# *Research Data Distribution Center*
# *LDS Carrier Claim Record*
# *Data Dictionary*

| ***Variable Name*** | ***Label*** |
|---|---|

*CLAIM_NO*

*CLAIM NUMBER*

The unique number used to identify a unique claim.

SAS ALIAS: CLAIM_NO
STANDARD ALIAS: CLAIM_NO

*DSYSRTKY*

*DESY SORT KEY*

This field contains the key to link data for each beneficiary across all claim files.

SAS ALIAS: DSYSRTKY
STANDARD ALIAS: DESY_SORT_KEY

*REC_LVL*

*NCH Near-Line Record Version Code*

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

CODES:
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

COMMENT:
Prior to Version H this field was named:
CLM_NEAR_LINE_REC_VRSN_CD

SOURCE:
NCH

*RIC_CD*

*NCN Near Line Record Identification Code*

A code defining the type of claim record being processed.
COMMON ALIAS: RIC

DBS ALAIS: NEAR_LINE_RIC_CD
SAS ALIAS: RIC_CD
STANDARD ALIAS: NHC_NEAR_LINE_RIC_CD
TITLE ALIAS: RIC

CODES:
REFER TO: NCH_NEAR_LINE_RIC_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was names:
RIC_CD

SOURCE: NCH

*CLM_TYPE* *NCH Claim Type Code*

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 through- out 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). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.

DB2 ALIAS: NCH_CLM_TYPE_CD
SAS ALIAS: CLM_TYPE
STANDARD ALIAS: ULTCARRI_NCH_CLM_TYPE_CD
SYSTEM ALIAS: LTTYPE
TITLE ALIAS: CLAIM_TYPE

DERIVATION:
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

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(HDC processing -- AVAILABLE IN NMUD)
FI_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
FROM: (HDC processing -- AVAILABLE IN NMUD)
FI_NUM
CLM_FAC_TYPE_CD
CLM_SRVC_CLSFCTN_TYPE_CD
CLM_FREQ_CD
NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(AVAILABLE IN NMUD)
CARR_NUM
CLM_DEMO_ID_NUM

OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(AVAILABLE IN NMUD)
FI_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE
DERIVED FROM: (AVAILABLE IN NMUD)
FI_NUM
CLM_FAC_TYPE_CD
CLM_SRVC_CLSFCTN_TYPE_CD
CLM_FREQ_CD

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 41 (OUTPATIENT 'FULL' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) 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'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1. FI_NUM = 80881
2. CLM_FAC_TYPE_CD = '1' OR '8';
CLM_SRVC_ CLSFCTN_TYPE_CD = '2', '3' OR '4'
& CLM_FREQ_CD = 'Z', 'Y' OR 'X'

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 (INPATIENT 'ABBREVIATED' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_ TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

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 73 (PHYSICIAN ENCOUNTER CLAIM--
EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING

CONDITIONS ARE MET:
1. CARR_NUM = 80882 AND
2. CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS 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).

CODES:
REFER TO: NCH_CLM_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
NCH

*STATE_CD* *Beneficiary Residence SSA Standard State Code*

The SSA standard state code of a beneficiary's residence.
DA3 ALIAS: SSA_STANDARD_STATE_CODE DB2 ALIAS: BENE_SSA_STATE_CD
SAS ALIAS: STATE_CD
STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD
TITLE ALIAS: BENE_STATE_CD

EDIT-RULES:
OPTIONAL: MAY BE BLANK

CODES:
REFER TO: GEO_SSA_STATE_TB
IN THE CODES APPENDIX

COMMENT:
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

*THRU_DT* *Claim Through Date*

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

For the ENCRYPTED Standard View of the Carrier files, the claim through date is coded as the quarter of the calendar year when the claim through date occurred.

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

8 DIGITS UNSIGNED

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

EDIT-RULES FOR ENCRYPTED DATA:
YYYYQ000 WHERE Q IS ONE OF
THE FOLLOWING VALUES.
1 = FIRST QUARTER OF THE CALENDAR YEAR
2 = SECOND QUARTER OF THE CALENDAR YEAR
3 = THIRD QUARTER OF THE CALENDAR YEAR
4 = FOURTH QUARTER OF THE CALENDAR YEAR

SOURCE:
CWF

*SGMT_CNT* *Claim Total Segment Count*

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.
2 DIGITS UNSIGNED
DB2 ALIAS: TOT_SGMT_CNT
SAS ALIAS: SGMT_CNT
STANDARD ALIAS: CLM_TOT_SGMT_CNT
TITLE ALIAS: SEGMENT_COUNT
SOURCE:
CWF

*SGMT_NUM* *Claim Segment Number*

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.
2 DIGITS UNSIGNED
DB2 ALIAS: CLM_SGMT_NUM
SAS ALIAS: SGMT_NUM
STANDARD ALIAS: CLM_SGMT_NUM
TITLE ALIAS: SEGMENT_NUMBER
SOURCE:
CWF

*CNTY_CD* *Beneficiary Residence SSA Standard County Code*

The SSA standard county code of a beneficiary's residence. DA3 ALIAS: SSA_STANDARD_COUNTY_CODE
DB2 ALIAS: BENE_SSA_CNTY_CD
SAS ALIAS: CNTY_CD
STANDARD ALIAS: BENE_RSDNC_SSA_STD_CNTY_CD
TITLE ALIAS: BENE_COUNTY_CD

EDIT-RULES:
OPTIONAL: MAY BE BLANK

SOURCE:
SSA/EDB

*CARR_NUM* *Carrier Number*

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

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

CODES:
REFER TO: CARR_NUM_TB
IN THE CODES APPENDIX

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

SOURCE:
CWF

*SEX* — *Beneficiary Sex Identification Code*

The sex of a beneficiary. COMMON ALIAS: SEX_CD
DA3 ALIAS: SEX_CODE
DB2 ALIAS: BENE_SEX_IDENT_CD
SAS ALIAS: SEX
STANDARD ALIAS: BENE_SEX_IDENT_CD
SYSTEM ALIAS: LTSEX
TITLE ALIAS: SEX_CD

EDIT-RULES:
REQUIRED FIELD

CODES:
1 = Male
2 = Female
0 = Unknown

SOURCE:
SSA,RRB,EDB

*RACE* — *Beneficiary Race Code*

The race of a beneficiary. DA3
ALIAS: RACE_CODE DB2
ALIAS: BENE_RACE_CD
SAS ALIAS: RACE
STANDARD ALIAS: BENE_RACE_CD
SYSTEM ALIAS: LTRACE
TITLE ALIAS: RACE_CD

CODES:
0 = Unknown
1 = White
2 = Black
3 = Other
4 = Asian
5 = Hispanic
6 = North American Native

SOURCE:
SSA

*BENE_DOB* — *Beneficiary Birth Date*

The beneficiary's date of birth.
For the ENCRYPTED Standard View of
the Carrier files, the beneficiary's
date of birth (age) is coded as a range.

8 DIGITS UNSIGNED

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

EDIT-RULES FOR ENCRYPTED
DATA: 0000000R
WHERE R HAS ONE OF THE FOLLOWING VALUES.

0 = Unknown
1 = <65
2 = 65 thru 69
3 = 70 thru 74
4 = 75 thru 79
5 = 80 thru 84
6 = >84

SOURCE:
CWF

## *MS_CD* — *CWF Beneficiary Medicare Status Code*

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

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

DERIVATION:
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. |

CODES:
10 = Aged without ESRD
11 = Aged with ESRD
20 = Disabled without ESRD
21 = Disabled with ESRD
31 = ESRD only

COMMENT:
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

## *PDGNS_CD* — *Claim Principal Diagnosis Code*

The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record 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.

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

EDIT-RULES:
ICD-9-CM

SOURCE:
CWF

*PMTDNLCD* *Carrier Claim Payment Denial Code*

The code on a noninstitutional claim indicating to whom payment was made or if the claim was denied.
DB2 ALIAS: CARR_PMT_DNL_CD
SAS ALIAS: PMTDNLCD
STANDARD ALIAS: CARR_CLM_PMT_DNL_CD
TITLE ALIAS: PMT_DENIAL_CD

CODES:
REFER TO: CARR_CLM_PMT_DNL_TB
IN THE CODES APPENDIX

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

SOURCE:
CWF

*TRTMT_CD* *Claim Excepted/Nonexcepted Medical Treatment Code*

*This field is no longer populated as it is unavailable from the data source.*

*PMT_AMT* *Claim Payment Amount*

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 sent; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible 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 daily per diem rate no matter what the charges are.)
Under IP PPS, inpatient hospital services are paid based a predetermined rate per discharge, using the DRG classification system and the PRICER program. On the PPS claim, the payment amount includes the DRG approved payment amount, disproportionate share 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). 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 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 '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 payment. The Medicare payment amount takes into account the wage adjustment and the beneficiary deductible and amounts. NOTE: There is no CWF edit check to validate the revenue center Medicare payment amount equals the

claim
level Medicare payment amount.

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

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

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

Exceptions: For claims involving demos and BBA 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.

9.2 DIGITS SIGNED

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

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was S9(7)V99. Als the noninstitutional claim records carried this field as a l item. Effective with Version H, this element is a claim lev field across all claim types (and the line item field has be renamed.)

SOURCE:
CWF

LIMITATIONS:
Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM_DISP_CD of '02', the amount shown as the

Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over or under the actual Medicare payment amount.

### *PRPAYAMT* — *Carrier Claim Primary Payer Paid Amount*

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

NOTE: During the Version H conversion, this field was populated with data throughout history (back to service year 1991) by summing up the line item primary payer amounts.
9.2 DIGITS SIGNED
DB2 ALIAS: CARR_PRMRY_PYR_AMT
SAS ALIAS: PRPAYAMT
STANDARD ALIAS: CARR_CLM_PRMRY_PYR_PD_AMT
TITLE ALIAS: PRIMARY_PAYER_AMOUNT

EDIT-RULES:
+9(9).99

SOURCE: CWF

### *RFR_UPIN* — *Carrier Claim Referring UPIN Number*

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

This field is ENCRYPTED for the ENCRYPTED Standard View of the Carrier file.

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

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

SOURCE:
CWF

### *ASGMNTCD* — *Carrier Claim Provider Assignment Indicator Switch*

A switch indicating whether or not the provider accepts assignment for the noninstitutional claim.
DB2 ALIAS: PRVDR_ASGNMT_SW
SAS ALIAS: ASGMNTCD
STANDARD ALIAS:
CARR_CLM_PRVDR_ASGNMT_IND_SW
TITLE ALIAS: ASSIGNMENT_SW

CODES:
A = Assigned claim
N = Non-assigned claim

COMMENT:
Prior to Version H this field was named:
CWFB_CLM_PRVDR_ASGNMT_IND_SW.
SOURCE: CWF

*PROV_PMT* — *NCH Claim Provider Payment Amount*

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

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

9.2 DIGITS SIGNED

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

EDIT-RULES:
+9(9).99

SOURCE:
NCH QA Process

*BENE_PMT* — *NCH Claim Beneficiary Payment Amount*

Effective with Version H, the total payments made to the beneficiary for this claim (sum of line payment amounts to the beneficiary.)
NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

9.2 DIGITS SIGNED

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

EDIT-RULES:
+9(9).99

SOURCE:
NCH QA Process

*BENEPAID* — *Carrier Claim Beneficiary Paid Amount*

*This field is no longer populated as it is unavailable from the data source*.

*SBMTCHRG* — *NCH Carrier Claim Submitted Charge Amount*

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

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

9.2 DIGITS SIGNED

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

EDIT-RULES:
+9(9).99

SOURCE:
NCH QA Process

*ALOWCHRG* *NCH Carrier Claim Allowed Charge Amount*

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

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

9.2 DIGITS SIGNED

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

EDIT-RULES:
+9(9).99

SOURCE:
NCH QA Process

*DEDAPPLY* *Carrier Claim Cash Deductible Applied Amount*

Effective with Version H, the amount of the cash deductible as submitted on the claim.
NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

9.2 DIGITS SIGNED

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

EDIT-RULES:
+9(9).99

SOURCE:
CWF

*RFR_PRFL* *Carrier Claim Referring PIN Number*

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

This field is ENCRYPTED for the ENCRYPTED Standard View of the Carrier File.

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

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

SOURCE:
CWF

*CPO_PROV* — *Care Plan Oversight (CPO) Provider Number*

*This field is no longer populated as it is unavailable from the data source.*

*BLDFRNSH* — *Claim Blood Pints Furnished Quantity*

*This field is no longer populated as it is unavailable from the data source.*

*BLD_DED* — *Claim Blood Deductible Pints Quantity*

*This field is no longer populated as it is unavailable from the data source.*

*CDGNCNT* — *Carrier Claim Diagnosis Code Count*

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

1 DIGIT UNSIGNED

DB2 ALIAS: CARR_DGNS_CD_CNT
SAS ALIAS: CDGNCNT
STANDARD ALIAS: CARR_CLM_DGNS_CD_CNT
EDIT-RULES:
RANGE: 0 TO 4

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

SOURCE:
NCH

*CLINECNT* — *Carrier Claim Line Count*

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

2 DIGITS UNSIGNED

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

EDIT-RULES:
RANGE: 1 TO 13

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

SOURCE:
CWFB CLAIMS

*RFR_NPI* — *Carrier Claim Referring Physician NPI Number*

The National Provider Identifier (NPI) number of the physician who referred the beneficiary to the physician who performed the Part B services.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, NPIs, OSCAR provider numbers, etc.) on the standard 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.

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

SAS ALIAS: ORD_NPI
STANDARD ALIAS: DMERC_CLM_ORDRG_PHYSN_NPI_NUM

### *DGNSCD{x}* *Claim Diagnosis Code*

*where { x } ranges from 1 to 4 (1 to 8 beginning in 2007)*

The ICD-9-CM based 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.

DB2 ALIAS: CLM_DGNS_CD
SAS ALIAS: DGNSCD{x}
STANDARD ALIAS: CLM_DGNS_CD{x}
TITLE ALIAS: DIAGNOSIS

EDIT-RULES:
ICD-9-CM

COMMENT:
Prior to Version H this field was named: CLM_OTHR_DGNS_CD.

### *PRFRFL{x}* *Carrier Line Performing PIN Number*

*where { x } ranges from 1 to 13*

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

This field is ENCRYPTED for the ENCRYPTED Standard View of the Carrier file.

COMMON ALIAS:
PHYSICIAN/SUPPLIER_PROVIDER_NUM
DB2 ALIAS: LINE_PRFRMG_PIN
SAS ALIAS: PRFPRFL{x}
STANDARD ALIAS: CARR_LINE_PRFRMG_PIN_NUM{x}
TITLE ALIAS: PRFRMG_PIN

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

SOURCE:
CWF

### *PRFUPN{x}* *Carrier Line Performing UPIN Number*

*where { x } ranges from 1 to 13*

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

This field is ENCRYPTED for the ENCRYPTED Standard View of the Carrier file.

DB2 ALIAS: LINE_PRFRMG_UPIN
SAS ALIAS: PRFUPIN{x}
STANDARD ALIAS: CARR_LINE_PRFRMG_UPIN_NUM{x}
TITLE ALIAS: PRFRMG_UPIN

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

SOURCE:
CWF

### *PRVSTT{x}* *Line NCH Provider State Code*

*where { x } ranges from 1 to 13*

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

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

DB2 ALIAS: LINE_PRVDR_STATE
SAS ALIAS: PRVSTT{x}
STANDARD ALIAS: LINE_NCH_PRVDR_STATE_CD{x}
TITLE ALIAS: PRVDR_STATE
DERIVATION:
DERIVED FROM:
CARR_LINE_PRFRMG_PRVDR_ZIP_CD

DERIVATION RULES:

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

CODES:
REFER TO: GEO_SSA_STATE_TB

SOURCE:
NCH

### *HCFPCL{x}* *Line HCFA Provider Specialty Code*

*where { x } ranges from 1 to 13*

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

DB2 ALIAS: HCFA_SPCLTY_CD
SAS ALIAS: HCFPCL{x}
STANDARD ALIAS: LINE_HCFA_PRVDR_SPCLTY_CD{x}
TITLE ALIAS: HCFA_PRVDR_SPCLTY

CODES:
REFER TO: HCFA_PRVDR_SPCLTY_TB
IN THE CODES APPENDIX

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

SOURCE:
CWF

### *PRTPTG{x}* *Line Provider Participating Indicator Code*

*where { x } ranges from 1 to 13*

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

DB2 ALIAS: PRVDR_PRTCPTG_CD
SAS ALIAS: PRTPTG{x}
STANDARD ALIAS: LINE_PRVDR_PRTCPTG_IND_CD{x}
TITLE ALIAS: PRVDR_PRTCPTG_IND

CODES:

REFER TO: LINE_PRVDR_PRTCPTG_IND_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CWFB_PRVDR_PRTCPTG_IND_CD.
SOURCE:
CWF

### *ASTTCD{x}* *Carrier Line Reduced Payment Physician Assistant Code*

*where { x } ranges from 1 to 13*

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

COMMON ALIAS: PA_65/75/85%_FEE
DB2 ALIAS: PHYSN_ASTNT_CD
SAS ALIAS: ASTTCD{x}
STANDARD ALIAS:
CARR_LINE_RDCD_PHYSN_ASTNT_CD{x}
TITLE ALIAS: PHYSN_ASTNT_CD

CODES:
REFER TO: CARR_LINE_RDCD_PHYSN_ASTNT_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CWFB_RDCD_PMT_PHYSN_ASTNT_CD.
SOURCE:
CWF

### *SRVCNT{x}* *Line Service Count*

*where { x } ranges from 1 to 13*

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

3 DIGITS SIGNED

DB2 ALIAS: SRVC_CNT
SAS ALIAS: SRVCNT{x}
STANDARD ALIAS: LINE_SRVC_CNT{x}

EDIT - RULES:
+999

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

SOURCE:
CWF

### *TYPVCB{x}* — *Line HCFA Type Service Code*

*where { x } ranges from 1 to 13*

Code indicating the type of service, as defined in the HCFA Medicare Carrier Manual, for this line item on the non-institutional claim.
DB2 ALIAS: HCFA_TYPE_SRVC_CD
SAS ALIAS: TYPVCB{x}
STANDARD ALIAS:
LINE_HCFA_TYPE_SRVC_CD {x}
SYSTEM ALIAS: LTTOS
TITLE ALIAS: HCFA_TYPE_SRVC

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

CODES:
REFER TO: HCFA_TYPE_SRVC_TB
IN THE CODES APPENDIX

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

SOURCE:
CWF

### *PLCRVC{x}* — *Line Place Of Service Code*

*where { x } ranges from 1 to 13*

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

COMMON ALIAS: POS
DB2 ALIAS: LINE_PLC_SRVC_CD
SAS ALIAS: PLCRVC[x}
STANDARD ALIAS: LINE_PLC_SRVC_CD{x}
TITLE ALIAS: PLC_SRVC

CODES:
REFER TO: LINE_PLC_SRVC_TB
IN THE CODES APPENDIX

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

SOURCE:
CWF

### *LCLYCD{x}* — *Carrier Line Pricing Locality Code*

*where { x } ranges from 1 to 13*

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

DB2 ALIAS: PRCNG_LCLTY_CD
SAS ALIAS: LCLYCD{x}
STANDARD ALIAS: CARR_LINE_PRCNG_LCLTY_CD[x}
TITLE ALIAS: PRICING_LOCALITY

EDIT-RULES:
CARRIER INFORMATION FILE
COMMENT:
Prior to Version H this field was named:
CWFB_CARR_PRCNG_LCLTY_CD.

SOURCE:
CWF

### *EXDT2_{x}* — *Line Last Expense Date*

*where { x } ranges from 1 to 13*

The ending date (last expense) for the line item service on the non-institutional claim.

8 DIGITS UNSIGNED

COBOL ALIAS: LST_EXP_DT
DB2 ALIAS: LINE_LAST_EXPNS_DT
SAS ALIAS: EXDT2_[x}
STANDARD ALIAS: LINE_LAST_EXPNS_DT{x}
TITLE ALIAS: LAST_EXPNS_DT

EDIT-RULES FOR ENCRYPTED DATA:
YYYYQ000 WHERE Q IS ONE OF
THE FOLLOWING VALUES.
1 = FIRST QUARTER OF THE CALENDAR YEAR
2 = SECOND QUARTER OF THE CALENDAR YEAR
3 = THIRD QUARTER OF THE CALENDAR YEAR
4 = FOURTH QUARTER OF THE CALENDAR YEAR

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

SOURCE:
CWF

### *HCPSCD{x}* — *Line HCPCS Code*

*where { x } ranges from 1 to 13*

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

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

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

Level I
Codes and descriptors copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4). These are 5 position numeric codes representing physician and non-physician 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 non-physician 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 non-physician services that are not represented in the level I or level II codes.

### *MDCD1_{x}* — *Line HCPCS Initial Modifier Code*

*where { x } ranges from 1 to 13*

A first modifier to the HCPCS procedure code to enable a more specific procedure identification for the line item on the non-institutional claim.

DB2 ALIAS: HCPCS_1ST_MDFR_CD
SAS ALIAS: MDCD1_[x}
STANDARD ALIAS: LINE_HCPCS_INITL_MDFR_CD{x}
TITLE ALIAS: INITIAL_MODIFIER

EDIT-RULES:
CARRIER INFORMATION FILE

COMMENT:
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

### *MDCD2_{x}* — *Line HCPCS Second Modifier Code*

*where { x } ranges from 1 to 13*

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

DB2 ALIAS: HCPCS_2ND_MDFR_CD
SAS ALIAS: MDCD2_[x}
STANDARD ALIAS: LINE_HCPCS_2ND_MDFR_CD{x}
TITLE ALIAS: SECOND_MODIFIER

EDIT-RULES:
CARRIER INFORMATION FILE

COMMENT:
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

### *BETOS{x}* — *Line NCH BETOS Code*

*where { x } ranges from 1 to 13*

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

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

DB2 ALIAS: LINE_NCH_BETOS_CD
SAS ALIAS: BETOS{x}
STANDARD ALIAS: LINE_NCH_BETOS_CD{x}
SYSTEM ALIAS: LTBETOS
TITLE ALIAS: BETOS

DERIVATION:
DERIVED FROM:
LINE_HCPCS_CD
LINE_HCPCS_INITL_MDFR_CD
LINE_HCPCS_2ND_MDFR_CD
HCPCS MASTER FILE

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

CODES:
REFER TO: BETOS_TB
IN THE CODES APPENDIX

SOURCE:
NCH

### *LNID{x}* — *Line IDE Number*

*This field is no longer populated as it is unavailable from the data source.*

### *NDC_CD{x}* — *Line National Drug Code*

*This field is no longer populated as it is unavailable from the data source.*

### *LNPMT{x}* — *Line NCH Payment Amount*

*where { x } ranges from 1 to 13*

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

9.2 DIGITS SIGNED

COMMON ALIAS: REIMBURSEMENT
DB2 ALIAS: LINE_NCH_PMT_AMT
SAS ALIAS: LNPMT{x}

STANDARD ALIAS: LINE_NCH_PMT_AMT{x}
TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H this line item field was named:

CLM_PMT_AMT and the size of this field was S9(7)V99.

SOURCE:
NCH

*LBNPMT{x}* *Line Beneficiary Payment Amount*

*where { x } ranges from 1 to 13*

Effective with Version H, the payment (reim- bursement) made to the beneficiary related to the line item service on the noninstitu-
tional claim.

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

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_BENE_PMT_AMT
SAS ALIAS: LBNPMT{x}
STANDARD ALIAS: LINE_BENE_PMT_AMT{x}
TITLE ALIAS: BENE_PMT_AMT

EDIT-RULES:
+9(9).99

SOURCE:
CWF

*LPRPMT{x}* *Line Provider Payment Amount*

*where { x } ranges from 1 to 13*

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

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.

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_PRVDR_PMT_AMT
SAS ALIAS: LPRPMT{x}
STANDARD ALIAS: LINE_PRVDR_PMT_AMT{x}
TITLE ALIAS: PRVDR_PMT_AMT

EDIT-RULES:
+9(9).99

SOURCE:
CWF

*LDDMT{x}* *Line Beneficiary Part B Deductible Amount*

*where { x } ranges from 1 to 13*

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

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_DDCTBL_AMT
SAS ALIAS: LDDMT{x}
STANDARD ALIAS: LINE_BENE_PTB_DDCTBL_AMT{x}
TITLE ALIAS: PTB_DED_AMT

EDIT-RULES:
+9(9).99

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

SOURCE:
CWF

*LPRYCD{x}* *Line Beneficiary Primary Payer Code*

*where { x } ranges from 1 to 13*

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

DB2 ALIAS: LINE_PRMRY_PYR_CD
SAS ALIAS: LPRYCD{x}
STANDARD ALIAS: LINE_BENE_PRMRY_PYR_CD{x}
TITLE ALIAS: PRIMARY_PAYER_CD

CODES:
REFER TO: BENE_PRMRY_PYR_TB
IN THE CODES APPENDIX
COMMENT:
Prior to Version H this field was named: BENE_PRMRY_PYR_CD.

SOURCE:
CWF,VA,DOL,SSA

*LPRDMT{x}* *Line Beneficiary Primary Payer Paid Amount*

*where { x } ranges from 1 to 13*

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

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_PRMRY_PYR_PD
SAS ALIAS: LPRDMT{x}
STANDARD ALIAS: LINE_BENE_PRMRY_PYR_PD_AMT{x}
TITLE ALIAS: PRMRY_PYR_PD

EDIT-RULES:
+9(9).99

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

SOURCE:
CWF

*CNMT{x}* *Line Coinsurance Amount*

*where { x } ranges from 1 to 13*

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

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

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_COINSRNC_AMT
SAS ALIAS: CNMT{x}
STANDARD ALIAS: LINE_COINSRNC_AMT{x}
TITLE ALIAS: COINSRNC_AMT

EDIT-RULES:
+9(9).99

SOURCE:
CWF

*LLMTMT{x}* *Carrier Line Psychiatric, Occupational Therapy, Physical*

*This field is no longer populated as it is unavailable from the data source.*

*LNTAMT{x}* *Line Interest Amount*

*This field is no longer populated as it is unavailable from the data source.*

*PRPYLW{x}* *Line Primary Payer Allowed Charge Amount*

*This field is no longer populated as it is unavailable from the data source.*

*PNLYMT{x}* *Line 10% Penalty Reduction Amount*

*This field is no longer populated as it is unavailable from the data source.*

*LBLDDD{x}* *Carrier Line Blood Deductible Pints Quantity*

*This field is no longer populated as it is unavailable from the data source.*

*LSBCHG{x}* *Line Submitted Charge Amount*

*where { x } ranges from 1 to 13*

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

DB2 ALIAS: LINE_SBMT_CHRG_AMT
SAS ALIAS: LSBCHG{x}
STANDARD ALIAS: LINE_SBMT_CHRG_AMT{x}
TITLE ALIAS: SBMT_CHRG

EDIT-RULES:

+9(9).99

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

SOURCE:
CWF

### *LLWCHG{x}* *Line Allowed Charge Amount*

*where { x } ranges from 1 to 13*

The amount of allowed charges for the line item service on the noninstitutional claim. This charge is used to compute pay to providers or reimbursement to beneficiaries. **NOTE: The allowed charge is determined by the lower of three charges: prevailing, customary or actual.

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_ALOW_CHRG_AMT
SAS ALIAS: LLWCHG{x}
STANDARD ALIAS: LINE_ALOW_CHRG_AMT{x}
TITLE ALIAS: ALOW_CHRG

EDIT-RULES:
+9(9).99

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

SOURCE:
CWF

### *LABNUM{x}* *Carrier Line Clinical Lab Number*

*This field is no longer populated as it is unavailable from the data source.*

### *LABAMT{x}* *Carrier Line Clinical Lab Charge Amount*

*This field is no longer populated as it is unavailable from the data source.*

### *PRCGND{x}* *Line Processing Indicator Code*

*where { x } ranges from 1 to 13*

The code indicating the reason a line item on the noninstitutional claim was allowed or denied.

DB2 ALIAS: LINE_PRCSG_IND_CD
SAS ALIAS: PRCGND{x}
STANDARD ALIAS: LINE_PRCSG_IND_CD{x}
TITLE ALIAS: PRCSG_IND

CODES:
REFER TO: LINE_PRCSG_IND_TB
IN THE CODES APPENDIX

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

SOURCE:
CWF

*PMTDSW{x}* *Line Payment 80%/100% Code*

*where { x } ranges from 1 to 13*

The code indicating that the amount shown in the payment field on the noninstitutional line item represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only.
COMMON ALIAS: REIMBURSEMENT_IND
DB2 ALIAS: LINE_PMT_80_100_CD
SAS ALIAS: PMTDSW{x}
STANDARD ALIAS: LINE_PMT_80_100_CD{x}
TITLE ALIAS: REINBURSEMENT_IND

CODES:
0 = 80% 1
= 100%
3 = 100% Limitation of liability only

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

SOURCE:
CWF

*DED_SW{x}* *Line Service Deductible Indicator Switch*

*where { x } ranges from 1 to 13*

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

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

CODES:
0 = Service subject to deductible
1 = Service not subject to deductible

COMMENT:
Prior to Version H this field was named: CWFB_SRVC_DDCTBL_IND_SW.
SOURCE: CWF

*PMTDCD{x}* *Line Payment Indicator Code*

*This field is no longer populated as it is unavailable from the data source.*

*MTSCNT{x}* *Carrier Line Miles/Time/Units/Services Count*

*where { x } ranges from 1 to 13*

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

3 DIGITS SIGNED

DB2 ALIAS: LINE_MTUS_CNT
SAS ALIAS: MTSCNT{x}
STANDARD ALIAS: CARR_LINE_MTUS_CNT{x}
TITLE ALIAS: MTUS_CNT

EDIT - RULES:

+999

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

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

SOURCE:
CWF

### *MTSIND{x}* — *Carrier Line Miles/Time/Units/Services Indicator Code*

*where { x } ranges from 1 to 13*

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

DB2 ALIAS: LINE_MTUS_IND_CD
SAS ALIAS: MTSIND{x}
STANDARD ALIAS: CARR_LINE_MTUS_IND_CD{x}
TITLE ALIAS: MTUS_IND

CODES:
0 = Values reported as zero (no allowed activities)
1 = Transportation (ambulance) miles
2 = Anesthesia time units
3 = Services
4 = Oxygen units
5 = Units of blood
6 = Anesthesia base and time units (prior to 1991; from BMAD)

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

SOURCE:
CWF

### *LNDGNS{x}* — *Line Diagnosis Code*

*where { x } ranges from 1 to 13*

The ICD-9-CM code indicating the diagnosis supporting this line item procedure/service on the noninstitutional claim.

DB2 ALIAS: LINE_DGNS_CD
SAS ALIAS: LNDGNS{x}
STANDARD ALIAS: LINE_DGNS_CD{x}
TITLE ALIAS: DGNS_CD

EDIT-RULES:
ICD-9-CM

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

SOURCE:
CWF

*CLLRT{x}* *Carrier Line CLIA Alert Indicator Code*

*This field is no longer populated as it is unavailable from the data source.*

*DMPRC{x}* *Line DME Purchase Price Amount*

*This field is no longer populated as it is unavailable from the data source.*

*PRFNPI{x}* *Carrier Line Performing NPI Number*
*Where {x} ranges from 1 to 13*

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

SAS ALIAS: PRFNPI{x}
STANDARD ALIAS: CARR_LINE_PRFRMG_NPI_NUM{x}

*GRPNPI{x}* *Carrier Line Performing Group NPI Number*
*Where {x} ranges from 1 to 13*

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

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

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

SAS ALIAS: GRPNPI{x}
STANDARD ALIAS: CARR_LINE_PRFRMG_GRP_NPI_NUM{x}