HCFA MEDICARE AUTOMATED DATA RETRIEVAL SYSTEM (MADRS) RECORD

All Medicare data for LTCS participants was supplied to the Center for Demographic Studies (CDS) by the Health Care Financing Administration. CDS has not altered the data except to blank out or remove confidential fields and to change packed decimal, integer binary, zoned decimal, and EBCDIC formats into ASCII character formats.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	MEDICARE AUTOMATED DATA RETRIEVAL SYSTEM (MADRS) RECORD	REC	231	1	231	CONTAINS 100% RAW INSTITUTIONAL CLAIMS DATA AND PHYSICIAN/SUPPLIER PART B PAYMENT RECORDS (1984-1990)
****	ITEMS COMMON TO ALL MADRS RECORDS	GROUP	61	1	61	
1.	SEQUENCE NUMBER	CHAR	5	1	5	LTCS SEQUENCE NUMBER: MIN=1,MAX=30308
2.	RECORD IDENTIFICATION CODE (RIC)	CHAR	1	6	6	THE RIC IDENTIFIES THE RECORD FORMAT BEING PROCESSED. CODES: R = PART B PAYMENT RECORD V = MEDICARE PART A BILL W = MEDICARE PART B BILL SOURCE: THIS FIELD IS CODED IN HCFA CENTRAL OFFICE.
3.	BENEFICIARY IDENTIFICATION CODE	CHAR	2	7	8	THE CODE IDENTIFYING THE TYPE OF RELATIONSHIP BETWEEN AN INDIVIDUAL AND A PRIMARY SOCIAL SECURITY ADMINISTRATION (SSA) BENEFICIARY. STANDARD ALIAS: BENE_IDENT_CD COMMON ALIAS: BIC

SAS ALIAS: BIC

CODES:
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-CK = 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)

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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
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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)

SOURCE:
SSA

4. EQUATED BENEFICIARY IDENTIFICATION CODE (BIC)	CHAR	2	9	10	THIS CODE SPECIFIES THE TYPE OF BENEFICIARY FOR CASH PAYMENT PROGRAMS AND IDENTIFIES THE TYPE OF RELATIONSHIP BETWEEN THE INDIVIDUAL INDIVIDUAL AND PRIMARY BENEFICIARY WHEN THE INDIVIDUAL IS QUALIFIED UNDER ANOTHER'S ACCOUNT. THE CODE IS EQUATED TO A COMMON BIC. FOR EXAMPLE, THE RECORDS FOR A WIFE (BIC B) WHO BECOMES A WIDOW (BIC D) IN THE FILE YEAR WOULD HAVE ALL RECORDS CODED TO THE FIRST BIC. COMMON ALIAS: BIC CODES: 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-CK = 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)

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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
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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
     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)
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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)

SOURCE:
SSA AND RRB BENEFICIARY RECORD SYSTEMS

5. STATE CODE	CHAR	2	11	12	THIS FIELD SPECIFIES THE STATE OF RESIDENCE OF THE BENEFICIARY AND IS BASED ON THE MAILING ADDRESS USED FOR CASH BENEFITS OR THE MAILING ADDRESS USED FOR OTHER PURPOSES (FOR EXAMPLE, PREMIUM BILLING). THIS INFORMATION IS

MAINTAINED FROM CHANGE OF ADDRESS NOTICES SENT IN BY THE BENEFICIARIES, AND IS APPENDED TO THE RECORD AT TIME OF PROCESSING IN CENTRAL OFFICE. THE CODING SYSTEM IS THE SSA SYSTEM, NOT THE FEDERAL INFORMATION PROCESSING STANDARD (FIPS).

STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD

CODES:
01 = ALABAMA
02 = ALASKA
03 = ARIZONA
04 = ARKANSAS
05 = CALIFORNIA
05 = 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; INSTITUTIONAL PROVIDER
OF SERVICES (IPS) ONLY
56 = CANADA
57 = CENTRAL AMERICA AND WEST INDIES
58 = EUROPE
59 = MEXICO
60 = OCEANIA
61 = PHILIPPINES
62 = SOUTH AMERICA
63 = U.S. POSSESSIONS
64 = AMERICAN SAMOA
65 = GUAM
66 = SAIPAN
67 = TEXAS; INSTITUTIONAL PROVIDER
OF SERVICES (IPS) ONLY
97 = NORTHERN MARIANAS
98 = GUAM
99 = WITH 000 COUNTY CODE IS AMERICAN SAMOA;
OTHERWISE UNKNOWN

					SOURCE: SSA AND RRB BENEFICIARY RECORD SYSTEMS. FOR RRB BENEFICIARIES, THE STATE IS CODED IN SSA BASED ON MAILING ADDRESS. LIMITATIONS: IN SOME CASES, THE CODE MAY NOT BE THE ACTUAL STATE OF RESIDENCE. (FOR EXAMPLE, IF THE BENEFICIARY HAS A REPRESENTATIVE PAYEE).
6. COUNTY CODE	CHAR	3	13	15	BLANK FOR ALL RECORDS
7. ZIP CODE OF RESIDENCE	CHAR	5	16	20	BLANK FOR ALL RECORDS
8. DATE OF BIRTH	CHAR	5	21	25	THIS FIELD INDICATES THE BENEFICIARY'S DATE OF BIRTH. 5 DIGITS STANDARD ALIAS: BENE_BIRTH_DT COBOL ALIAS: BIRTH-DT EDIT-RULES: YYDDD SOURCE: SSA AND RRB BENEFICIARY RECORD SYSTEMS
9. AGE	NUM	3	26	28	THIS FIELD DENOTES THE AGE AS OF THE DATE OF ADMISSION OR DATE OF SERVICE. 3 DIGITS SOURCE: CALCULATED IN HCFA FROM ORIGINAL BILLS AND PAYMENT RECORDS
10. SEX	CHAR	1	29	29	THIS FIELD INDICATES THE SEX OF THE BENEFICIARY. STANDARD ALIAS: BENE_SEX_IDENT_CD

					0 = UNKNOWN 1 = MALE 2 = FEMALE SOURCE: SSA AND RRB BENEFICIARY RECORD SYSTEMS LIMITATIONS: UNKNOWN IS USUALLY AN RRB DEFICIENCY IN REPORTING. IF THE SEX IS NOT INDICATED ON THE BILL, CODE THE SEX AS UNKNOWN.
11. RACE	CHAR	1	30	30	THIS FIELD SPECIFIES THE RACE OF THE BENEFICIARY. STANDARD ALIAS: BENE_RACE_CD CODES: 0 = UNKNOWN 1 = WHITE 2 = BLACK 3 = OTHER SOURCE: SSA AND RRB BENEFICIARY RECORD SYSTEMS LIMITATIONS: RACE AS GIVEN BY BENEFICIARY TO SSA ON APPLICATION FOR SSN, NOT VERIFIED.
12. CURRENT REASON FOR ENTITLEMENT CODE	CHAR	1	31	31	THIS FIELD INDICATES THE REASON FOR THE BENEFICIARY'S CURRENT ENTITLEMENT TO MEDICARE BENEFITS. CODES: 0 = OLD AGE AND SURVIVOR'S INSURANCE (OASI) 1 = DISABILITY INSURANCE BENEFITS (DIB) 2 = ESRD 3 = DIB AND ESRD SOURCE: ENROLLMENT DATA BASE

13. ORIGINAL REASON FOR ENTITLEMENT	CHAR	1	32	32	THIS FIELD INDICATES THE REASON FOR THE BENEFICIARY'S ORIGINAL ENTITLEMENT TO MEDICARE BENEFITS. CODES: 0 = OLD AGE AND SURVIVORS INSURANCE (OASI) 1 = DISABILITY INSURANCE BENEFITS (DIB) 2 = ESRD 3 = BOTH DIB AND ESRD SOURCE: SSA AND RRB BENEFICIARY RECORD SYSTEMS
14. RISI-PUDI CODE	CHAR	1	33	33	RISI INDICATES THAT THE BENEFICIARY'S ENTITLEMENT TO HEALTH INSURANCE BENEFITS IS BASED ON THE FULLY OR CURRENTLY INSURED WORKER'S EARNINGS AND NOT ON THE BENEFICIARY'S OWN EARNINGS. PUDI INDICATES THAT THE WAS PREVIOUSLY DISABLED BUT NOT ENOUGH TO QUALIFY FOR HI ON THAT BASIS. CODES: 0 = NEITHER 1 = RISI 2 = PUDI 3 = RISI AND PUDI SOURCE: UNIFORM BILL HCFA FORM 1450
15. MEDICARE STATUS CODE	CHAR	2	34	35	THIS FIELD SPECIFIES THE REASON FOR THE BENEFICIARY'S ENTITLEMENT. STANDARD ALIAS: BENE_MDCR_STUS_CD COMMON ALIAS: MSC CODES: 10 = AGED WITHOUT ESRD 11 = AGED WITH ESRD 20 = DISABLED WITHOUT ESRD 21 = DISABLED WITH ESRD

					31 = ESRD ONLY SOURCE: THIS FIELD IS CODED FROM AGE, ORIGINAL REASON FOR ENTITLEMENT, CURRENT REASON FOR ENTITLEMENT AND ESRD INDICATOR CONTAINED IN THE ENROLLMENT DATA BASE AT THE CENTRAL OFFICE AT THE DATE OF PROCESSING.
16. DATE OF SERVICE	CHAR	5	36	40	THIS FIELD DENOTES THE DATE THE SERVICE WAS INCURRED. 5 DIGITS EDIT-RULES: YYDDD SOURCE: UNIFORM BILL FORM 1450, ITEM 22 LIMITATIONS: SUMMARY RECORDS SHOW ZEROES IN THIS FIELD.
17. DEBIT/CREDIT INDICATOR	CHAR	1	41	41	(NOT USED--DOLLAR FIELDS ARE SIGNED. -CDS)
18. REIMBURSEMENT AMOUNT	NUM	10	42	51	THE AMOUNT PAID BY MEDICARE. PASS-THRU, INTERIM LUMP SUM ADJUSTMENTS, AND COST STATEMENT SETTLEMENTS NOT INCLUDED. 7.2 DIGITS SIGNED EDIT-RULES: $$$$$$$.CC SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM F UNDER 'FOR INTERMEDIARY USE ONLY' LIMITATIONS: THIS FIELD MAY BE ZEROES IF THE PATIENT'S DEDUCTIBLE HAS NOT BEEN MET.

19.	TOTAL CHARGES	NUM	10	52	61	THIS ITEM RECORDS THE TOTAL CHARGES, INCLUDING NON-COVERED CHARGES, FOR THE BENEFICIARY AS REPORTED BY THE PROVIDER. 7.2 DIGITS SIGNED EDIT-RULES: $$$$$$$.CC SOURCE: UNIFORM BILL HCFA FORM 1450, REVENUE CODE 001
****	ALL RECORDS OTHER THAN PAYMENT RECORDS AREA	GROUP	170	62	231	
****	ITEMS COMMON TO ALL RECORDS OTHER THAN PAYMENT RECORDS	GROUP	69	62	130	
20.	PAYMENT/EDIT CODE	CHAR	1	62	62	THIS CODE INDICATES THE TYPE OF BILL SUBMITTED FOR PAYMENT OF BENEFITS. CODES: C = INPATIENT, SNF D = OUTPATIENT E = CHRISTIAN SCIENCE F = HOME HEALTH G = NON-PAYMENT BILLS I = HOSPICE SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 4
21.	TRANSACTION CODE	CHAR	1	63	63	THIS ITEM INDICATES THE TYPE OF INSTITUTIONAL PROVIDER. CODES: 0 = CHRISTIAN SCIENCE SNF 1 = PSYCHIATRIC HOSPITAL 2 = TUBERCULOSIS HOSPITAL 3 = GENERAL CARE HOSPITAL 4 = REGULAR SNF 5 = HOME HEALTH AGENCY

					6 = OUTPATIENT C = COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (PATBILL ONLY) H = HOSPICE SOURCE: UNIFORM BILL HCFA FORM 1450
22. QUERY CODE	CHAR	1	64	64	THIS FIELD INDICATES THE STATUS OF THE BILL RECEIVED. CODES: 0 = CREDIT ADJUSTMENT 1 = INTERIM 2 = VISITS/HHA BENEFITS EXHAUSTED 3 = FINAL BILL 4 = DISCHARGE NOTICE 5 = DEBIT ADJUSTMENT 7 = SPECIAL DISCHARGE NOTICE SOURCE: GENERATED IN ADMINISTRATIVE SYSTEMS IN HCFA CENTRAL OFFICE
23. MEDICARE PROVIDER NUMBER	CHAR	6	65	70	THIS FIELD SPECIFIES THE INSTITUTION THAT RENDERED SERVICES TO A BENEFICIARY. THIS IS THE UNIQUE NUMBER ISSUED BY THE HCFA REGIONAL OFFICE TO A PROVIDER OF SERVICES UPON INITIAL CERTIFICATION FOR PARTICIPATION IN THE MEDICARE PROGRAM. CODES: SSTPPP WHERE: SS = STATE OF THE PROVIDER (SSA STANDARD STATE CODES) T = TYPE OF PROVIDER PPP = PROVIDER SEQUENCE NUMBER - FIRST TWO POSITIONS ARE THE STATE CODE. CODING SCHEME: REFER TO SSA_STD_STATE_TB - 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:

0001-0899	SHORT-TERM (GENERAL AND SPECIALTY) HOSPITALS
0900-0999	MULTIPLE HOSPITAL COMPONENT IN A MEDICAL COMPLEX (NUMBERS RETIRED)
1000-1199	RESERVED FOR FUTURE USE
1200-1220	ALCOHOL/DRUG HOSPITALS (EXCLUDED FROM PPS-NUMBERS RETIRED)
1221-1299	MEDICAL ASSISTANCE FACILITIES (MONTANA PROJECT)
1300-1399	RURAL PRIMARY CARE HOSPITAL (RPCH)
1400-1499	RESERVED FOR FUTURE USE
1500-1799	HOSPICES
1800-1899	FEDERALLY-FUNDED COMPREHENSIVE HEALTH CENTERS
1900-1989	RESERVED FOR FUTURE USE
1990-1999	CHRISTIAN SCIENCE SANATORIA (HOSPITAL SERVICES)
2000-2299	LONG-TERM HOSPITALS (EXCLUDED FROM PPS)
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 (EXCLUDED FROM PPS)
3100-3299	RESERVED FOR FUTURE USE
3300-3399	CHILDREN'S HOSPITALS (EXCLUDED FROM PPS)
3400-3499	RESERVED FOR FUTURE USE
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 (EXCLUDED

	FROM PPS)
4500-4599	COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)
4600-4999	RESERVED FOR FUTURE USE
5000-5999	SKILLED NURSING FACILITIES
6000-6499	RESERVED FOR FUTURE USE (2) (3)
6500-6899	OUTPATIENT PHYSICAL THERAPY SERVICES
6900-6989	RESERVED FOR FUTURE USE
6990-6999	CHRISTIAN SCIENCE SANATORIA (SKILLED NURSING SERVICES)
7000-7299	HOME HEALTH AGENCIES (4)
7300-7399	SUBUNITS OF 'NONPROFIT' AND 'PROPRIETARY' HOME HEALTH AGENCIES (5)
7400-7799	CONTINUATION OF 7000-7299 SERIES
7800-7999	SUBUNITS OF STATE AND LOCAL GOVERNMENTAL HOME HEALTH AGENCIES (5)
8000-8999	RESERVED FOR FUTURE USE
9000-9799	RESERVED FOR FUTURE USE
9800-9999	RESERVED FOR FUTURE USE
A001-A999	NURSING FACILITY
B001-B999	NURSING FACILITY (EXPANSION OF A001-A999)
E001-E999	NURSING FACILITY
F001-F999	NURSING FACILITY (EXPANSION OF E001-E999)
G001-G999	INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED
H001-H999	INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (EXPANSION OF G001-G999)
P001-P999	ORGAN PROCUREMENT ORGANIZATION

(1) THESE FACILITIES (SPRDFS) WILL BE ASSIGNED THE SAME PROVIDER NUMBER WHENEVER THEY ARE RECERTIFIED.

(2) THIS SERIES OF PROVIDER NUMBERS HAS BEEN RELEASED FOR USE BY THE STATE OF CALIFORNIA (05) FOR SKILLED NURSING FACILITIES ONLY.

(3) 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.

(4) IN VIRGINIA (49), THE SERIES 7100-7299 HAS BEEN RESERVED FOR STATEWIDE SUBUNIT COMPONENTS OF THE VIRGINIA STATE HOME HEALTH AGENCIES.

(5) PARENT AGENCY MUST HAVE A NUMBER IN THE 7000-7299 OR 7400-7799 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:

S = PSYCHIATRIC UNIT (EXCLUDED FROM PPS)
T = REHABILITATION UNIT (EXCLUDED FROM PPS)
U = SHORT TERM/ACUTE CARE SWING-BED HOSPITAL
V = ALCOHOL DRUG UNIT (PRIOR TO 10/87 ONLY)
W = LONG TERM SNF SWING-BED HOSPITAL (EFF 3/91)
Y = REHAB HOSPITAL SWING-BED (EFF 9/92)
Z = RURAL PRIMARY CARE HOSPITALS (TO BE EFFECTIVE IN 1994)

SOURCE:
UNIFORM BILL 82, FORM HCFA-1450, ITEM 7 (MEDICARE PROVIDER NUMBER).

LIMITATIONS:
THE MEDPAR FILE CONTAINS ONLY INPATIENT HOSPITAL RECORDS. PROVIDER NUMBERS ARE AGAINST A FILE OF MEDICARE-CERTIFIED PROVIDERS BY THE INTERMEDIARY. HOWEVER, HOWEVER, THIS PROCESS IS NOT REPEATED WHEN THE MEDPAR FILE IS CONSTRUCTED.

24. DISTINCT PART CODE	CHAR	1	71	71	THIS FIELD IS DERIVED FROM THE THIRD DIGIT OF THE PROVIDER NUMBER WHICH HAS BEEN RESET

TO ZERO. A VALUE OF 'S', 'T', OR 'U' INDICATES A PART OF A SHORT STAY HOSPITAL NOT COVERED BY PPS. A 'U' INDICATES A BED USED AS AN SNF BED.

CODES:
BLANK = PROVIDER NUMBER NOT CHANGED
S = PSYCHIATRIC UNIT
T = REHABILITATION UNIT
U = SWING-BED HOSPITAL DESIGNATION
V = ALCOHOL/DRUG UNIT

SOURCE:
THIS IS A UNIQUE IDENTIFIER ISSUED BY THE HCFA REGIONAL OFFICE TO A PROVIDER OF SERVICE. THE CODE REPLACES THE THIRD DIGIT OF THE PROVIDER NUMBER.

LIMITATIONS:
EFFECTIVE WITH PROVIDER COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1987, THE ALCOHOL/DRUG UNITS ARE NO LONGER PPS-EXEMPT UNITS. A 'U' INDICATES A SNF.

25.	NUMBER OF DIAGNOSIS CODES	NUM	1	72	72

THIS FIELD INDICATES THE NUMBER OF DIAGNOSIS CODES PRESENT IN THE RECORD.

1 DIGIT

EDIT-RULES:
RANGE 0 THRU 5

SOURCE:
CALCULATED IN HCFA

****	DIAGNOSTIC CODES	GROUP	25	73	97

THESE FIELDS SPECIFY THE PRINCIPAL AND OTHER DIAGNOSIS CODES THAT ARE OBTAINED FROM THE PATIENT'S DISCHARGE BILL. PRINCIPAL IS DEFINED AS THE CONDITION ESTABLISHED, AFTER STUDY, TO BE CHIEFLY RESPONSIBLE FOR OCCASIONING THE ADMISSION OF THE PATIENT.

					CODING IS BASED ON INTERNATIONAL CLASSIFICATION OF DISEASES 9TH REVISION, CLINICAL MODIFICATION (ICD-9-CM). PROVIDERS KEY THE ICD-9-CM CODE FROM THE BILLS AND REPORT THE INFORMATION TO HCFA AS PART OF THE CLAIMS TAPE RECORD. EACH CODE CAN BE UP TO FIVE CHARACTERS, LEFT JUSTIFIED. A MAXIMUM OF FIVE CODES IS CARRIED IN THE RECORD.
26. DIAGNOSIS CODE	CHAR	5	73	77	THE ICD-9-CM BASED CODE IDENTIFYING THE BENEFICIARY'S DIAGNOSIS. OCCURS: 5 TIMES SOURCE: UNIFORM BILL 82, FORM HCFA-1450, ITEMS 77 THROUGH 81 LIMITATIONS: MAY CONTAIN INVALID CODES
27. DATE OF FIRST PROCEDURE	CHAR	5	98	102	THIS IS THE DATE OF THE FIRST SURGICAL PROCEDURE. 5 DIGITS EDIT-RULES: YYDDD ZERO = DATE NOT SUBMITTED. SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 84
28. NUMBER OF PROCEDURE CODES	NUM	1	103	103	THIS FIELD INDICATES THE NUMBER OF PROCEDURE CODES PRESENT IN THE RECORD. 1 DIGIT EDIT-RULES: RANGE: 0 TO 3 SOURCE:

						CALCULATED IN HCFA
****	PROCEDURE CODES	GROUP	12	104	115	THESE CODES INDICATE WHICH SURGICAL PROCEDURES, IF ANY, WERE PERFORMED DURING THE STAY. CODING IS BASED ON ICD-9-CM MANUAL, VOLUME 3. PROVIDERS KEY THE ICD-9-CM CODE AND REPORT THE INFORMATION TO HCFA AS PART OF THE CLAIMS TAPE RECORD. EACH CODE CAN BE UP TO FOUR CHARACTERS, LEFT JUSTIFIED. A MAXIMUM OF THREE CODES ARE CARRIED IN THE RECORD. THIS FIELD IS BLANK IF NO CODE IS SUBMITTED.
29.	PROCEDURE CODE	CHAR	4	104	107	OCCURS: 3 TIMES SOURCE: UNIFORM BILL HCFA-1450, ITEMS 84 THROUGH 86 LIMITATIONS: MAY CONTAIN INVALID CODE
30.	DATE OF SECOND PROCEDURE	CHAR	5	116	120	THIS IS THE DATE OF THE SECOND SURGICAL PROCEDURE PERFORMED. 5 DIGITS EDIT-RULES: YYDDD ZEROS = DATE NOT SUBMITTED UNIFORM BILL HCFA FORM 1450, ITEM 85
31.	DATE OF THIRD PROCEDURE	CHAR	5	121	125	THIS IS THE DATE OF THE THIRD SURGICAL PROCEDURE PERFORMED. 5 DIGITS EDIT-RULES: YYDDD ZEROS = DATE NOT SUBMITTED SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 86

32.	APPROVAL DATE	CHAR	5	126	130	THE APPROVAL DATE SHOWS THE DATE THE BILL WAS APPROVED BY THE INTERMEDIARY. 5 DIGITS EDIT-RULES: YYDDD SOURCE: UNIFORM BILL HCFA FORM 1450, IN 'FOR INTERMEDIARY USE ONLY', ITEM K LIMITATIONS: THIS FIELD IS NOT ALWAYS PRESENT. ALSO, THE SUMMARY RECORD WILL EXHIBIT ZEROES IN THIS FIELD.
****	INPATIENT SNF CHRISTIAN SCIENCE BILLS AND NO PAYMENT BILLS	GROUP	101	131	231	
33.	PPS INDICATOR	CHAR	1	131	131	THIS FIELD SPECIFIES WHETHER A HOSPITAL IS BEING PAID UNDER THE PROSPECTIVE PAYMENT SYSTEM (PPS). CODES: 1 = YES 0 = NO SOURCE: THE PPS INDICATOR IS SET AT THE CENTRAL OFFICE AND IS CODED BY THE INTERMEDIARY. A CODE OTHER THAN '65' IN THE UNIBILL CONDITION CODE FIELD INDICATES THAT THIS IS A PPS PROVIDER. LIMITATIONS: EXPERIENCE WITH THE INDICATOR SHOWS THAT IT WAS UNRELIABLE IN 1983, 1984, AND 1985.
34.	DIAGNOSIS RELATED GROUP (DRG) CODE	NUM	3	132	134	EACH DRG REPRESENTS BROAD CLINICAL CATEGORIES THAT ARE BASED ON BODY SYSTEM INVOLVEMENT AND

DISEASE ETIOLOGY. EACH CATEGORY IS SIMILAR IN ITS USE OF DIAGNOSTIC RESOURCES AND IS USING SPECIFIC GUIDELINES. EACH CATEGORY MUST HAVE BEEN CLINICALLY CONSISTENT, HAD A SUFFICIENT NUMBER OF PATIENTS, AND COVERED THE COMPLETE RANGE OF DIAGNOSES REPRESENTED IN THE ICD-9-CM WITHOUT OVERLAP. THE CATEGORIES WERE DEVELOPED BY A YALE UNIVERSITY RESEARCH TEAM AND REVISED BY HEALTH SERVICES INTERNATIONAL, INC.

3 DIGITS

EDIT-RULES:
NUMERIC

SOURCE:
ADDED TO THE RECORD BY THE INTERMEDIARY'S GROUPER SOFTWARE WHICH TRANSLATES VARIABLES SUCH AS AGE, SEX, DIAGNOSIS AND SURGICAL CODES INTO THE SINGLE APPLICABLE DRG.

THE GROUPER SOFTWARE IS UPDATED PERIODICALLY AS AS SHOWN BELOW:

- VERSION 2.0 (EFF 1/1/83 - 4/30/86)
- VERSION 3.0 (EFF 5/1/86 - 9/30/86)
- VERSION 4.0 (EFF 10/1/86 - 9/30/87)
- VERSION 5.0 (EFF 10/1/87 - 9/30/88)
- VERSION 6.0 (EFF 10/1/88 - 9/30/89)
- VERSION 7.0 (EFF 10/1/89 - 9/30/90)

LIMITATIONS:
DRG 467 AND DRG 470 ARE CATEGORIES WHICH COULD NOT BE ACCURATELY CLASSIFIED INTO VALID DRG'S.

35. DISCHARGE DESTINATION	NUM	2	135	136	THIS FIELD SPECIFIES THE DESTINATION OF THE PATIENT UPON DISCHARGE FROM THE HOSPITAL.

2 DIGITS

CODES:
01 = TO HOME, SELF-CARE

02 = TO SHORT-TERM HOSPITAL
03 = TO SNF
04 = TO ICF
05 = TO OTHER TYPE FACILITY
06 = TO HOME HEALTH SERVICE CARE
07 = LEFT AGAINST MEDICAL ADVICE
08 = TO HOME, HOME IV THERAPY PROVIDER
20 = DIED
30 = STILL A PATIENT OR EXPECTED TO RETURN FOR OUTPATIENT SERVICES

SOURCE:
UNIFORM BILL 82, FORM HCFA-1450, ITEM 21

LIMITATIONS:
THIS FIELD HAS NOT BEEN VALIDATED. THERE IS SOME QUESTION OF ITS RELIABLILTY.

36. MEDICAL RECORD NUMBER	CHAR	17	137	153	THIS NUMBER IS ASSIGNED BY THE PROVIDER TO PATIENT RECORDS. SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 3 LIMITATIONS: THIS IS AN UNEDITED ELEMENT.
37. DATE OF ADMISSION	CHAR	5	154	158	THIS FIELD CONTAINS THE DATE THE BENEFICIARY WAS ADMITTED FOR INPATIENT CARE TO THE INSTITUTION. 5 DIGITS EDIT-RULES: YYDDD SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 15 LIMITATIONS: MODIFICATION MAY PLACE THE DATE OUTSIDE THE FILE YEAR.

38. FROM DATE	CHAR	5	159	163	BEGINNING DATE OF STAY OR SERVICE. 5 DIGITS EDIT-RULES: YYDDD SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 22
39. LENGTH OF STAY	NUM	4	164	167	THIS FIELD GIVES THE TOTAL LENGTH OF A PATIENT'S HOSPITAL STAY FROM THE DATE OF ADMISSION TO THE DATE OF DISCHARGE. 3 DIGITS SIGNED EDIT-RULES: THE DIFFERENCE OBTAINED BY SUBTRACTING THE DATE OF ADMISSION FROM THE DATE OF DISCHARGE. SAME DAY DISCHARGES ARE CODED AS 001. SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 22 (THROUGH DATE) MINUS ITEM 15 (ADMISSION DATE) LIMITATIONS: 999 MAY BE EITHER A VALID ENTRY OR AN INDICATION OF FIELD OVERFLOW RESULTING FROM A DIFFERENCE LARGER THAN THREE CHARACTERS. CODE 001 CAN REPRESENT A STAY WHERE ADMISSION AND DISCHARGE DATES ARE THE SAME DAY OR ONE DAY'S DIFFERENCE.
40. TOTAL INPATIENT DAYS	NUM	4	168	171	NUMBER OF DAYS FROM ADMISSION TO 'THROUGH DATE' ON THIS BILL. 3 DIGITS SIGNED SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 22

41. TOTAL NUMBER OF INPATIENT COVERED DAYS	NUM	4	172	175	3 DIGITS SIGNED SOURCE: MEDICARE UTILIZATION RECORDS LIMITATIONS: NOT AVAILABLE FOR UTILIZATION PRIOR TO 1982
42. DISPROPORTIONATE SHARE RATE	NUM	9	176	184	RATE REFLECTING INDIGENT POPULATION SERVED. THIS FACTOR IS INCLUDED IN REIMBURSEMENT AMOUNT. 6.2 DIGITS SIGNED EDIT-RULES: UNIBILL VALUE CODE 18 AMOUNT FROM THE INTERMEDIARY PRICER REPORT SOURCE: PRICER LIMITATIONS: NOT SHOWN ON MOST RECORDS
43. INDIRECT MEDICAL EDUCATION (IME) AMOUNT	NUM	9	185	193	THIS FIELD SPECIFIES THE ADDITIONAL AMOUNT PAID TO TEACHING HOSPITALS FOR IME. 6.2 DIGITS SIGNED EDIT-RULES: UNIBILL VALUE CODE 19 AMOUNT FROM THE PRICER REPORT. SOURCE: PRICER LIMITATIONS: CALCULATED FROM THE PRICE REPORT
44. ORGAN ACQUISITION CHARGE	NUM	9	194	202	ACTUAL COST TO ACQUIRE AN ORGAN. NOT INCLUDED IN REIMBURSEMENT AMOUNT. SINCE THIS COST CAN CAN VARY GREATLY WITH EACH INDIVIDUAL CASE, PAYMENT IS MADE TO EACH PROVIDER BASED ON THE

					ACTUAL TOTAL COST PER YEAR. THIS IS ONE OF THE PASS-THRU AMOUNTS. 6.2 DIGITS SIGNED EDIT-RULES: $$$$$$.CC SOURCE: PRICER LIMITATIONS: THIS CHARGE IS CALCULATED FROM THE COST REPORT.
45. PASS-THRU PER DIEM	NUM	9	203	211	THE PASS-THRU PER DIEM AMOUNT CONSISTS OF THE PASS-THRU PER DIEM RATE TIMES THE NUMBER OF MEDICARE DAYS BILLED. THE PASS-THRU PER DIEM RATE CONSISTS OF THE ESTABLISHED REIMBURSABLE COSTS FOR THE CURRENT YEAR DIVIDED BY THE ESTIMATED MEDICARE DAYS FOR THE CURRENT YEAR. IT IS NOT INCLUDED IN THE REIMBURSEMENT AMOUNT; THESE AMOUNTS ARE A PART OF THE INTERIM LUMP SUM ADJUSTMENTS MADE PERIODICALLY TO THE PROVIDER. 6.2 DIGITS SIGNED EDIT-RULES: $$$$$$.CC SOURCE: PRICER LIMITATIONS: THIS AMOUNT IS CALCULATED FROM THE COST REPORT.
46. COINSURANCE AMOUNT	NUM	9	212	220	THIS AMOUNT, REPORTED AS COINSURANCE, IS TO BE PAID BY THE BENEFICIARY. 6.2 DIGITS SIGNED EDIT-RULES:

$$$$$$.CC

SOURCE:
UNIFORM BILL HCFA FORM 1450, ITEM 61

47. PRIMARY PAYER CODE	CHAR	1	221	221	THIS FIELD INDICATES WHO IS PRIMARILY RESPONSIBLE FOR PAYMENT.

CODES:
A = WORKING AGED BENE/SPOUSE WITH EMPLOYER GROUP HEALTH PLAN (EGHP)
B = END STAGE RENAL DISEASE (ESRD) BENEFICIARY IN THE 12 MONTH COORDINATION PERIOD WITH AN EMPLOYER GROUP HEALTH PLAN
C = CONDITIONAL PAYMENT BY MEDICARE; FUTURE REIMBURSEMENT EXPECTED
D = AUTOMOBILE NO-FAULT OR ANY LIABILITY INSURANCE
E = WORKERS' COMPENSATION
F = PUBLIC HEALTH SERVICE OR OTHER FEDERAL AGENCY (OTHER THAN DEPT. OF VETERANS AFFAIRS)
G = WORKING DISABLED
H = BLACK LUNG
I = DEPT. OF VETERANS AFFAIRS
1 = POTENTIAL WORKERS' COMPENSATION
2 = POTENTIAL BLACK LUNG
3 = POTENTIAL DEPT. OF VETERANS AFFAIRS

*EFFECTIVE 12/90 FOR CWFB CLAIMS;
10/93 FOR INSTITUTIONAL CLAIMS

M = OVERRIDE CODE: EGHP SERVICES INVOLVED
N = OVERRIDE CODE: NON-EGHP SERVICES INVOLVED
X = OVERRIDE CODE MSP COST AVOIDED
BLANK = MEDICARE IS PRIMARY PAYER

PRIOR TO 12/90

Y = OTHER SECONDARY PAYER INVESTIGATION SHOWS MEDICARE AS PRIMARY PAYER
Z = MEDICARE IS PRIMARY PAYER

						SOURCE: FROM THE FISCAL INTERMEDIARY
48.	PRIMARY PAYOR AMOUNT	NUM	9	222	230	THE AMOUNT OF MEDICARE EXPENSES PAID BY PRIMARY PAYOR. 6.2 DIGITS SIGNED EDIT-RULES: $$$$$$.CC ZERO FOR CODES C AND Z. NINES FILLED ON OVERFLOW. SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 64
49.	PASS-THRU SOURCE CODE BILL	CHAR	1	231	231	A UNIQUE CODE INDICATING WHERE PASS-THRU AMOUNT ORIGINATED. CODES: H = PASS-THRU AMOUNT FROM COST REPORT B = PASS-THRU AMOUNT FROM BILL X = NO PASS-THRU AMOUNT SOURCE: BUREAU OF DATA MANAGEMENT AND STRATEGY, HCFA
****	OUTPATIENT	GROUP	32	131	162	REDEFINITION OF: IP-SNF-CS-AREA
50.	NUMBER OF HCPCS CODES	NUM	1	131	131	THIS FIELD SHOWS THE NUMBER OF HCPCS SURGICAL PROCEDURES PERFORMED. 1 DIGIT SOURCE: CALCULATED IN HCFA
****	HCPCS CODES	GROUP	15	132	146	THIS FIELD CONTAINS UP TO THREE HCPCS CODES.
51.	HCFA COMMON PROCEDURE CODING SYSTEM CODE	CHAR	5	132	136	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:

LEVEL I
CODES COPYRIGHTED BY THE AMERICAN MEDICAL ASSOCIATION'S CURRENT PROCEDURAL TERMINOLOGY, FOURTH EDITION (CPT-4). THESE THESE ARE 5 POSITION NUMERIC CODES REPRESENTING PHYSICIAN AND NONPHYSICIAN SERVICES.

LEVEL II
CODES APPROVED AND MAINTAINED JOINTLY BY THE ALPHA-NUMERIC WORKGROUP (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 PHYSICIAN AND NONPHYSICIAN SERVICES THAT ARE NOT REPRESENTED IN THE LEVEL I CODES.

LEVEL III
CODES 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 PHYSICIAN AND NONPHYSICIAN SERVICES THAT ARE NOT REPRESENTED IN THE LEVEL I OR LEVEL II CODES.

OCCURS: 3 TIMES

STANDARD ALIAS: HCPCS_CD

SOURCE:
UNIFORM BILL HCFA FORM 1450,
ITEM 50 - DESCRIPTION

					LIMITATIONS: THESE CODES ARE USED FOR OUTPATIENT SERVICES ONLY.
52. DATE OF FIRST HCPCS PROCEDURE	CHAR	5	147	151	THIS DENOTES THE DATE OF THE FIRST HCPCS PROCEDURE. 5 DIGITS EDIT-RULES: YYDDD ZEROS = DATE NOT SUBMITTED SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 84
53. DATE OF SECOND HCPCS PROCEDURE	CHAR	5	152	156	THIS FIELD DENOTES THE DATE OF THE SECOND HCPCS PROCEDURE. 5 DIGITS EDIT-RULES: YYDDD ZEROS = DATE NOT SUBMITTED SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 85
54. DATE OF THIRD HCPCS PROCEDURE	CHAR	5	157	161	THIS FIELD DENOTES THE DATE OF THE THIRD HCPCS PROCEDURE. 5 DIGITS EDIT-RULES: YYDDD ZEROS = DATE NOT SUBMITTED SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 86
55. INTERVENING CARE INDICATOR	CHAR	1	162	162	THIS ONE DIGIT FIELD SHOWS WHETHER THE BENEFICIARY RECEIVED ANY INTERVENING CARE.

						CODES: N = NO INTERVENING CARE Y = YES, BENEFICIARY RECEIVED INTERVENING CARE SOURCE: SET BY BILL PROCESSING (MISSING FOR SOME OUTPATIENT RECORDS. -CDS)
****	HOME HEALTH AGENCY	GROUP	19	131	149	REDEFINITION OF: IP-SNF-CS-AREA
56.	PATIENT STATUS	CHAR	1	131	131	A CODE DESCRIBING THE CURRENT STATUS OF THE PATIENT REGARDING HOME HEALTH AGENCY SERVICES CODES: A = DISCHARGE B = DIED C = STILL PATIENT D = VISITS EXHAUSTED (HHA ONLY) SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 21
57.	SERVICE FROM DATE	CHAR	5	132	136	A FIELD USED TO SHOW THE BEGINNING DATE OF THE SERVICE. 5 DIGITS CODES: YYDDD SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 22
58.	TOTAL HHA VISITS	NUM	4	137	140	THIS FIELD REFLECTS THE TOTAL NUMBER OF VISITS PROVIDED BY THE HOME HEALTH AGENCY. 3 DIGITS SIGNED SOURCE: UNIFORM BILL HCFA FORM 1450, ACCUMULATED UNITS

						OF SERVICES, REVENUE CODES 42X - 44X, 47X, AND 55X - 58X
59.	TOTAL HHA VISIT CHARGES	NUM	9	141	149	THIS FIELD REFLECTS THE TOTAL OF ALL HOME HEALTH AGENCY VISIT CHARGES INCURRED ON THIS ACCOUNT. 6.2 DIGITS SIGNED EDIT-RULES: $$$$$$.CC SOURCE: UNIFORM BILL HCFA FORM 1450, ACCUMULATED UNITS OF CHARGES
****	HOSPICE	GROUP	21	131	151	REDEFINITION OF: IP-SNF-CS-AREA
60.	HOSPICE DISCHARGE DESTINATION	CHAR	2	131	132	CODE INDICATES DESTINATION UPON DISCHARGE FROM FACILITY 2 DIGITS CODES: 01 = TO HOME, SELF-CARE 02 = TO SHORT-TERM HOSPITAL 03 = TO SNF 04 = TO ICF 05 = TO OTHER TYPE OF FACILITY 06 = TO HOME HEALTH SERVICE CARE 07 = LEFT AGAINST MEDICAL ADVICE 30 = STILL PATIENT 40 = DIED AT HOME 41 = DIED IN A MEDICAL INSTITUTION 42 = PLACE OF DEATH UNKNOWN SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 21 LIMITATIONS: THIS FIELD HAS NOT BEEN VALIDATED. THERE IS SOME QUESTION OF ITS RELIABILITY.

61. HOSPICE PERIOD NUMBER	NUM	1	133	133	AN INDIVIDUAL MAY ELECT TO RECEIVE MEDICARE COVERAGE OF THREE ELECTIVE PERIODS OF HOSPICE CARE. THE PERIODS CONSIST OF TWO 90-DAY PERIODS AND ONE 30-DAY PERIOD. THE TWO 90-DAY PERIODS MUST BE USED BEFORE THE 30-DAY PERIOD. 1 DIGIT CODES: 1 = PERIOD 1 2 = PERIOD 2 3 = PERIOD 3 SOURCE: HDHIMA FILE
62. SERVICE FROM DATE	CHAR	5	134	138	DATE THAT BEGINS THE STAY OR SERVICE 5 DIGITS EDIT-RULES: YYDDD SOURCE: UNIFORM BILL HCFA FORM 1450, ITEM 22
63. HOSPICE START DATE	CHAR	5	139	143	DATE OF ADMISSION TO HOSPICE 5 DIGITS EDIT-RULES: YYDDD SOURCE: ANCILLARY ENTITLEMENT RECORD ON HDHIMA FILE
64. INPATIENT DAYS OF CARE	NUM	4	144	147	TOTAL INPATIENT DAYS OF CARE. 3 DIGITS SIGNED EDIT-RULES:

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                                                    001 = ZERO DAYS OF CARE

                                                    SOURCE:
                                                    UNIFORM BILL HCFA FORM 1450, ITEM 22 MINUS ITEM 15

  65. LENGTH OF BILLING PERIOD     NUM       4   148  151  DATE OF ADMISSION THROUGH DATE OF LAST SERVICE.
                                                           NOT COMPUTED FOR INTERIM BILLS.

                                                           3 DIGITS SIGNED

                                                           EDIT-RULES:
                                                           THREE DIGITS
                                                           IF ZERO, VALUE SET TO ONE DAY

                                                           SOURCE:
                                                           UNIFORM BILL HCFA FORM 1450, ITEM 22

****  PAYMENT RECORD DATA          GROUP    26    62   87  REDEFINITION OF: MADRS-NOT-PMT-REC-AREA

  66. ENTRY CODE                   CHAR      1    62   62  INDICATES THE TYPE OF PAYMENT RECORD SUBMITTED

                                                           CODES:
                                                           1 = ORIGINAL DEBIT
                                                           2 = SUPPLEMENTAL DEBIT
                                                           3 = FULL CREDIT
                                                           4 = PARTIAL CREDIT
                                                           5 = REPLACEMENT DEBIT
                                                           6 = PARTIAL DEBIT

                                                           SOURCE:
                                                           THIS FIELD IS CODED BY THE CARRIER.

  67. ENTRY RE-CODE                CHAR      1    63   63  CODE FURTHER DEFINING ENTRY CODES

                                                           CODES:
                                                           1,3,5,7,9 = INITIALLY SUBMITTED, ACCEPTED
                                                                       RECORDS
                                                           2,4,6,8   = RESUBMITTED, ACCEPTED RECORDS
                                                           A,C,E,G   = INITIALLY SUBMITTED, REJECTED
                                                                       RECORDS
                                                           B,D,F,H   = RESUBMITTED, REJECTED RECORDS
                                                           X         = ACKNOWLEDGES AN A REJECT
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PREVIOUSLY SUBMITTED

SOURCE:
THIS FIELD IS CODED BY HCFA CENTRAL OFFICE.

68. CARRIER NUMBER	CHAR	5	64	68	HCFA-ASSIGNED IDENTIFICATION NUMBER CODES: NNNNN = IDENTIFICATION NUMBER SUMRY = OFFICE VISITS WHICH ARE SUMMARIZED SOURCE: MEDICARE PAYMENT RECORDS
69. PLACE OF SERVICE	CHAR	1	69	69	THIS FIELD REFLECTS THE PLACE OF SERVICE. PLACE OF SERVICE IS DETERMINED BY THE LARGEST ALLOWED CHARGE REPORTED ON THE BILL. CODES: 1 = OFFICE 2 = HOME 3 = INPATIENT HOSPITAL 4 = ECF/NURSING HOME 5 = OUTPATIENT HOSPITAL 6 = INDEPENDENT LABORATORIES 7 = OTHER 8 = INDEPENDENT KIDNEY DISEASE TREATMENT CENTER 9 = AMBULATORY SURGERY CENTER H = HOSPICE SOURCE: MEDICARE PAYMENT RECORDS
70. TYPE OF SERVICE	CHAR	1	70	70	THIS CODE DELINEATES THE TYPE OF SERVICE ADMINISTERED. TYPE OF SERVICE IS DETERMINED BY THE LARGEST ALLOWED CHARGE REPORTED ON THE BILL. CODES: 0 = WHOLE BLOOD OR PACKED RED CELLS 1 = MEDICAL CARE 2 = SURGERY

3 = CONSULTATION
4 = DIAGNOSTIC X-RAY
5 = DIAGNOSTIC LABORATORY
6 = RADIATION THERAPY
7 = ANESTHESIA
8 = ASSISTANCE AT SURGERY
9 = OTHER MEDICAL SERVICES
A = PURCHASE/RENTAL DURABLE MEDICAL EQUIPMENT (DME)
F = AMBULATORY SURGICAL CENTER (FACILITY USAGE)
L = RENAL SUPPLIES IN THE HOME
M = ALTERNATIVE PAYMENT METHOD FOR MAINTENANCE DIALYSIS
N = KIDNEY DONOR
V = PNEUMOCOCCAL VACCINE
W = PHYSICAL THERAPY
Y = SURGICAL SECOND OPINION
Z = SURGICAL THIRD OPINION

SOURCE:
MEDICARE PAYMENT RECORDS

71. PHYSICIAN SPECIALTY OR SUPPLIER SPECIALTY CODE	CHAR	2	71	72	CODE INDICATING THE PHYSICIAN'S OR SUPPLIER'S MAJOR SPECIALTY.

CODES:
PRIOR TO 3/92

01 = GENERAL PRACTICE
02 = GENERAL SURGERY
03 = ALLERGY (REVISED 10/91 TO MEAN ALLERGY/ IMMUNOLOGY)
04 = OTOLOGY, LARYNGOLOGY, RHINOLOGY (REVISED 10/91 TO MEAN OTOLARYNGOLOGY)
05 = ANESTHESIOLOGY
06 = CARDIOVASCULAR DISEASE (REVISED 10/91 TO MEAN CARDIOLOGY)
07 = DERMATOLOGY
08 = FAMILY PRACTICE
09 = GYNECOLOGY--OSTEOPATHS ONLY (DELETED 10/91; CHANGED TO '16')
10 = GASTROENTEROLOGY

11 = INTERNAL MEDICINE
12 = MANIPULATIVE THERAPY (OSTEOPATHS ONLY) (REVISED 10/91 TO MEAN OSTEOPATHIC MANIPULATIVE THERAPY)
13 = NEUROLOGY
14 = NEUROLOGICAL SURGERY (REVISED 10/91 TO MEAN NEUROSURGERY)
15 = OBSTETRICS--OSTEOPATHS ONLY (DELETED 10/91; CHANGED TO '16')
16 = OB-GYNECOLOGY
17 = OPHTHALMOLOGY, OTOLOGY, LARYNGOLOGY RHINOLOGY--OSTEOPATHS ONLY (DELETED 10/91; CHANGED TO '18' IF PHYSICIANS PRACTICE IS MORE THAN 50% OPHTHALMOLOGY OR TO '04' IF PHYSICIAN'S PRACTICE IS MORE THAN 50% OTOLARYNGOLOGY. IF PRACTICE IS 50/50, CHOOSE SPECIALTY WITH GREATER ALLOWED CHARGES.
18 = OPHTHALMOLOGY
19 = ORAL SURGERY (DENTISTS ONLY)
20 = ORTHOPEDIC SURGERY
21 = PATHOLOGIC ANATOMY, CLINICAL PATHOLOGY-OSTEOPATHS ONLY (DELETED 10/91; CHANGED TO '22')
22 = PATHOLOGY
23 = PERIPHERAL VASCULAR DISEASE OR SURGERY (DELETED 10/91; CHANGED TO '76')
24 = PLASTIC SURGERY (REVISED TO MEAN PLASTIC AND RECONSTRUCTIVE SURGERY).
25 = PHYSICAL MEDICINE AND REHABILITATION
26 = PSYCHIATRY
27 = PSYCHIATRY, NEUROLOGY (OSTEOPATHS ONLY) (DELETED 10/91; CHANGED TO '86')
28 = PROCTOLOGY (REVISED 10/91 TO MEAN COLORECTAL SURGERY).
29 = PULMONARY DISEASE
30 = RADIOLOGY (REVISED 10/91 TO MEAN DIAGNOSTIC RADIOLOGY)
31 = ROENTGENOLOGY, RADIOLOGY (OSTEOPATHS) (DELETED 10/91; CHANGED TO '30')
32 = RADIATION THERAPY--OSTEOPATHS (DELETED 10/91; CHANGED TO '92')

33 = THORACIC SURGERY
34 = UROLOGY
35 = CHIROPRACTOR, LICENSED (REVISED 10/91 TO MEAN CHIROPRACTIC)
36 = NUCLEAR MEDICINE
37 = PEDIATRICS (REVISED 10/91 TO MEAN PEDIATRIC MEDICINE)
38 = GERIATRICS (REVISED 10/91 TO MEAN GERIATRIC MEDICINE)
39 = NEPHROLOGY
40 = HAND SURGERY
41 = OPTOMETRIST - SERVICES RELATED TO CONDITION OF APHAKIA (REVISED 10/91 TO MEAN OPTOMETRIST)
42 = CERTIFIED NURSE MIDWIFE (ADDED 7/88)
43 = CERTIFIED REGISTERED NURSE ANESTHETIST (REVISED 10/91 TO MEAN CRNA, ANESTHESIA ASSISTANT)
44 = INFECTIOUS DISEASE
46 = ENDOCRINOLOGY (ADDED 10/91)
48 = PODIATRY - SURGERY CHIROPODY (REVISED 10/91 TO MEAN PODIATRY)
49 = MISCELLANEOUS (INC ASCS)
51 = MEDICAL SUPPLY COMPANY WITH C.O. CERTIFICATION (CERTIFIED ORTHOTIST - CERTIFIED BY AMERICAN BOARD FOR CERTIFICATION IN PROSTHETICS AND ORTHOTICS.
52 = MEDICAL SUPPLY COMPANY WITH C.P. CERTIFICATION (CERTIFIED PROSTHETIST - CERTIFIED BY AMERICAN BOARD FOR CERTIFICATION IN PROSTHETICS AND ORTHOTICS).
53 = MEDICAL SUPPLY COMPANY WITH C.P.O. CERTIFICATION (CERTIFIED PROSTHETICS - ORTHOTIST - CERTIFIED BY AMERICAN BOARD FOR CERTIFICATION IN PROSTHETICS AND ORTHOTICS).
54 = MEDICAL SUPPLY COMPANY NOT INCLUDED IN 51, 52, OR 53.
55 = INDIVIDUAL CERTIFIED ORTHOTIST
56 = INDIVIDUAL CERTIFIED PROSTHETIST
57 = INDIVIDUAL CERTIFIED PROSTHETICS -

ORTHOTIST
58 = INDIVIDUALS NOT INCLUDED IN 55,56 OR 57
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--BILLING INDEPENDENTLY (REVISED 10/91 TO MEAN PORTABLE X-RAY SUPPLIER)
64 = AUDIOLOGIST (BILLING INDEPENDENTLY)
65 = PHYSICAL THERAPIST (INDEPENDENT PRACTICE)
66 = RHEUMATOLOGY (ADDED 10/91)
67 = OCCUPATIONAL THERAPIST--INDEPENDENT PRACTICE
68 = CLINICAL PSYCHOLOGIST
69 = INDEPENDENT LABORATORY--BILLING INDEPENDENTLY (REVISED 10/91 TO MEAN INDEPENDENT CLINICAL LABORATORY -- BILLING INDEPENDENTLY)
70 = CLINIC OR OTHER GROUP PRACTICE, EXCEPT GROUP PRACTICE PREPAYMENT PLAN (GPPP)
71 = GROUP PRACTICE PREPAYMENT PLAN - DIAGNOSTIC X-RAY
72 = GROUP PRACTICE PREPAYMENT PLAN - DIAGNOSTIC LABORATORY
73 = GROUP PRACTICE PREPAYMENT PLAN - PHYSIOTHERAPY
74 = GROUP PRACTICE PREPAYMENT PLAN - OCCUPATIONAL THERAPY
75 = GROUP PRACTICE PREPAYMENT PLAN - OTHER MEDICAL CARE
76 = PERIPHERAL VASCULAR DISEASE (ADDED 10/91)
77 = VASCULAR SURGERY (ADDED 10/91)
78 = CARDIAC SURGERY (ADDED 10/91)

79 = ADDICTION MEDICINE (ADDED 10/91)
8O = CLINICAL SOCIAL WORKER (1991)
81 = CRITICAL CARE-INTENSIVISTS (ADDED 10/91
82 = OPHTHALMOLOGY, CATARACTS SPECIALTY
(ADDED 10/91)
83 = HEMATOLOGY/ONCOLOGY (ADDED 10/91)
84 = PREVENTIVE MEDICINE (ADDED 10/91)
85 = MAXILLOFACIAL SURGERY (ADDED 10/91)
86 = NEUROPSYCHIATRY (ADDED 10/91)
87 = ALL OTHER (E.G. DRUG AND DEPARTMENT
STORES) (REVISED 10/91 TO MEAN ALL
OTHER SUPPLIERS)
88 = UNKNOWN (REVISED 10/91 TO MEAN
PHYSICIAN ASSISTANT)
90 = MEDICAL ONCOLOGY (ADDED 10/91)
91 = SURGICAL ONCOLOGY (ADDED 10/91)
92 = RADIATION ONCOLOGY (ADDED 10/91)
93 = EMERGENCY MEDICINE (ADDED 10/91)
94 = INTERVENTIONAL RADIOLOGY (ADDED 10/91)
95 = INDEPENDENT PHYSIOLOGICAL LABORATORY
(ADDED 10/91)
96 = UNKNOWN PHYSICIAN SPECIALTY
(ADDED 10/91)
99 = UNKNOWN--INCL. SOCIAL WORKER'S PSY-
CHIATRIC SERVICES (REVISED 10/91 TO
MEAN UNKNOWN SUPPLIER/PROVIDER)

EFFECTIVE 3/92

00 = CARRIER WIDE
01 = GENERAL PRACTICE
02 = GENERAL SURGERY
03 = ALLERGY/IMMUNOLOGY
04 = OTOLARYNGOLOGY
05 = ANESTHESIOLOGY
06 = CARDIOLOGY
07 = DERMATOLOGY
08 = FAMILY PRACTICE
09 = GYNECOLOGY (OSTEOPATHS ONLY)
(DISCONTINUED 4/92 USE CODE 16)
10 = GASTROENTEROLOGY
11 = INTERNAL MEDICINE

12 = OSTEOPATHIC MANIPULATIVE THERAPY
13 = NEUROLOGY
14 = NEUROSURGERY
15 = OBSTETRICS (OSTEOPATHS ONLY)
(DISCONTINUED 4/92 USE CODE 16)
16 = OBSTETRICS/GYNECOLOGY
17 = OPHTHALMOLOGY, OTOLOGY, LARYNGOLOGY,
RHINOLOGY (OSTEOPATHS ONLY)
(DISCONTINUED 4/92 USE CODES 18 OR 04
DEPENDING ON PERCENTAGE OF PRACTICE)
18 = OPHTHALMOLOGY
19 = ORAL SURGERY (DENTISTS ONLY)
20 = ORTHOPEDIC SURGERY
21 = PATHOLOGIC ANATOMY, CLINICAL
PATHOLOGY (OSTEOPATHS ONLY)
(DISCONTINUED 4/92 USE CODE 22)
22 = PATHOLOGY
23 = PERIPHERAL VASCULAR DISEASE, MEDICAL
OR SURGICAL (OSTEOPATHS ONLY)
(DISCONTINUED 4/92 USE CODE 76)
24 = PLASTIC AND RECONSTRUCTIVE SURGERY
25 = PHYSICAL MEDICINE AND REHABILITATION
26 = PSYCHIATRY
27 = PSYCHIATRY, NEUROLOGY (OSTEOPATHS
ONLY) (DISCONTINUED 4/92 USE CODE 86)
28 = COLORECTAL SURGERY (FORMERLY
PROCTOLOGY)
29 = PULMONARY DISEASE
30 = DIAGNOSTIC RADIOLOGY
31 = ROENTGENOLOGY, RADIOLOGY (OSTEOPATHS
ONLY) (DISCONTINUED 4/92 USE CODE 30)
32 = RADIATION THERAPY (OSTEOPATHS ONLY)
(DISCONTINUED 4/92 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, ANESTHESIA ASSISTANT (EFF 1/87)
44 = INFECTIOUS DISEASE
45 = MAMMOGRAPHY SCREENING CENTER
46 = ENDOCRINOLOGY (EFF 4/92)
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)
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 (INDEPENDENTLY PRACTICING)
66 = RHEUMATOLOGY (EFF 4/92)
67 = OCCUPATIONAL THERAPIST (INDEPENDENTLY PRACTICING)
68 = CLINICAL PSYCHOLOGIST
69 = CLINICAL LABORATORY (BILLING INDEPENDENTLY)
70 = MULTISPECIALTY CLINIC OR GROUP PRACTICE
71 = DIAGNOSTIC X-RAY (GPPP) (NOT TO BE ASSIGNED AFTER 5/92)
72 = DIAGNOSTIC LABORATORY (GPPP) (NOT TO BE ASSIGNED AFTER 5/92)
73 = PHYSIOTHERAPY (GPPP) (NOT TO BE ASSIGNED AFTER 5/92)
74 = OCCUPATIONAL THERAPY (GPPP) (NOT TO BE ASSIGNED AFTER 5/92)
75 = OTHER MEDICAL CARE (GPPP) (NOT TO ASSIGNED AFTER 5/92)
76 = PERIPHERAL VASCULAR DISEASE (EFF 4/92)
77 = VASCULAR SURGERY (EFF 4/92)
78 = CARDIAC SURGERY (EFF 4/92)
79 = ADDICTION MEDICINE (EFF 4/92)
80 = LICENSED CLINICAL SOCIAL WORKER
81 = CRITICAL CARE (INTENSIVISTS) (EFF 4/92)
82 = HEMATOLOGY (EFF 4/92)
83 = HEMATOLOGY/ONCOLOGY (EFF 4/92)
84 = PREVENTIVE MEDICINE (EFF 4/92)
85 = MAXILLOFACIAL SURGERY (EFF 4/92)
86 = NEUROPSYCHIATRY (EFF 4/92)
87 = ALL OTHER SUPPLIERS (E.G., DRUG AND DEPARTMENT STORES) (REVISED 10/93 TO MEAN DEPARTMENT STORE)

88 = UNKNOWN SUPPLIER/PROVIDER (REVISED 10/93 TO MEAN GROCERY STORE)
89 = CERTIFIED CLINICAL NURSE SPECIALIST
90 = MEDICAL ONCOLOGY (EFF 4/92)
91 = SURGICAL ONCOLOGY (EFF 4/92)
92 = RADIATION ONCOLOGY (EFF 4/92)
93 = EMERGENCY MEDICINE (EFF 4/92)
94 = INTERVENTIONAL RADIOLOGY (EFF 4/92)
95 = INDEPENDENT PHYSIOLOGICAL LABORATORY (EFF 4/92)
96 = UNKNOWN PHYSICIAN SPECIALTY (REVISED 10/93 TO MEAN OPTICIAN)
97 = PHYSICIAN ASSISTANT (EFF 5/92)
99 = UNKNOWN SUPPLIER/PROVIDER
A0 = HOSPITAL (EFF 10/93)
A1 = SNF (EFF 10/93)
A2 = INTERMEDIATE CARE NURSING FACILITY (EFF 10/93)
A3 = NURSING FACILITY, OTHER (EFF 10/93)
A4 = HHA (EFF 10/93)
A5 = PHARMACY (EFF 10/93)
A6 = MEDICAL SUPPLY COMPANY WITH RESPIRATORY THERAPIST (EFF 10/93)

SOURCE:
MEDICARE PAYMENT RECORDS

72. PHYSICIAN IDENTIFICATION NUMBER	CHAR	9	73	81	THIS FIELD SHOWS THE NUMBER USED TO IDENTIFY INDIVIDUAL PHYSICIANS, GROUPS, OR CLINICS. SOURCE: ORIGINAL PAYMENT RECORDS LIMITATIONS: THERE ARE PROBLEMS WITH THE USE OF THIS FIELD DUE TO THE LATITUDE PERMITTED IN ASSIGNMENT.
73. TYPE OF PHYSICIAN IDENTIFICATION NUMBER	CHAR	1	82	82	THIS FIELD DESCRIBES THE TYPE OF PHYSICIAN OR SUPPLIER PROVIDING THE SERVICE AND THE TYPE OF IDENTIFICATION NUMBER BEING USED. CODES:

1 = PHYSICIAN/SUPPLIER AS SOLO PRACTITIONERS
SSN USED
2 = PHYSICIAN/SUPPLIER AS SOLO PRACTITIONERS
CARRIER ID USED
3 = SUPPLIERS OTHER THAN SOLO
EMPLOYER IDENTIFICATION (EI) NUMBER USED
4 = SUPPLIERS OTHER THAN SOLO
CARRIER ID USED
5 = HOSPITALS
EI NUMBER USED
6 = HOSPITALS
PROVIDER NUMBER USED
7 = CLINICS, GROUPS, ASSOCIATIONS, OR
PARTNERSHIPS EI NUMBER USED
8 = GROUP PRACTICE PREPAYMENT PLANS
EI NUMBER USED
0 = CLINICS, GROUPS, ASSOCIATIONS, OR
PARTNERSHIPS CARRIER ID USED

SOURCE:
ORIGINAL PAYMENT RECORDS

74. DATE PAID	CHAR	5	83	87	DATE REIMBURSEMENT PAYMENT IS APPROVED

5 DIGITS

EDIT-RULES:
YYDDD

SOURCE:
MEDICARE PAYMENT RECORDS