-private 3 and 4 beds-oncology  
0138 = Semi-private 3 and 4 beds-rehabilitation  
0139 = Semi-private 3 and 4 beds-other  
0140 = Private (deluxe)-general classification  
0141 = Private (deluxe)-medical/surgical/GYN  
0142 = Private (deluxe)-OB  
0143 = Private (deluxe)-pediatric  
0144 = Private (deluxe)-psychiatric  
0145 = Private (deluxe)-hospice  
0146 = Private (deluxe)-detoxification  
0147 = Private (deluxe)-oncology  
0148 = Private (deluxe)-rehabilitation  
0149 = Private (deluxe)-other  
0150 = Room&Board ward (medical or general)  
general classification  
0151 = Room&Board ward (medical or general)  
medical/surgical/GYN  
0152 = Room&Board ward (medical or general)-OB  
0153 = Room&Board ward (medical or general)-pediatric  
0154 = Room&Board ward (medical or general)-psychiatric  
0155 = Room&Board ward (medical or general)-hospice  
0156 = Room&Board ward (medical or general)-detoxification  
0157 = Room&Board ward (medical or general)-oncology  
0158 = Room&Board ward (medical or general)-rehabilitation  
0159 = Room&Board ward (medical or general)-other  
0160 = Other Room&Board-general classification

0164 = Other Room&Board-sterile environment  
0167 = Other Room&Board-self care  
0169 = Other Room&Board-other  
0170 = Nursery-general classification  
0171 = Nursery-newborn  
    level I (routine)  
0172 = Nursery-premature  
    newborn-level II (continuing care)  
0173 = Nursery-newborn-level III (intermediate care)  
    (eff 10/96)  
0174 = Nursery-newborn-level IV (intensive care)  
    (eff 10/96)  
0175 = Nursery-neonatal ICU (obsolete eff 10/96)  
0179 = Nursery-other  
0180 = Leave of absence-general classification  
0182 = Leave of absence-patient convenience charges  
    billable  
0183 = Leave of absence-therapeutic leave  
0184 = Leave of absence-ICF mentally retarded-any reason  
    (obsolete)  
0185 = Leave of absence-nursing home (hospitalization)  
0189 = Leave of absence-other leave of absence  
0190 = Subacute care - general classification  
    (eff. 10/97)  
0191 = Subacute care - level I (eff. 10/97)  
0192 = Subacute care - level II (eff. 10/97)  
0193 = Subacute care - level III (eff. 10/97)  
0194 = Subacute care - level IV (eff. 10/97)  
0199 = Subacute care - other (eff 10/97)  
0200 = Intensive care-general classification  
0201 = Intensive care-surgical  
0202 = Intensive care-medical  
0203 = Intensive care-pediatric  
0204 = Intensive care-psychiatric  
0206 = Intensive care-post ICU; redefined as  
    intermediate ICU (eff 10/96)  
0207 = Intensive care-burn care  
0208 = Intensive care-trauma  
0209 = Intensive care-other intensive care  
0210 = Coronary care-general classification  
0211 = Coronary care-myocardial infraction  
0212 = Coronary care-pulmonary care  
0213 = Coronary care-heart transplant  
0214 = Coronary care-post CCU; redefined as  
    intermediate CCU (eff 10/96)  
0219 = Coronary care-other coronary care  
0220 = Special charges-general classification  
0221 = Special charges-admission charge  
0222 = Special charges-technical support charge  
0223 = Special charges-UR service charge  
0224 = Special charges-late discharge, medically  
    necessary  
0229 = Special charges-other special charges  
0230 = Incremental nursing charge rate-general

classification

- 0231 = Incremental nursing charge rate-nursery
- 0232 = Incremental nursing charge rate-OB
- 0233 = Incremental nursing charge rate-ICU (include transitional care)
- 0234 = Incremental nursing charge rate-CCU (include transitional care)
- 0235 = Incremental nursing charge rate-hospice
- 0239 = Incremental nursing charge rate-other
- 0240 = All inclusive ancillary-general classification
- 0241 = All inclusive ancillary-basic
- 0242 = All inclusive ancillary-comprehensive
- 0243 = All inclusive ancillary-specialty
- 0249 = All inclusive ancillary-other inclusive ancillary
- 0250 = Pharmacy-general classification
- 0251 = Pharmacy-generic drugs
- 0252 = Pharmacy-nongeneric drugs
- 0253 = Pharmacy-take home drugs
- 0254 = Pharmacy-drugs incident to other diagnostic service-subject to payment limit
- 0255 = Pharmacy-drugs incident to radiology-subject to payment limit
- 0256 = Pharmacy-experimental drugs
- 0257 = Pharmacy-non-prescription
- 0258 = Pharmacy-IV solutions
- 0259 = Pharmacy-other pharmacy
- 0260 = IV therapy-general classification
- 0261 = IV therapy-infusion pump
- 0262 = IV therapy-pharmacy services (eff 10/94)
- 0263 = IV therapy-drug supply/delivery (eff 10/94)
- 0264 = IV therapy-supplies (eff 10/94)
- 0269 = IV therapy-other IV therapy
- 0270 = Medical/surgical supplies-general classification (also see 062X)
- 0271 = Medical/surgical supplies-nonsterile supply
- 0272 = Medical/surgical supplies-sterile supply
- 0273 = Medical/surgical supplies-take home supplies
- 0274 = Medical/surgical supplies-prosthetic/orthotic devices
- 0275 = Medical/surgical supplies-pace maker
- 0276 = Medical/surgical supplies-intraocular lens
- 0277 = Medical/surgical supplies-oxygen-take home
- 0278 = Medical/surgical supplies-other implants
- 0279 = Medical/surgical supplies-other devices
- 0280 = Oncology-general classification
- 0289 = Oncology-other oncology
- 0290 = DME (other than renal)-general classification
- 0291 = DME (other than renal)-rental
- 0292 = DME (other than renal)-purchase of new DME
- 0293 = DME (other than renal)-purchase of used DME
- 0294 = DME (other than renal)-related to and listed as DME
- 0299 = DME (other than renal)-other
- 0300 = Laboratory-general classification
- 0301 = Laboratory-chemistry

0302 = Laboratory-immunology  
0303 = Laboratory-renal patient (home)  
0304 = Laboratory-non-routine dialysis  
0305 = Laboratory-hematology  
0306 = Laboratory-bacteriology & microbiology  
0307 = Laboratory-urology  
0309 = Laboratory-other laboratory  
0310 = Laboratory pathological-general classification  
0311 = Laboratory pathological-cytology  
0312 = Laboratory pathological-histology  
0314 = Laboratory pathological-biopsy  
0319 = Laboratory pathological-other  
0320 = Radiology diagnostic-general classification  
0321 = Radiology diagnostic-angiocardiology  
0322 = Radiology diagnostic-arthrography  
0323 = Radiology diagnostic-arteriography  
0324 = Radiology diagnostic-chest X-ray  
0329 = Radiology diagnostic-other  
0330 = Radiology therapeutic-general classification  
0331 = Radiology therapeutic-chemotherapy injected  
0332 = Radiology therapeutic-chemotherapy oral  
0333 = Radiology therapeutic-radiation therapy  
0335 = Radiology therapeutic-chemotherapy IV  
0339 = Radiology therapeutic-other  
0340 = Nuclear medicine-general classification  
0341 = Nuclear medicine-diagnostic  
0342 = Nuclear medicine-therapeutic  
0343 = Nuclear medicine-diagnostic radiopharmaceuticals  
0344 = Nuclear medicine-therapeutic radiopharmaceuticals  
0349 = Nuclear medicine-other  
0350 = Computed tomographic (CT) scan-general  
classification  
0351 = CT scan-head scan  
0352 = CT scan-body scan  
0359 = CT scan-other CT scans  
0360 = Operating room services-general classification  
0361 = Operating room services-minor surgery  
0362 = Operating room services-organ transplant,  
other than kidney  
0367 = Operating room services-kidney transplant  
0369 = Operating room services-other operating room  
services  
0370 = Anesthesia-general classification  
0371 = Anesthesia-incident to RAD and  
subject to the payment limit  
0372 = Anesthesia-incident to other diagnostic service  
and subject to the payment limit  
0374 = Anesthesia-acupuncture  
0379 = Anesthesia-other anesthesia  
0380 = Blood-general classification  
0381 = Blood-packed red cells  
0382 = Blood-whole blood  
0383 = Blood-plasma  
0384 = Blood-platelets

0385 = Blood-leukocytes  
0386 = Blood-other components  
0387 = Blood-other derivatives (cryoprecipitates)  
0389 = Blood-other blood  
0390 = Blood storage and processing-general  
classification  
0391 = Blood storage and processing-blood  
administration  
0392 = Blood storage and processing - storage  
and processing  
0399 = Blood storage and processing-other  
0400 = Other imaging services-general classification  
0401 = Other imaging services-diagnostic mammography  
0402 = Other imaging services-ultrasound  
0403 = Other imaging services-screening mammography  
(eff 1/1/91)  
0404 = Other imaging services-positron emission  
tomography (eff 10/94)  
0409 = Other imaging services-other  
0410 = Respiratory services-general classification  
0412 = Respiratory services-inhalation services  
0413 = Respiratory services-hyperbaric oxygen therapy  
0419 = Respiratory services-other  
0420 = Physical therapy-general classification  
0421 = Physical therapy-visit charge  
0422 = Physical therapy-hourly charge  
0423 = Physical therapy-group rate  
0424 = Physical therapy-evaluation or re-evaluation  
0429 = Physical therapy-other  
0430 = Occupational therapy-general classification  
0431 = Occupational therapy-visit charge  
0432 = Occupational therapy-hourly charge  
0433 = Occupational therapy-group rate  
0434 = Occupational therapy-evaluation or re-evaluation  
0439 = Occupational therapy-other (may include  
restorative therapy)  
0440 = Speech language pathology-general classification  
0441 = Speech language pathology-visit charge  
0442 = Speech language pathology-hourly charge  
0443 = Speech language pathology-group rate  
0444 = Speech language pathology-evaluation or  
re-evaluation  
0449 = Speech language pathology-other  
0450 = Emergency room-general classification  
0451 = Emergency room-emptala emergency medical screening  
services (eff 10/96)  
0452 = Emergency room-ER beyond emptala screening  
(eff 10/96)  
0456 = Emergency room-urgent care (eff 10/96)  
0459 = Emergency room-other  
0460 = Pulmonary function-general classification  
0469 = Pulmonary function-other  
0470 = Audiology-general classification  
0471 = Audiology-diagnostic

0472 = Audiology-treatment  
0479 = Audiology-other  
0480 = Cardiology-general classification  
0481 = Cardiology-cardiac cath lab  
0482 = Cardiology-stress test  
0483 = Cardiology-Echocardiology  
0489 = Cardiology-other  
0490 = Ambulatory surgical care-general classification  
0499 = Ambulatory surgical care-other  
0500 = Outpatient services-general classification  
0509 = Outpatient services-other  
0510 = Clinic-general classification  
0511 = Clinic-chronic pain center  
0512 = Clinic-dental center  
0513 = Clinic-psychiatric  
0514 = Clinic-OB-GYN  
0515 = Clinic-pediatric  
0516 = Clinic-urgent care clinic (eff 10/96)  
0517 = Clinic-family practice clinic (eff 10/96)  
0519 = Clinic-other  
0520 = Free-standing clinic-general classification  
0521 = Free-standing clinic-Clinic visit by a member to RHC/FQHC (eff. 7/1/06). Prior to 7/1/06 - Rural Health-Clinic  
0522 = Free-standing clinic-Home visit by RHC/FQHC practitioner (eff. 7/1/06). Prior to 7/1/06 - Rural Health-Home  
0523 = Free-standing clinic-family practice  
0524 = Free-standing clinic - visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF. (eff. 7/1/06)  
0525 = Free-standing clinic - visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility. (eff. 7/1/06)  
0526 = Free-standing clinic-urgent care (eff 10/96)  
0527 = Free-standing clinic-RHC/FQHC visiting nurse service(s) to a member's home when in a home health shortage area. (eff. 7/1/06)  
0528 = Free-standing clinic-visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g. scene of accident). (eff. 7/1/06)  
0529 = Free-standing clinic-other  
0530 = Osteopathic services-general classification  
0531 = Osteopathic services-osteopathic therapy  
0539 = Osteopathic services-other  
0540 = Ambulance-general classification  
0541 = Ambulance-supplies  
0542 = Ambulance-medical transport  
0543 = Ambulance-heart mobile  
0544 = Ambulance-oxygen  
0545 = Ambulance-air ambulance  
0546 = Ambulance-neo-natal ambulance  
0547 = Ambulance-pharmacy



0548 = Ambulance-telephone transmission EKG  
0549 = Ambulance-other  
0550 = Skilled nursing-general classification  
0551 = Skilled nursing-visit charge  
0552 = Skilled nursing-hourly charge  
0559 = Skilled nursing-other  
0560 = Medical social services-general classification  
0561 = Medical social services-visit charge  
0562 = Medical social services-hourly charges  
0569 = Medical social services-other  
0570 = Home health aid (home health)-general  
classification  
0571 = Home health aid (home health)-visit charge  
0572 = Home health aid (home health)-hourly charge  
0579 = Home health aid (home health)-other  
0580 = Other visits (home health)-general  
classification (under HHPPS, not allowed  
as covered charges)  
0581 = Other visits (home health)-visit charge  
(under HHPPS, not allowed as covered charges)  
0582 = Other visits (home health)-hourly charge  
(under HHPPS, not allowed as covered charges)  
0583 = Other visits (home health) - assessments  
(under HHPPS, not allow as covered charges)  
0589 = Other visits (home health)-other  
(under HHPPS, not allowed as covered charges)  
0590 = Units of service (home health)-general  
classification (under HHPPS, not allowed  
as covered charges)  
0599 = Units of service (home health)-other  
(under HHPPS, not allowed as covered charges)  
(obsolete)  
0600 = Oxygen/Home Health-general classification  
0601 = Oxygen/Home Health-stat or port equip/supply  
or count  
0602 = Oxygen/Home Health-stat/equip/under 1 LPM  
0603 = Oxygen/Home Health-stat/equip/over 4 LPM  
0604 = Oxygen/Home Health-stat/equip/portable add-on  
0609 = Oxygen/Home Health - Other (Obsolete)  
0610 = Magnetic resonance technology (MRT)-general  
classification  
0611 = MRT/MRI-brain (including brainstem)  
0612 = MRT/MRI-spinal cord (including spine)  
0614 = MRT/MRI-other  
0615 = MRT/MRA-Head and Neck  
0616 = MRT/MRA-Lower Extremities  
0618 = MRT/MRA-other  
0619 = MRT/Other MRT  
0620 = Reserved (Use 0270 for general classification)  
0621 = Medical/surgical supplies-incident to radiology-  
subject to the payment limit - extension of 027X  
0622 = Medical/surgical supplies-incident to other  
diagnostic service-subject to the payment limit -  
extension of 027X

0623 = Medical/surgical supplies-surgical dressings  
(eff 1/95) - extension of 027X

0624 = Medical/surgical supplies-medical investigational  
devices and procedures with FDA approved IDE's  
(eff 10/96) - extension of 027X

0630 = Reserved (eff. 1/98)

0631 = Drugs requiring specific identification-single drug  
source (eff 9/93)

0632 = Drugs requiring specific identification-multiple drug  
source (eff 9/93)

0633 = Drugs requiring specific identification-restrictive  
prescription (eff 9/93)

0634 = Drugs requiring specific identification-EPO under  
10,000 units

0635 = Drugs requiring specific identification-EPO 10,000  
units or more

0636 = Drugs requiring specific identification-detailed  
coding (eff 3/92)

0637 = Self-administered drugs administered in an  
emergency situation - not requiring detailed  
coding

0640 = Home IV therapy-general classification  
(eff 10/94)

0641 = Home IV therapy-nonroutine nursing  
(eff 10/94)

0642 = Home IV therapy-IV site care, central line  
(eff 10/94)

0643 = Home IV therapy-IV start/change peripheral line  
(eff 10/94)

0644 = Home IV therapy-nonroutine nursing, peripheral line  
(eff 10/94)

0645 = Home IV therapy-train patient/caregiver, central  
line (eff 10/94)

0646 = Home IV therapy-train disabled patient, central  
line (eff 10/94)

0647 = Home IV therapy-train patient/caregiver, peripheral  
line (eff 10/94)

0648 = Home IV therapy-train disabled patient, peripheral  
line (eff 10/94)

0649 = Home IV therapy-other IV therapy services  
(eff 10/94)

0650 = Hospice services-general classification

0651 = Hospice services-routine home care

0652 = Hospice services-continuous home care-1/2

  

0655 = Hospice services-inpatient care

0656 = Hospice services-general inpatient care  
(non-respite)

0657 = Hospice services-physician services

0658 = Hospice services-Hospice Room & Board -  
Nursing Facility

0659 = Hospice services-other

0660 = Respite care (HHA)-general classification  
(eff 9/93)

0661 = Respite care (HHA)-hourly charge/skilled nursing  
(eff 9/93)

0662 = Respite care (HHA)-hourly charge/home health aide/  
homemaker (eff 9/93)

0663 = Respite care-daily respite care

0669 = Respite care-other respite care

0670 = OP special residence charges - general  
classification

0671 = OP special residence charges - hospital based

0672 = OP special residence charges - contracted

0679 = OP special residence charges - other special  
residence charges

0680 = Trauma Response-not used

0681 = Trauma response-Level I Trauma

0682 = Trauma response-Level II Trauma

0683 = Trauma response-Level III Trauma

0684 = Trauma response-Level IV Trauma

0689 = Trauma response-Other trauma response

0690 = Pre-hospice/Palliative Care Services - general  
(eff. 7/1/17)

0691 = Pre-hospice/Palliative Care Services - visit  
(eff. 7/1/17)

0692 = Pre-hospice/Palliative Care Services - hourly  
(eff. 7/1/17)

0693 = Pre-hospice/Palliative Care Services - evaluation  
(eff. 7/1/17)

0694 = Pre-hospice/Palliative Care Services - consultation &  
education (eff. 7/1/17)

0695 = Pre-hospice/Palliative Care Services - Inpatient  
(eff. 7/1/17)

0696 = Pre-hospice/Palliative Care Services - Physician  
(eff. 7/1/17)

0699 = Pre-hospice/Palliative Care Services - Other  
(eff. 7/1/17)

0700 = Cast room-general classification

0709 = Cast room-other (obsolete)

0710 = Recovery room-general classification

0719 = Recovery room-other (obsolete)

0720 = Labor room/delivery-general classification

0721 = Labor room/delivery-labor

0722 = Labor room/delivery-delivery

0723 = Labor room/delivery-circumcision

0724 = Labor room/delivery-birthing center

0729 = Labor room/delivery-other

0730 = EKG/ECG-general classification

0731 = EKG/ECG-Holter monitor

0732 = EKG/ECG-telemetry (include fetal monitoring until  
9/93)

0739 = EKG/ECG-other

0740 = EEG-general classification

0749 = EEG (electroencephalogram)-other (Obsolete)

0750 = Gastro-intestinal services-general classification

0759 = Gastro-intestinal services-other (Obsolete)

0760 = Treatment or observation room-general

classification

0761 = Treatment or observation room-treatment room  
(eff 9/93)

0762 = Treatment or observation room-observation room  
(eff 9/93)

0769 = Treatment or observation room-other

0770 = Preventative care services-general classification  
(eff 10/94)

0771 = Preventative care services-vaccine administration  
(eff 10/94)

0779 = Preventative care services-other (eff 10/94) (Obsolete)

0780 = Telemedicine - general classification  
(eff 10/97)

0789 = Telemedicine - telemedicine (eff 10/97) (Obsolete)

0790 = Extra-Corporeal Shock Wave Therapy (ESWT) - general  
classification - formerly Lithotripsy

0799 = Lithotripsy-other (Obsolete)

0800 = Inpatient renal dialysis-general classification

0801 = Inpatient renal dialysis-inpatient hemodialysis

0802 = Inpatient renal dialysis-inpatient peritoneal  
(non-CAPD)

0803 = Inpatient renal dialysis-inpatient CAPD

0804 = Inpatient renal dialysis-inpatient CCPD

0809 = Inpatient renal dialysis-other inpatient dialysis

0810 = Organ acquisition-general classification

0811 = Organ acquisition-living donor (eff 10/94);  
prior to 10/94, defined as living donor kidney

0812 = Organ acquisition-cadaver donor (eff 10/94);  
prior to 10/94, defined as cadaver donor kidney

0813 = Organ acquisition-unknown donor (eff 10/94)  
prior to 10/94, defined as unknown donor kidney

0814 = Organ acquisition - unsuccessful organ search-  
donor bank charges (eff 10/94); prior to 10/94,  
defined as other kidney acquisition

0815 = Allogeneic Stem Cell Acquisition/Donor Services

0816 = Organ acquisition-other heart acquisition  
(obsolete, eff 10/94)

0817 = Organ acquisition-donor-liver  
(obsolete, eff 10/94)

0819 = Organ acquisition-other donor (eff 10/94);  
prior to 10/94, defined as other

0820 = Hemodialysis OP or home dialysis-general  
classification

0821 = Hemodialysis OP or home dialysis-hemodialysis-  
composite or other rate

0822 = Hemodialysis OP or home dialysis-home supplies

0823 = Hemodialysis OP or home dialysis-home equipment

0824 = Hemodialysis OP or home dialysis-maintenance/100%

0825 = Hemodialysis OP or home dialysis-support services

0826 = Hemodialysis OP or home dialysis- Hemo short  
(eff. 7/1/17)

0829 = Hemodialysis OP or home dialysis-other

0830 = Peritoneal dialysis OP or home-general  
classification

0831 = Peritoneal dialysis OP or home-peritoneal-composite or other rate

0832 = Peritoneal dialysis OP or home-home supplies

0833 = Peritoneal dialysis OP or home-home equipment

0834 = Peritoneal dialysis OP or home-maintenance/100%

0835 = Peritoneal dialysis OP or home-support services

0839 = Peritoneal dialysis OP or home-other

0840 = CAPD outpatient-general classification

0841 = CAPD outpatient-CAPD/composite or other rate

0842 = CAPD outpatient-home supplies

0843 = CAPD outpatient-home equipment

0844 = CAPD outpatient-maintenance/100%

0845 = CAPD outpatient-support services

0849 = CAPD outpatient-other

0850 = CCPD outpatient-general classification

0851 = CCPD outpatient-CCPD/composite or other rate

0852 = CCPD outpatient-home supplies

0853 = CCPD outpatient-home equipment

0854 = CCPD outpatient-maintenance/100%

0855 = CCPD outpatient-support services

0859 = CCPD outpatient-other

0860 = Magnetoencephalography (MEG) - general classification

0861 = Magnetoencephalography (MEG) - MEG

0880 = Miscellaneous dialysis-general classification

0881 = Miscellaneous dialysis-ultrafiltration

0882 = Miscellaneous dialysis-home dialysis aide visit (eff 9/93)

0889 = Miscellaneous dialysis-other

0890 = Other donor bank-general classification; changed to reserved for national assignment (eff 4/94)

0891 = Other donor bank-bone; changed to reserved for national assignment (eff 4/94)

0892 = Other donor bank-organ (other than kidney); changed to reserved for national assignment (eff 4/94) (term. 3/2020)

0892 = Special Processed Drugs - FDA Approved Gene Therapy (eff. 4/2020)

0893 = Other donor bank-skin; changed to reserved for national assignment (eff 4/94)

0899 = Other donor bank-other; changed to reserved for national assignment (eff 4/94)

0900 = Behavior Health Treatment/Services - general classification (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-general classification

0901 = Behavior Health Treatment/Services - electroshock treatment (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-electroshock treatment

0902 = Behavior Health Treatment/Services - milieu therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-milieu therapy

- 0903 = Behavior Health Treatment/Services - play therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-play therapy
- 0904 = Behavior Health Treatment/Services - activity therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-activity therapy
- 0905 = Behavior Health Treatment/Services - intensive outpatient services-psychiatric (eff. 10/2004)
- 0906 = Behavior Health Treatment/Services - intensive outpatient services-chemical dependency (eff. 10/2004)
- 0907 = Behavior Health Treatment/Services - community behavioral health program-day treatment (eff. 10/2004)
- 0909 = Reserved for National Use (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-other
- 0910 = Behavioral Health Treatment/Services-Reserved for National Assignment (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-general classification
- 0911 = Behavioral Health Treatment/Services-rehabilitation (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-rehabilitation
- 0912 = Behavioral Health Treatment/Services-partial hospitalization-less intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-less intensive
- 0913 = Behavioral Health Treatment/Services-partial hospitalization-intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-intensive
- 0914 = Behavioral Health Treatment/Services-individual therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-individual therapy
- 0915 = Behavioral Health Treatment/Services-group therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-group therapy
- 0916 = Behavioral Health Treatment/Services-family therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-family therapy
- 0917 = Behavioral Health Treatment/Services-bio feedback (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-bio feedback
- 0918 = Behavioral Health Treatment/Services-testing (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-testing
- 0919 = Behavioral Health Treatment/Services-other

(eff. 10/2004); prior to 10/2004 defined as  
Psychiatric/psychological services-other  
0920 = Other diagnostic services-general classification  
0921 = Other diagnostic services-peripheral vascular lab  
0922 = Other diagnostic services-electromyogram  
0923 = Other diagnostic services-pap smear  
0924 = Other diagnostic services-allergy test  
0925 = Other diagnostic services-pregnancy test  
0929 = Other diagnostic services-other  
0931 = Medical Rehabilitation Day Program - Half Day  
0932 = Medical Rehabilitation Day Program - Full Day  
0940 = Other therapeutic services-general classification  
0941 = Other therapeutic services-recreational therapy  
0942 = Other therapeutic services-education/training  
(include diabetes diet training)  
0943 = Other therapeutic services-cardiac rehabilitation  
0944 = Other therapeutic services-drug rehabilitation  
0945 = Other therapeutic services-alcohol  
rehabilitation  
0946 = Other therapeutic services-routine complex  
medical equipment  
0947 = Other therapeutic services-ancillary complex  
medical equipment (eff 3/92)  
0948 = Other therapeutic services- pulmonary rehab  
0949 = Other therapeutic services-other  
0951 = Professional Fees-athletic training (extension  
of 094X)  
0952 = Professional Fees-kinesiotherapy (extension  
of 094X)  
0953 = Chemical Dependency (eff. 4/2013)  
0960 = Professional fees-general classification  
0961 = Professional fees-psychiatric  
0962 = Professional fees-ophthalmology  
0963 = Professional fees-anesthesiologist (MD)  
0964 = Professional fees-anesthetist (CRNA)  
0969 = Professional fees-other  
NOTE: 097X is an extension of 096X  
0971 = Professional fees-laboratory  
0972 = Professional fees-radiology diagnostic  
0973 = Professional fees-radiology therapeutic  
0974 = Professional fees-nuclear medicine  
0975 = Professional fees-operating room  
0976 = Professional fees-respiratory therapy  
0977 = Professional fees-physical therapy  
0978 = Professional fees-occupational therapy  
0979 = Professional fees-speech pathology  
NOTE: 098X is an extension of 096X & 097X  
0981 = Professional fees-emergency room  
0982 = Professional fees-outpatient services  
0983 = Professional fees-clinic  
0984 = Professional fees-medical social services  
0985 = Professional fees-EKG  
0986 = Professional fees-EEG  
0987 = Professional fees-hospital visit

- 0988 = Professional fees-consultation
- 0989 = Professional fees-private duty nurse
- 0990 = Patient convenience items-general classification
- 0991 = Patient convenience items-cafeteria/guest tray
- 0992 = Patient convenience items-private linen service
- 0993 = Patient convenience items-telephone/telecom
- 0994 = Patient convenience items-tv/radio
- 0995 = Patient convenience items-nonpatient room rentals
- 0996 = Patient convenience items-late discharge charge
- 0997 = Patient convenience items-admission kits
- 0998 = Patient convenience items-beauty shop/barber
- 0999 = Patient convenience items-other
- 1000 = Behavioral Health Accommodations -  
general classification
- 1001 = Behavioral Health Accommodations -  
residential treatment -Psychiatric
- 1002 = Behavioral Health Accommodations -  
residential treatment - chemical  
dependency
- 1003 = Behavioral Health Accommodations -  
supervised living
- 1004 = Behavioral Health Accommodations -  
halfway house
- 1005 = Behavioral Health Accommodations -  
group home
- 2100 = Alternative Therapy Services - general  
classification
- 2101 = Alternative Therapy Services -  
Acupuncture
- 2102 = Alternative Therapy Services -  
Acupressure
- 2103 = Alternative Therapy Services -  
massage
- 2104 = Alternative Therapy Services -  
reflexology
- 2105 = Alternative Therapy Services -  
biofeedback
- 2106 = Alternative Therapy Services -  
hypnosis
- 2109 = Alternative Therapy Services -  
other alternative therapy service
- 3100 = Adult Care - Reserved
- 3101 = Adult Care - adult day care, medical  
and social hourly
- 3102 = Adult Care - adult day care, social-  
hourly
- 3103 = Adult Care - adult day care, medical  
and social - daily
- 3104 = Adult Care - adult day care, social -  
daily
- 3105 = Adult Care - adult foster care daily
- 3109 = Adult Care - other adult care

NOTE: Following Revenue Codes reported



for NHCMQ (RUGS) demo claims effective  
2/96.

- 9000 = RUGS-no MDS assessment available
- 9001 = Reduced physical functions-  
RUGS PA1/ADL index of 4-5
- 9002 = Reduced physical functions-  
RUGS PA2/ADL index of 4-5
- 9003 = Reduced physical functions-  
RUGS PB1/ADL index of 6-8
- 9004 = Reduced physical functions-  
RUGS PB2/ADL index of 6-8
- 9005 = Reduced physical functions-  
RUGS PC1/ADL index of 9-10
- 9006 = Reduced physical functions-  
RUGS PC2/ADL index of 9-10
- 9007 = Reduced physical functions-  
RUGS PD1/ADL index of 11-15
- 9008 = Reduced physical functions-  
RUGS PD2/ADL index of 11-15
- 9009 = Reduced physical functions-  
RUGS PE1/ADL index of 16-18
- 9010 = Reduced physical functions-  
RUGS PE2/ADL index of 16-18
- 9011 = Behavior only problems-  
RUGS BA1/ADL index of 4-5
- 9012 = Behavior only problems-  
RUGS BA2/ADL index of 4-5
- 9013 = Behavior only problems-  
RUGS BB1/ADL index of 6-10
- 9014 = Behavior only problems-  
RUGS BB2/ADL index of 6-10
- 9015 = Impaired cognition-  
RUGS IA1/ADL index of 4-5
- 9016 = Impaired cognition-  
RUGS IA2/ADL index of 4-5
- 9017 = Impaired cognition-  
RUGS IB1/ADL index of 6-10
- 9018 = Impaired cognition-  
RUGS IB2/ADL index of 6-10
- 9019 = Clinically complex-  
RUGS CA1/ADL index of 4-5
- 9020 = Clinically complex-  
RUGS CA2/ADL index of 4-5d
- 9021 = Clinically complex-  
RUGS CB1/ADL index of 6-10
- 9022 = Clinically complex-  
RUGS CB2/ADL index of 6-10d
- 9023 = Clinically complex-  
RUGS CC1/ADL index of 11-16
- 9024 = Clinically complex-  
RUGS CC2/ADL index of 11-16d
- 9025 = Clinically complex-  
RUGS CD1/ADL index of 17-18

9026 = Clinically complex-  
RUGS CD2/ADL index of 17-18d  
9027 = Special care-  
RUGS SSA/ADL index of 7-13  
9028 = Special care-  
RUGS SSB/ADL index of 14-16  
9029 = Special care-  
RUGS SSC/ADL index of 17-18  
9030 = Extensive services-  
RUGS SE1/1 procedure  
9031 = Extensive services-  
RUGS SE2/2 procedures  
9032 = Extensive services-  
RUGS SE3/3 procedures  
9033 = Low rehabilitation-  
RUGS RLA/ADL index of 4-11  
9034 = Low rehabilitation-  
RUGS RLB/ADL index of 12-18  
9035 = Medium rehabilitation-  
RUGS RMA/ADL index of 4-7  
9036 = Medium rehabilitation-  
RUGS RMB/ADL index of 8-15  
9037 = Medium rehabilitation-  
RUGS RMC/ADL index of 16-18  
9038 = High rehabilitation-  
RUGS RHA/ADL index of 4-7  
9039 = High rehabilitation-  
RUGS RHB/ADL index of 8-11  
9040 = High rehabilitation-  
RUGS RHC/ADL index of 12-14  
9041 = High rehabilitation-  
RUGS RHD/ADL index of 15-18  
9042 = Very high rehabilitation-  
RUGS RVA/ADL index of 4-7  
9043 = Very high rehabilitation-  
RUGS RVB/ADL index of 8-13  
9044 = Very high rehabilitation-  
RUGS RVC/ADL index of 14-18

\*\*\*Changes effective for providers entering\*\*\*

\*\*RUGS Demo Phase III as of 1/1/97 or later\*\*

9019 = Clinically complex-  
RUGS CA1/ADL index of 11  
9020 = Clinically complex-  
RUGS CA2/ADL index of 11D  
9021 = Clinically complex-  
RUGS CB1/ADL index of 12-16  
9022 = Clinically complex-  
RUGS CB2/ADL index of 12-16D  
9023 = Clinically complex-  
RUGS CC1/ADL index of 17-18  
9024 = Clinically complex-  
RUGS CC2/ADL index of 17-18D

- 9025 = Special care-  
RUGS SSA/ADL index of 14
- 9026 = Special care-  
RUGS SSB/ADL index of 15-16
- 9027 = Special care-  
RUGS SSC/ADL index of 17-18
- 9028 = Extensive services-  
RUGS SE1/ADL index 7-18/1 procedure
- 9029 = Extensive services-  
RUGS SE2/ADL index 7-18/2 procedures
- 9030 = Extensive services-  
RUGS SE3/ADL index 7-18/3 procedures
- 9031 = Low rehabilitation-  
RUGS RLA/ADL index of 4-13
- 9032 = Low rehabilitation-  
RUGS RLB/ADL index of 14-18
- 9033 = Medium rehabilitation-  
RUGS RMA/ADL index of 4-7
- 9034 = Medium rehabilitation-  
RUGS RMB/ADL index of 8-14
- 9035 = Medium rehabilitation-  
RUGS RMC/ADL index of 15-18
- 9036 = High rehabilitation-  
RUGS RHA/ADL index of 4-7
- 9037 = High rehabilitation-  
RUGS RHB/ADL index of 8-12
- 9038 = High rehabilitation-  
RUGS RHC/ADL index of 13-18
- 9039 = Very High rehabilitation-  
RUGS RVA/ADL index of 4-8
- 9040 = Very high rehabilitation-  
RUGS RVB/ADL index of 9-15
- 9041 = Very high rehabilitation-  
RUGS RVC/ADL index of 16
- 9042 = Very high rehabilitation-  
RUGS RUA/ADL index of 4-8
- 9043 = Very high rehabilitation-  
RUGS RUB/ADL index of 9-15
- 9044 = Ultra high rehabilitation-  
RUGS RUC/ADL index of 16-18

REV\_CNTR\_THRPY\_CAP\_IND\_CD\_TB

Revenue Center Therapy CAP Indicator Code Table

A = Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator will be used on institutional claims only).

B = Critical Access Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator will be used on institutional claims only). Note: Currently, Critical Access Hospital claims are not subject to any therapy cap policies.

Indicator B is created here to prepare for possible future legislation to include these claims.

C = The therapy cap exceptions process, as indicated by the submission of the KX modifier, no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

D = The \$3700 threshold for review therapy services no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

REV\_CNTR\_VLNTRY\_SRVC\_IND\_TB            Revenue Center Voluntary Service Indicator Table

V = A voluntary procedure code  
Blank = A required procedure code

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

QUERY: RIFQQ11, RIFQQ21 ON DB2T  
\*\*\*\*\*END OF TOC APPENDIX FOR RECORD: FI\_IP\_SNF\_CLM\_REC\*\*\*\*\*

1  
LIMITATIONS APPENDIX FOR RECORD: FI\_IP\_SNF\_CLM\_REC, STATUS: PROD, VERSION: 21104  
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:**

**CLM\_POA\_IND\_CD\_LIM**

FULL NAME: Claim Present on Admission Indicator Code Limitation

**DESCRIPTION :**

**DESCRIPTION:**

Missing present on admission (POA) indicators on the NCH claims.

**BACKGROUND :**

A problem has been discovered with the Inpatient claims received from CWF from July 6, 2009 through October 4, 2009. The claims received during this timeperiod have no POA indicators. The problem was a result of a defect in the conversion code used by CWF to convert the new 5010 record format back to the 4010 format for the NCH. The reason CWF was converting the claims to the 4010 format was because they implemented the 5010 format beginning in July 2009 but the NCH is still using the 4010 until 1/3/2011.

**CORRECTIVE ACTION :**

**CORRECTIVE ACTION:**

CWF will be sending in adjustment claims to correct the problem. The claims will come into the NCH the week of December 19, 2009. There were approximately 3 million claims missing the POA indicator.

**SOURCE:**

**ADMINISTRATIVE DATA:**

START DATE : 7/6/09

END DATE : 10/5/09

**CONTACT**

CONTACT act: OIS/EDG/DIDPM

**CLM\_PRCRDR\_PRCRFRM\_DT\_LIM**

FULL NAME: Claim Procedure Perform Date Limitation

**DESCRIPTION :**

The principal procedure perform date is missing from all Inpatient/SNF claims processed from January 1/2012 through March 31, 2012. Service years involved are 2011 and 2012.

**BACKGROUND :**

Back in February 2012, a data user of our NCH 100% Monthly TAP file noticed that the principal procedure perform date was missing on the Inpatient/SNF claims starting in January 2012. After further investigation by CWF, it was discovered the problem originated from a coding change in the CWF January 2012 Quarterly Release.

In March 2013, another data user realized the date was missing from the claims. The principal procedure date is a critical data element for this data user and their Value Based Purchasing Project. They asked if we could have CWF send in adjustments to correct those erroneous claims.

**CORRECTIVE ACTION :**

This issue is being resolved in two Phases:

(1) Because CWF accidentally stripped the principal procedure date from the claims, FISS will need to provide the date to data user. The data user pulled claims information (HICN, from/thru date, etc.) from the NCH SAF to create a "trigger" file for FISS to use to pull the claims from their system to capture the principal procedure date. FISS will update the trigger file with the missing date so the user can include the date in their algorithms to produce their payment measures.

(2) FISS will provide the "trigger" file to CWF so they can create credit/debit claims for the NCH. NCH will update the 2011 and 2012 SAF to include those adjustments.

**SOURCE:**

**ADMINISTRATIVE DATA:**

START DATE : 01/01/2012

END DATE : 03/31/2012

CONTACT : OIS/EDG/DDOM

**CLM\_SNF\_VRSN\_I\_REC\_LIM**

FULL NAME: Claim SNF Version 'I' Record Limitation

**DESCRIPTION :**

SNF Version 'I' claims were incorrectly identified in the NCH Nearline as Inpatient encounter claims.

**BACKGROUND :**

SNF claims matching the Inpatient encounter data criteria were incorrectly identified as Inpatient encounters (NCH Claim Type Code is '61', rather than '20' or '30').

If the SNF claims were identified as Inpatient encounters, the MCO Paid Switch was set to '1'.

**CORRECTIVE ACTION :**

The problem was corrected during the NCH quarterly update in March 2001. The NCH Claim Type was correctly identified as '20' or '30'. The MCO Paid Switch was changed to '0'. A patch code trailer was added to the record: Patch Code '14' and a patch apply date of '20010330'.

**SOURCE:**

ADMINISTRATIVE DATA:

START DATE : 07/07/00  
END DATE : 01/26/01  
CONTACT : OIS/EDG/DMUDD

CLM\_TRANS\_CD\_LIM

FULL NAME: Claim Transaction Code Limitation

DESCRIPTION :

Claim Transaction Code missing from 1999 inpatient records and there was also a problem identified in the May and June 2000 data.

BACKGROUND :

Users of the data discovered that the claim transaction code was missing values 2 & 3 for service year 1999 and for the months of May and June, 2000. This information was confirmed and OIS/BSOG was notified.

CORRECTIVE ACTION :

In July 2000 the problem was fixed and the claim transaction code contained the correct values.

SOURCE:

CONTACT : OIS/EDG/DMUDD

CNCL\_CLM\_LIM

FULL NAME: Cancel Claim Limitation

DESCRIPTION :

It was brought to our attention in May 2012, that the expected volume of cancel claims (query code '0') was drastically reduced in the Inpatient claims files sent from CWF to NCH from April 2nd to May 8th.

BACKGROUND :

It was our understanding at the time the issue was first raised, in May, there were missing cancel claims on the April files.

In November 2012, we were notified by another data user that it appeared not all of the cancel claims were sent in the "special" file (received in May) so the problem still remained. After further investigation, we determined from CWF that the cancel claims were not truly missing from the April - May files, but the query code on those claims was incorrectly set for claims with an Action code of 4 or 6 which caused the appearance of a decrease in cancel claims. Claims with an action code of 4 or 6 should only have a query code of '0'.

It was determined that the CWF Spell Rewrite changes implemented with the CWF April 2012 Quarterly release was creating query codes of '0', '1', '3' and '5' for action codes 4 and 6.

When CWF created the utility to fix the problem reported in May, they pulled all claims processed from the timeframe of 4/2/12 - 5/8/12 that had an action code of 4 or 6 and changed the query code to a '0'. Not knowing that the issue with the original files was the claims were there but the query code was set

incorrectly, we processed the special file through our systems and loaded the data into our repositories. This means we have the claims with the incorrect query code and the same claims (from the special file) with the correct query code.

This issue caused a problem for users who were trying to create debit/credit pairs instead of using the standard final action routine. OIS/EDG/DDOM ran a subset of the problem claims through our final action algorithm and it appears that the claim are falling out correctly during SAF processing.

**CORRECTIVE ACTION :**

Once the original issue was brought to our attention in May, we notified CWF of the "missing" cancel claims. CWF put in an emergency fix on May 8th to correct the problem going forward. They also ran a utility to create the "special" file of the cancel claims and sent the file to the NCH on Saturday, May 12th. The special file processed through the NCH with the May data load.

As for the 2nd data user notification in November 2012, we notified CWF of the miscommunication of the exact problem with the original data. It was determined that CWF could unable to create adjustments to back out the incorrect claims sent in the original files. CWF no longer had the special file they created, so they had no way of identifying the claims that needed to be adjusted. It was determined that users who were doing debit/credit pairing instead of using the NCH SAFs could remove the incorrect claims by using the following criteria:

Pull any claims with an NCH Weekly Process Date of April 6th, April 13, April 20th, April 27th, May 4th, May 11th or May 18th that has an Action Code of 4 or 6 and Claim Query Codes of '1', '3' or '5'.

**SOURCE:**

**ADMINISTRATIVE DATA:**

START DATE : 04/02/2012  
END DATE : 05/08/2012  
CONTACT : OIS/EDG/DDOM

**HHA\_HCPCS\_LIM**

**FULL NAME:** Home Health HCPCS Limitation

**DESCRIPTION :**

It was determined that providers were not complying with the 15-minute increment billing instructions for using the 'G' HCPCS codes.

**BACKGROUND :**

The instructions state that providers are to use the newly created 'G' codes to identify services of the six home health disciplines during an HH episode of care. These 'G' codes (G0151, G0152, G0153, G0154, G0155, G0156) are subject to 15-minute interval billing. As a result the user can not trust the 'G' codes for visit



counting. For a more accurate accounting of services the user should rely on the revenue center codes rather than the HCPCS.

Currently there is a check that if the 15-minute increment 'G' codes appear, the revenue center code must be the corresponding HH discipline; however, there is no check to see if the discipline revenue center code appears and that the HCPCS contains the corresponding 'G' code.

**CORRECTIVE ACTION :**

The Standard Systems has put a fix in to correct this problem.

**SOURCE:**

**CONTACT : OIS/EDG/DMUDD**

**IP\_IME\_GME\_LIM**

**FULL NAME:** Inpatient IME/GME Limitation

**DESCRIPTION :**

Special payment records to reimburse teaching hospitals for direct/indirect graduate medical education costs (IME/GME payment records) were mistakenly put into the NCH.

**BACKGROUND :**

During the recovery from CWF history of NCH dropped claims, we were unaware that the files contained the IME/GME payment records. Normally, these claims are received in separate transmittals from the FFS claims and full UB-92 encounters; and are not stored in the NCH. The total number of IME/GMEs inserted was 181,693, representing \$57.76 million in reimbursement; involving service years 1998 and 1999.

To identify these claims, look for service years 1998 and 1999 inpatient claims with claim related condition codes 04 and 69. Condition code '69' is the identifying characteristic.

**NOTE:** There could be identical full inpatient encounter claims in history that match to these erroneous IME/GME records, except that they will not contain a condition code '69'. If the IME/GMEs are not deleted, it is possible when running the final action algorithm that the IME/GME record will remain and the full inpatient encounter claim could be dropped.

**CORRECTIVE ACTION :**

The IME/GME claims were not removed from the NCH, due to the impact it would have on the balancing counts. They were removed from the 1999 service year SAFs. The 1998 finalized SAFs were not rerun to incorporate the relevant dropped claims (only missing receipts for 6/18/99 and 6/25/99 weeks); the IME/GMEs are not in the 1998 SAFs.

**SOURCE:** NCH

CONTACT : OIS/EDG/DMUDD  
MCO\_PD\_SW\_LIM

FULL NAME: Claim MCO Paid Switch Limitation

DESCRIPTION :

The MCO paid switch made consistent with criteria used to identify an inpatient encounter claim.

BACKGROUND :

During the NCH Version 'I' conversion, history was populated with an NCH Claim Type Code that will identify the record as an inpatient encounter claim.

When applying the CWF logic to identify an inpatient encounter claim, it was discovered that when all the criteria was met the MCO paid switch was sometimes a blank or '0' (reflecting that the MCO did not pay the provider).

CORRECTIVE ACTION :

With the inception of the Version 'I' processing (7/00), if all the criteria for identifying an inpatient encounter claim is met but the MCO paid switch is a blank or '0' it is changed to a '1'.

A patch code = '13' was applied to all claims back to 7/1/97 service year thru date.

SOURCE:

CONTACT : OIS/EDG/DMUDD  
MLTPL\_REV\_CNTR\_0001\_CD\_LIM

FULL NAME: Multiple Revenue Center '0001' Code Limitation

DESCRIPTION :

Multiple total charge '0001' revenue center codes appearing on outpatient, hospice and home health claim records.

BACKGROUND :

On outpatient, home health and hospice it appears that more than one '0001' revenue center code is showing up on the claims. The first total charge line adds the revenue center codes above it correctly; the problem exists below the first total charge line where garbage may be present due to the FI Standard System not clearing out fields before processing the next claim. We believe the error began with the change-over to a different claims processing contractor in 1/98.

CORRECTIVE ACTION :

CWF created an edit to reject multiple '0001' revenue center codes, effective 6/28/99. EDG's CWFMQA process implemented an edit to drop any revenue center line items below the first total charge line. The NCH Nearline File, as well as the 1998 Standard Analytic Files (SAFs), have been patched/corrected to delete the multiple '0001' codes where present on any of the institutional claim types. Also, HCIS will be correcting the revenue center summaries during the next refresh.

The NCH\_PATCH\_CD field will reflect a value '10'.

SOURCE:

CONTACT : OIS/EDG/DMUDD

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 anomaly 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 conjunction 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 will have final payment information for claims.

**CORRECTIVE ACTION :**

According to Veritus (FI), the problem was caught in their system using a pre-payment edit prior to sending out the payments. The erroneous MSA value was corrected and the claims were then sent to PRICER again and paid correctly.

The claims were corrected and correct payments were made but these new payment amounts were never sent to CWF and are not reflected in the NCH.

**SOURCE:**

**CONTACT :** OIS/EDG/DMUDD

**PPS\_CPTL\_DRG\_WT\_NUM\_LIM**

**FULL NAME:** Claim PPS Capital DRG Weight Number Limitation

**DESCRIPTION :**

Field erroneously blanked out on segments 2-10.

**BACKGROUND :**

During the Version 'I' conversion of all service years (1991-6/30/00) the following field was erroneously blanked out on segments 2-10.

During the Version 'I' planning process, it was decided that all codes, dates, numbers, names and percent fields would be populated on all segments of a claim; but amount, counts, and quantities would be zeroed out on segments 2-10 to eliminate the risk of overstating values.

**CORRECTIVE ACTION :**

This data can not be recovered.

**SOURCE:**

**CONTACT :** OIS/EDG/DMUDD

**PPS\_CPTL\_DSCHRG\_FRCTN\_PCT\_LIM**

**FULL NAME:** Claim PPS Capital Discharge Fraction Percent Limitation

**DESCRIPTION :**

Field erroneously blanked out on segments 2-10.

**BACKGROUND :**

During the Version 'I' conversion of all service years (1991 through 6/30/00) the following field was erroneously blanked out on segments 2-10.

During the Version 'I' planning process, it was decided that all codes, dates, numbers, names and percent fields would be populated on all segments of a claim; but amount, counts, and quantities would be zeroed out on segments 2-10 to eliminate the risk of overstating values.

**CORRECTIVE ACTION :**

This data can not be recovered.

**SOURCE:**

**CONTACT :** OIS/EDG/DMUDD

**REV\_CNTR\_IDE\_NDC\_UPC\_LIM**

**FULL NAME:** Revenue Center IDE, NDC, UPC Limitation

**DESCRIPTION :**

Missing data in the REV\_CNTR\_IDE\_NDC\_UPC\_NUM

field.

**BACKGROUND :**

Prior to Version 'I', this field housed only the 7-position exemption number assigned by the FDA to an investigational device after a manufacturer has been approved to conduct a clinical trial on that device. With Version 'I', this field expanded to 24 positions to accommodate the future receipt of the National Drug Code and the Uniform Product Code. The CWFMQA editing process was moving the IDE to the expanded field, but then incorrectly blanked it out (positions 8-24 should be blank).

**CORRECTIVE ACTION :**

CWFMQA fixed the code and the problem was corrected with claims processed with NCH weekly process date 9/15/00.

**SOURCE:**

**ADMINISTRATIVE DATA:**

START DATE : 06/09/00  
END DATE : 09/08/00  
CONTACT : OIS/EDG/DMUDD

**REV\_CNTR\_RNDRNG\_SPCLTY\_CD\_LIM**

**FULL NAME:** Revenue Center Rendering Specialty Code Limitation

**DESCRIPTION :**

It was discovered that the specialty code at the line level on Outpatient claims was erroneous due to the truncation of the the revenue center rendering physician NPI number.

**BACKGROUND :**

In March 2013, it was discovered that since January 2013 FISS was sending CWF/NCH truncated revenue center rendering physician NPI numbers. Because the NPI was being truncated this also caused erroneous data in the specialty code field. This issue only impacts outpatient claims.

After further investigation, it was determined that the correct outpatient copybook was not being used with the implementation of the January release.

**CORRECTIVE ACTION :**

The fix for this anomaly is being handled in two phases:

Phase 1 -- a fix was put in the FISS system on 4/22/2013 to correct the issue going forward.

Phase 2 -- the second fix will be to send debit/credit adjustmentss to correct the data in the NCH/SAF.

**SOURCE:**

**ADMINISTRATIVE DATA:**

START DATE : 01/01/2013  
END DATE : 04/22/2013  
CONTACT : OIS/EDG/DDOM

**REV\_CNTR\_TOT\_CHRG\_AMT\_LIM**

**FULL NAME:** Revenue Center Total Charge Amount Limitation

**DESCRIPTION :**

Revenue center total charge amount field being

populated on segments 2-10 of the Version 'I' record.

**BACKGROUND :**

Under Version 'I', a decision was made that any amount, count and quantity field would be zeroed out to eliminate the risk of overstating values during an accumulation.

**CORRECTIVE ACTION :**

The CWFMQA front-end process was modified to zero out the total charge amount field in segments 2-10.

**SOURCE:**

**ADMINISTRATIVE DATA:**

START DATE : 07/01/00

END DATE : 02/02/01

CONTACT : OIS/EDG/DMUDD

**REV\_RNDRNG\_PHYSN\_NPI\_NUM\_LIM**

FULL NAME: Revenue Center Rendering Physician NPI Number Limitation

**DESCRIPTION :**

It was discovered that the NPI at the line level on Outpatient claims was being truncated since January 2013.

**BACKGROUND :**

In March 2013, it was discovered that since January 2013 FISS was sending CWF/NCH truncated revenue center rendering physician NPI numbers (REV-CNTR-RNDRNG-PHYSN-NPI-NUM). The NPIs were coming in as 8 bytes instead of 10 bytes. Because the NPI is truncated it is also causing erroneous data in the specialty code (REV-CNTR-RNDRNG-SPCLTY-CD) field. The issue only impacts outpatient claims.

After further investigation, it was determined that the correct outpatient copybook was not being used with the implementation of the January release.

**CORRECTIVE ACTION :**

The fix for this anomaly is being handled in two phases:

Phase 1 -- a fix was put in the FISS system on 4/22/13 to correct the issue going forward.

Phase 2 -- A second fix will be to send in debit/credit adjustments to correct the data in the NCH/SAF.

**SOURCE:**

**ADMINISTRATIVE DATA:**

START DATE : 01/01/2013

END DATE : 04/22/2013

CONTACT : OIS/EDG/DDOM

**TOT\_CHRG\_AMT\_LIM**

FULL NAME: Claim Total Charge Amount Limitation

**DESCRIPTION :**

The total charge amount field in the fixed portion was truncated on outpatient, hospice and home health claims.

**BACKGROUND :**

For outpatient, hospice and home health claims, the

total charge amount field in the fixed portion was truncated (the cents were dropped off; the decimal point was moved, making cents out of dollars) in the CWFMQA process beginning with data received from CWF 1/4/99 through 5/14/99. The problem occurred when CWF increased the size of the field.

CORRECTIVE ACTION :

The CWFMQA front-end was fixed. The Nearline was patched during the quarterly merge in 7/99 for service years 1998 and 1999. The NCH\_PACTCH\_CD field will be populated with a value '11'. The 1998 and 1999 SAFs were corrected when finalized in 7/99.

The patch involved moving the total charge amount in the revenue center trailer to the total charge amount field in the fixed portion, for records with NCH Daily Process Date 1/4/99 - 5/14/99.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 01/04/99  
END DATE : 05/14/99  
CONTACT : OIS/EDG/DMUDD

QUERY: RIFQQ41 ON DB2T

\*\*\*\*\*END OF LIMITATION APPENDIX FOR RECORD: FI\_IP\_SNF\_CLM\_REC\*\*\*\*\*