The following variables have been deleted from this data for reasons of confidentiality.

- BENEFICIARY CLAIM ACCOUNT NUMBER
- BENEFICIARY CLAIM ACCOUNT NUMBER
- BENEFICIARY MAILING CONTACT ZIP CODE
- BENEFICIARY MAILING CONTACT ZIP CODE
- BENEFICIARY NCH STATE SEGMENT NEAR-LINE CODE
- BENEFICIARY RESIDENCE SSA STANDARD COUNTY CODE
- BENEFICIARY RESIDENCE SSA STANDARD COUNTY CODE
- CARRIER CLAIM REFERRING PHYSICIAN NPI NUMBER
- CARRIER CLAIM REFERRING PIN NUMBER
- CARRIER CLAIM REFERRING UPIN NUMBER
- CARRIER LINE PERFORMING NPI NUMBER
- CARRIER LINE PERFORMING PROVIDER ZIP CODE
- CLAIM ATTENDING PHYSICIAN GIVEN NAME
- CLAIM ATTENDING PHYSICIAN MIDDLE INITIAL NAME
- CLAIM ATTENDING PHYSICIAN NPI NUMBER
- CLAIM ATTENDING PHYSICIAN SURNAME
- CLAIM ATTENDING PHYSICIAN UPIN NUMBER
- CLAIM OPERATING PHYSICIAN GIVEN NAME
- CLAIM OPERATING PHYSICIAN MIDDLE INITIAL NAME
- CLAIM OPERATING PHYSICIAN NPI NUMBER
- CLAIM OPERATING PHYSICIAN SURNAME
- CLAIM OPERATING PHYSICIAN UPIN NUMBER
- CLAIM OTHER PHYSICIAN GIVEN NAME
- CLAIM OTHER PHYSICIAN IDENTIFICATION NUMBER
- CLAIM OTHER PHYSICIAN MIDDLE INITIAL NAME
- CLAIM OTHER PHYSICIAN NPI NUMBER
- CLAIM OTHER PHYSICIAN SURNAME
- CLAIM OTHER PHYSICIAN UPIN NUMBER
- CLAIM PATIENT 1ST INITIAL GIVEN NAME
- CLAIM PATIENT 1ST INITIAL GIVEN NAME
- CLAIM PATIENT 1ST INITIAL MIDDLE NAME
- CLAIM PATIENT 1ST INITIAL MIDDLE NAME
- CLAIM PATIENT 6 POSITION SURNAME
- CLAIM PATIENT 6-POSITION SURNAME
- CLAIM PRIMARY CARE PHYSICIAN IDENTIFICATION NUMBER
- CLAIM PRINCIPAL PROCEDURE PHYSICIAN IDENTIFICATION NUMBER
- CROSS REFERENCE CANBIC
- CWFB PERFORMING PROVIDER PROFILING NUMBER
Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

<table>
<thead>
<tr>
<th>POSITIONS</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Record Length Count</td>
<td>PACK</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>Effective with Version H, the count (in bytes) of the length of the claim record.</td>
</tr>
</tbody>
</table>

**** Carrier Claim Record                    REC     VAR Carrier claim record (other than DMERC) for version I of the NCH.

STANDARD ALIAS: CARR_CLM_REC  
SYSTEM ALIAS: UTLCARRI

**** Carrier Claim Fixed Group              GROUP   375  1  375 Fixed portion of the carrier claim record for version I of the NCH.

STANDARD ALIAS: CARR_CLM_FIX_GRP

**** Claim Record Identification Group      GROUP   8    1  8 Effective with Version 'I' the record length, version code, record identification, code and NCH derived claim type code were moved to this group for internal NCH processing.

STANDARD ALIAS: CLM_REC_IDENT_GRP

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

5 DIGITS SIGNED

DB2 ALIAS: REC_LENGTH_CNT
SAS ALIAS: REC_LEN
STANDARD ALIAS: REC_LENGTH_CNT

SOURCE:
NCH

2. NCH Near-Line Record Version Code

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to Version H this field was named: CLM_NEAR_LINE_REC_VRSN_CD.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMMENT:

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001
3. NCH Near Line Record Identification Code

CHAR 1 5 5 A code defining the type of claim record being processed.

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

CODES:
REFER TO: NCH_NEAR_LINE_RIC_TB
IN THE CODES APPENDIX

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

SOURCE: NCH

4. NCH MQA RIC Code

CHAR 1 6 6 Effective with Version H, the code used (for internal editing purposes) to identify the record being processed through HCFA’s CWFMQA system.

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

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

CODES:
1 = Inpatient
2 = SNF
3 = Hospice
4 = Outpatient
5 = Home Health Agency
6 = Physician/Supplier

SOURCE: NCH
5. **NCH Claim Type Code**

   **CHAR** 2 7 8

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

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

   **NOTE2:** During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). 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:** 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 CODE
DERIVED FROM: (AVAILABLE IN NMUD)
    FI_NUM
    CLM_FAC_TYPE_CD

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

<table>
<thead>
<tr>
<th>POSITION</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CLM_SRVC_CLSFCTN_TYPE_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CLM_FREQ_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 'ABBREVIATED' 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:

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

<table>
<thead>
<tr>
<th>POSITION</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>CLM_NEAR_LINE_RIC_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>EQUAL 'V'</td>
</tr>
<tr>
<td>2.</td>
<td>PMT_EDIT_RIC_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>EQUAL 'C' OR 'E'</td>
</tr>
<tr>
<td>3.</td>
<td>CLM_TRANS_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>EQUAL '1' OR '2' OR '3'</td>
</tr>
</tbody>
</table>

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' OR '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 DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL ‘M’
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:

---

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

<table>
<thead>
<tr>
<th>POSITION</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CLM_NEAR_LINE_RIC_CD EQUAL ‘M’</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).</td>
</tr>
</tbody>
</table>

CODES:
REFER TO: NCH_CLM_TYPE_TB
IN THE CODES APPENDIX

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

** Carrier/DMERC Claim Link Group

<table>
<thead>
<tr>
<th>GROUP</th>
<th>125</th>
<th>9</th>
<th>133</th>
</tr>
</thead>
</table>
| **STANDARD ALIAS**: CARR_DMERC_CLM_LINK_GRP

<table>
<thead>
<tr>
<th>GROUP</th>
<th>11</th>
<th>9</th>
<th>19</th>
</tr>
</thead>
</table>
| **COMMON ALIAS**: HIC  
**STANDARD ALIAS**: CLM_LCTR_NUM_GRP  
**TITLE ALIAS**: HICAN

6. Beneficiary Claim Account Number

<table>
<thead>
<tr>
<th>CHAR</th>
<th>9</th>
<th>9</th>
<th>17</th>
</tr>
</thead>
</table>
| **COMMON ALIAS**: CAN  
**DA3 ALIAS**: CLAIM_ACCOUNT_NUMBER  
**DB2 ALIAS**: BENE_CLM_ACNT_NUM  
**SAS ALIAS**: CAN  
**STANDARD ALIAS**: BENE_CLM_ACNT_NUM  
**TITLE ALIAS**: CAN

<table>
<thead>
<tr>
<th>CHAR</th>
<th>2</th>
<th>18</th>
<th>19</th>
</tr>
</thead>
</table>
| **SOURCE**: SSA, RRB

**LIMITATIONS**:  
RRB-issued numbers contain an overpunch in the first position that may appear as a plus zero or A-G. RRB-formatted numbers may cause matching problems on non-IBM machines.

7. NCH Category Equatable Beneficiary Identification Code

<table>
<thead>
<tr>
<th>CHAR</th>
<th>2</th>
<th>18</th>
<th>19</th>
</tr>
</thead>
</table>
| **The code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner.**
The equitable BIC module electronically matches two records that contain different BICs where it is apparent that both are records for the same beneficiary. It validates the BIC and returns a base BIC under which to house the record in the National Claims History (NCH) databases. (All records for a beneficiary are stored under a single BIC.)

**COMMON ALIAS:** NCH_BASE_CATEGORY_BIC  
**DB2 ALIAS:** CTGRY_EQTBL_BIC  
**SAS ALIAS:** EQ_BIC  
**STANDARD ALIAS:** NCH_CTGRY_EQTBL_BIC_CD  
**TITLE ALIAS:** EQUATED_BIC

**CODES:**  
REFER TO: CTGRY_EQTBL_BENE_IDENT_TB  
IN THE CODES APPENDIX

**COMMENT:**  
Prior to Version H this field was named: CTGRY_EQTBL_BENE_IDENT_CD.

**SOURCE:**  
BIC EQUATE MODULE

8. **Beneficiary Identification Code**  

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Beneficiary Identification Code</td>
<td>CHAR</td>
<td>2</td>
<td>20</td>
<td>21</td>
<td>The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary.</td>
</tr>
</tbody>
</table>

**COMMON ALIAS:** BIC  
**DA3 ALIAS:** BENE_IDENT_CODE  
**DB2 ALIAS:** BENE_IDENT_CD  
**SAS ALIAS:** BIC  
**STANDARD ALIAS:** BENE_IDENT_CD  
**TITLE ALIAS:** BIC
EDIT-RULES:
EDB REQUIRED FIELD

CODES:
  REFER TO: BENE_IDENT_TB
  IN THE CODES APPENDIX

SOURCE:
SSA/RRB

9. NCH State Segment Code       CHAR      1    22   22  The code identifying the segment of the NCH Nearline file containing the beneficiary’s record for a specific service year. Effective 12/96, segmentation is by CLM_LCTR_NUM, then final action sequence within residence state. (Prior to 12/96, segmentation was by ranges of county codes within the residence state.)
DB2 ALIAS: NCH_STATE_SGMT_CD
SAS ALIAS: ST_SGMT
STANDARD ALIAS: NCH_STATE_SGMT_CD
TITLE ALIAS: NEAR_LINE_SEGMENT

DA3 ALIAS: SSA_STANDARD_STATE_CODE
11. Claim From Date          NUM      8    25   32

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

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Claim Through Date</td>
<td>NUM</td>
<td>8</td>
<td>33</td>
<td>40</td>
<td>The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').</td>
</tr>
<tr>
<td>SOURCE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CWF</td>
</tr>
<tr>
<td>NOTE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.</td>
</tr>
<tr>
<td>8 DIGITS UNSIGNED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: CLM_THRU_DT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: THRU_DT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: CLM_THRU_DT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TITLE ALIAS: THRU_DATE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>EDIT-RULES:</td>
</tr>
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<td>YYYYMMDD</td>
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<td>SOURCE:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CWF</td>
</tr>
<tr>
<td>13. NCH Weekly Claim Processing Date</td>
<td>NUM</td>
<td>8</td>
<td>41</td>
<td>48</td>
<td>The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8 DIGITS UNSIGNED</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: NCH_WKLY_PROC_DT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: WKLY_DT</td>
</tr>
</tbody>
</table>
14. CWF Claim Accretion Date     NUM     8     49     56
The date the claim record is accreted (posted/processed) to the beneficiary master record at the CWF host site and authorization for payment is returned to the fiscal intermediary or carrier.

15. CWF Claim Accretion Number   PACK    2     57     58
The sequence number assigned to the claim record when accreted (posted/processed) to the beneficiary master record at the CWF host site on a given date. This element indicates the position of the claim within that day’s
processing at the CWF host. *(Exception: If the claim record is missing the accretion date HCFA’s CWFMQA system places a zero in the accretion number.

3 DIGITS SIGNED

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

SOURCE:
CWF

16. Carrier Claim Control Number

CHAR  15  59  73  Unique control number assigned by a carrier to a non-institutional claim.

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

EDIT-RULES:
LEFT JUSTIFY

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

SOURCE:
CWF

17. FILLER

CHAR  38  74  111

18. NCH Daily Process Date

NUM  8  112  119  Effective with Version H, the date the claim record was processed at the CWF host.
processed by HCFA’s CWFMQA system (used for internal editing purposes).

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

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

SOURCE:
NCH

19. NCH Segment Link Number PACK 5 120 124 Effective with Version ‘I’, the system generated number used in conjunction with the NCH daily process date to keep records/segments belonging to a specific claim together. This field was added to ensure that records/segments that come in on the same batch with the same identifying information in the link group are not mixed with each other.

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

9 DIGITS SIGNED

DB2 ALIAS: NCH_SGMT_LINK_NUM
20. Claim Total Segment Count  NUM  2  125  126  Effective with Version I, the count used to identify the total number of segments associated with a given claim. Each claim could have up to 10 segments.

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

1

21. Claim Segment Number  NUM  2  127  128  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

22. Claim Total Line Count  NUM  3 129 131 Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim.

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

3 DIGITS UNSIGNED

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

SOURCE:
CWF
23. Claim Segment Line Count  

**NUM** 2 132 133  
Effective with Version I, the count used to identify the number of revenue center lines on a record/segment.

**NOTE:** During the Version I conversion this field was populated with data throughout history (back to service year 1991). The maximum line count per record/segment is 45.

2 DIGITS UNSIGNED

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

24. FILLER  

**CHAR** 5 134 138

25. Carrier Claim Entry Code  

**CHAR** 1 139 139
Carrier-generated code describing whether the Part B claim is an original debit, full credit, or replacement debit.

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

**CODES:**
1 = Original debit; void of original debit  
   (If CLM_DISP_CD = 3, code 1 means voided original debit)  
3 = Full credit

**** Carrier/DMERC Claim Common  

GROUP 194 134 327
Information common to both carrier and DMERC claims for version I of NCH.

STANDARD ALIAS: CARR_DMERC_CLM_CMN_1_GRP

SOURCE: CWF

1 Group
5 = Replacement debit
9 = Accrete bill history only (internal; effective 2/22/91)

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

SOURCE:
CWF

<table>
<thead>
<tr>
<th>POSITION</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.</td>
<td>FILLER</td>
<td>CHAR</td>
<td>1</td>
<td>140</td>
<td>140</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>Claim Disposition Code</td>
<td>CHAR</td>
<td>2</td>
<td>141</td>
<td>142</td>
<td>Code indicating the disposition or outcome of the processing of the claim record.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: CLM_DISP_CD</td>
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<td></td>
<td>SAS ALIAS: DISP_CD</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: CLM_DISP_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TITLE ALIAS: DISPOSITION_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CODES: REFER TO: CLM_DISP_TB</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IN THE CODES APPENDIX</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>SOURCE: CWF</td>
</tr>
</tbody>
</table>

| 28.      | NCH Edit Disposition Code         | CHAR | 2      | 143 | 144 | Effective with Version H, a code used (for internal editing purposes) to indicate the disposition of the claim after editing in the CWFMQA process. |
|          |                                   |      |        |     |     | NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. |
|          |                                   |      |        |     |     | DB2 ALIAS: NCH_EDIT_DISP_CD |
SAS ALIAS: EDITDISP
STANDARD ALIAS: NCH_EDIT_DISP_CD
TITLE ALIAS: NCH_EDIT_DISP

CODES:
00 = No MQA errors
10 = Possible duplicate
20 = Utilization error
30 = Consistency error
40 = Entitlement error
50 = Identification error
60 = Logical duplicate
70 = Systems duplicate

SOURCE:
NCH QA Process

29. NCH Claim BIC Modify H Code  CHAR  1 145 145
Effective with Version H, the code used (for internal editing purposes) to identify a claim record that was submitted with an incorrect HA, HB, or HC BIC.

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

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

1
Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

POSITIONS

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
</table>

CODES:
H = BIC submitted by CWF = HA, HB or HC
blank = No HA, HB or HC BIC present

SOURCE:
NCH QA Process
<table>
<thead>
<tr>
<th>Field Name</th>
<th>Field Type</th>
<th>Start</th>
<th>End</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>30. Beneficiary Residence SSA</td>
<td>CHAR</td>
<td>146</td>
<td>148</td>
<td>The SSA standard county code of a beneficiary’s residence.</td>
</tr>
<tr>
<td>EDIT-RULES:</td>
<td></td>
<td></td>
<td></td>
<td>OPTIONAL: MAY BE BLANK</td>
</tr>
<tr>
<td>SOURCE:</td>
<td></td>
<td></td>
<td></td>
<td>SSA/EDB</td>
</tr>
<tr>
<td>31. Carrier Claim Receipt Date</td>
<td>NUM</td>
<td>149</td>
<td>156</td>
<td>The date the carrier receives the non-institutional claim.</td>
</tr>
<tr>
<td>8 DIGITS UNSIGNED</td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: CARR_CLM_RCPT_DT&lt;br&gt;SAS ALIAS: RCPT_DT&lt;br&gt;STANDARD ALIAS: CARR_CLM_RCPT_DT&lt;br&gt;TITLE ALIAS: RECEIPT_DT</td>
</tr>
<tr>
<td>EDIT-RULES:</td>
<td></td>
<td></td>
<td></td>
<td>YYYYMMDD</td>
</tr>
<tr>
<td>COMMENT:</td>
<td></td>
<td></td>
<td></td>
<td>Prior to Version H this field was named: FICARR_CLM_RCPT_DT.</td>
</tr>
<tr>
<td>SOURCE:</td>
<td></td>
<td></td>
<td></td>
<td>CWF</td>
</tr>
<tr>
<td>32. Carrier Claim Scheduled Payment Date</td>
<td>NUM</td>
<td>157</td>
<td>164</td>
<td>The scheduled date of payment to the physician or supplier, as appearing on the original non-institutional claim sent to the CWF host.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Note:</strong> This date is considered to be the date paid since no additional information as to the actual payment date is available.</td>
</tr>
<tr>
<td>8 DIGITS UNSIGNED</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Prior to Version H this field was named: FICARR_CLM_PMT_DT.

SOURCE: CWF

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

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

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

<table>
<thead>
<tr>
<th>POSITION</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>35.</td>
<td>FILLER</td>
<td>CHAR</td>
<td>8</td>
<td>178</td>
<td>185</td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>CWF Transmission Batch Number</td>
<td>CHAR</td>
<td>4</td>
<td>186</td>
<td>189</td>
<td>Effective with Version H, the number assigned to each batch of claims transactions sent from CWF (used for internal editing purposes).</td>
</tr>
</tbody>
</table>

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

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

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

SOURCE:
37. Beneficiary Mailing Contact ZIP Code

**ZIP Code**

9 190 198

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

- **DB2 ALIAS**: BENE_MLG_ZIP_CD
- **SAS ALIAS**: BENE_ZIP
- **STANDARD ALIAS**: BENE_MLG_CNTCT_ZIP_CD
- **TITLE ALIAS**: BENE_ZIP

**SOURCE:**

- **EDB**

38. Beneficiary Sex Identification Code

**CHAR**

1 199 199

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**

39. Beneficiary Race Code

**CHAR**

1 200 200

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
### 40. Beneficiary Birth Date

**Type:** NUM  
**Length:** 8  
**BEG:** 201  
**END:** 208

The beneficiary’s date of birth.

**8 DIGITS UNSIGNED**

- **DB2 ALIAS:** BENE_BIRTH_DT  
- **SAS ALIAS:** BENEDOB  
- **STANDARD ALIAS:** BENE_BIRTH_DT  
- **TITLE ALIAS:** BENE_BIRTH_DATE

**EDIT-RULES:**  
YYYMMDD

**SOURCE:**  
SSA

### 41. CWF Beneficiary Medicare Status Code

**Type:** CHAR  
**Length:** 2  
**BEG:** 209  
**END:** 210

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:

<table>
<thead>
<tr>
<th>MSC</th>
<th>OASI</th>
<th>DIB</th>
<th>ESRD</th>
<th>AGE</th>
<th>BIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>YES</td>
<td>N/A</td>
<td>NO</td>
<td>65 and over</td>
<td>N/A</td>
</tr>
<tr>
<td>11</td>
<td>YES</td>
<td>N/A</td>
<td>YES</td>
<td>65 and over</td>
<td>N/A</td>
</tr>
<tr>
<td>20</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>under 65</td>
<td>N/A</td>
</tr>
<tr>
<td>21</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>under 65</td>
<td>N/A</td>
</tr>
<tr>
<td>31</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>any age</td>
<td>T.</td>
</tr>
</tbody>
</table>

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
</table>

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
42. Claim Patient 6 Position Surname

| CHAR | 6 211 216 |

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

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

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

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

SOURCE:
CWF

43. Claim Patient 1st Initial Given Name

| CHAR | 1 217 217 |

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

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

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

COMMON ALIAS: PATIENT_GIVEN_NAME

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>End</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>44. Claim Patient First Initial Middle Name</td>
<td>CHAR</td>
<td>1 218 218</td>
<td>The first initial of the Medicare patient’s middle name as reported by the provider on the claim.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>COMMON ALIAS: PATIENT_MIDDLE_NAME</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>DB2 ALIAS: 1ST_INITL_MDL_NAME</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: MDL_INIT</td>
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<td></td>
<td>STANDARD ALIAS: CLM_PTNT_1ST_INITL_MDL_NAME</td>
</tr>
<tr>
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<td></td>
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<td></td>
<td>TITLE ALIAS: PATIENT_MIDDLE_INITIAL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SOURCE: CWF</td>
</tr>
<tr>
<td>45. Beneficiary CWF Location Code</td>
<td>CHAR</td>
<td>1 219 219</td>
<td>The code that identifies the Common Working File (CWF) location (the host site) where a beneficiary’s Medicare utilization records are maintained.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>COMMON ALIAS: CWF_HOST</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: BENE_CWF_LOC_CD</td>
</tr>
</tbody>
</table>
### 46. Claim Principal Diagnosis Code

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Principal Diagnosis Code</td>
<td>CHAR</td>
<td>5</td>
<td>220</td>
<td>224</td>
<td>The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.</td>
</tr>
</tbody>
</table>

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

**SOURCE:**
CWF
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
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<tbody>
<tr>
<td>47. FILLER</td>
<td>CHAR</td>
<td>1</td>
<td>225</td>
<td>225</td>
<td></td>
</tr>
<tr>
<td>48. Carrier Claim Payment Denial Code</td>
<td>CHAR</td>
<td>1</td>
<td>226</td>
<td>226</td>
<td>The code on a noninstitutional claim indicating to whom payment was made or if the claim was denied.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: CARR_PMT_DNL_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: PMT_DNL_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: CARR_CLM_PMT_DNL_CD</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td>TITLE ALIAS: PMT_DENIAL_CD</td>
</tr>
<tr>
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<td>CODES:</td>
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<td></td>
<td></td>
<td></td>
<td>REFER TO: CARR_CLM_PMT_DNL_TB</td>
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<td>IN THE CODES APPENDIX</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>COMMENT:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prior to Version H this field was named: CWF_CLM_PMT_DNL_CD.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SOURCE:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CWF</td>
</tr>
<tr>
<td>49. Claim Excepted/Nonexcepted Medical Treatment Code</td>
<td>CHAR</td>
<td>1</td>
<td>227</td>
<td>227</td>
<td>Effective with Version I, the code used to identify whether or not the medical care or treatment received by a beneficiary, who has elected care from a Religious Nonmedical Health Care Institution (RNHCI), is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is required under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: EXCPTD_NEXCPTD_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: TRTMT_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: CLM_EXCPTD_NEXCPTD_TRTMT_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TITLE ALIAS: EXCPTD_NEXCPTD_CD</td>
</tr>
</tbody>
</table>

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001
CODES:
0 = No Entry
1 = Excepted
2 = Nonexcepted

SOURCE:
CWF

50. Claim Payment Amount       PACK       6  228  233

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

Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). 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 code = '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount.
Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total payment. The Medicare payment amount takes into account the wage index adjustment and the beneficiary deductible and coinsurance amounts. NOTE: There is no CWF edit check to validate that the revenue center Medicare payment amount equals the claim level Medicare payment amount.

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

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>POSITIONS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

For demo Ids ‘05’,'15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.
For demo Ids ‘06’, ‘07’, ‘08’ -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A payment would have been, check value code = ’Y4’. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

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

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:
$$$$$$$$$CC

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

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001
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.

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

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

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:
$$$$$$$$$CC

SOURCE:
CWF

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

COMMON ALIAS: REFERRING_PHYSICIAN_UPIN
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Claim Referring Physician NPI Number</td>
<td>CHAR</td>
<td>10</td>
<td>247</td>
<td>256</td>
<td>A placeholder field (effective with Version H) for storing the NPI assigned to the referring physician.</td>
</tr>
<tr>
<td>COMMON ALIAS: REFERRING_PHYSICIAN_NPI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DB2 ALIAS: CARR_RFRG_UPIN_NUM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: RFR_UPIN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: CARR_CLM_RFRG_UPIN_NUM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: REFERRING_PHYSICIAN_UPIN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prior to Version H this field was named: CWFB_CLM_RFRG_UPIN_NUM.

SOURCE:
Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

55. Carrier Claim Provider Assignment Indicator Switch | CHAR | 1 | 257 | 257 | 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
56. 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

SOURCE:
NCH QA Process

57. 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
58. Carrier Claim Beneficiary Paid Amount

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

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

9.2 DIGITS SIGNED

59. 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
<table>
<thead>
<tr>
<th>Positions</th>
<th>Name</th>
<th>Type</th>
<th>Length</th>
<th>Begin</th>
<th>End</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>60.</td>
<td>NCH Carrier Claim Allowed Charge Amount</td>
<td>PACK</td>
<td>6</td>
<td>282</td>
<td>287</td>
<td>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</td>
</tr>
<tr>
<td>61.</td>
<td>Carrier Claim Cash Deductible Applied Amount</td>
<td>PACK</td>
<td>6</td>
<td>288</td>
<td>293</td>
<td>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</td>
</tr>
</tbody>
</table>
62. Carrier Claim HCPCS Year Code

NUM 1 294 294

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

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

1 DIGIT UNSIGNED

63. Carrier Claim MCO Override Indicator Code

CHAR 1 295 295

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

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.
Effective with Version H, the code used to indicate whether or not an Hospice investigation applies to the claim (used for internal CWFMQA editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Claim Referring PIN</td>
<td>CHAR</td>
<td>14</td>
<td>328</td>
<td>341</td>
<td>Carrier-assigned identification (profiling) number of the physician who referred the beneficiary to the physician that performed the Part B services.</td>
</tr>
</tbody>
</table>

Prior to Version H this field was named: CWFB_CLM_RFRG_PHYSN_PRFLG_NUM.

Source: CWF

67. Care Plan Oversight (CPO) Provider Number

Effective with NCH weekly process date 3/7/97, the Medicare provider number of the HHA or Hospice rendering Medicare covered services during the physician's care plan oversight period. The purpose of this field is to ensure compliance with the CPO requirement that the beneficiary must be receiving covered HHA or Hospice services during the billing period. There can be only one CPO provider number per claim, and no other services but CPO physician services are to be reported on the claim. This field is only present on the non-DMEC processed carrier claim.

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

Common Alias: RFRG_PIN

DB2 Alias: CARR_RFRG_PIN_NUM

SAS Alias: RFR_PPL

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.
### DB2 ALIAS: CPO_PRVDR_NUM
### SAS ALIAS: CPO_PROV
### STANDARD ALIAS: CPO_PRVDR_NUM
### TITLE ALIAS: CPO_PRVDR

**SOURCE:**
CWF

---

### 68. CPO Organization NPI Number

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPO Organization NPI Number</td>
<td>CHAR</td>
<td>10</td>
<td>348</td>
<td>357</td>
</tr>
</tbody>
</table>

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

**DB2 ALIAS:** CPO_ORG_NPI_NUM

**SAS ALIAS:** CPO_NPI

**STANDARD ALIAS:** CPO_ORG_NPI_NUM

**TITLE ALIAS:** CPO_ORG_NPI

**SOURCE:**
CWF

---

### 69. Claim Blood Pints Furnished Quantity

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Blood Pints Furnished Quantity</td>
<td>PACK</td>
<td>2</td>
<td>358</td>
<td>359</td>
</tr>
</tbody>
</table>

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

**EDIT-RULES:**
NUMERIC

**COMMENT:**

3 DIGITS SIGNED

**DB2 ALIAS:** BLOOD_PT_FRNSH_QTY

**SAS ALIAS:** BLDFRNSH

**STANDARD ALIAS:** CLM_BLOOD_PT_FRNSH_QTY

**TITLE ALIAS:** BLOOD_PINTS_FURNISHED
Prior to Version H this field was stored in a blood trailer. Version H eliminated the blood trailer.

**SOURCE:**
CWF

### 70. Claim Blood Deductible

<table>
<thead>
<tr>
<th>Description</th>
<th>Type</th>
<th>Pack</th>
<th>Start</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pints Quantity</td>
<td>PACK</td>
<td>2</td>
<td>360</td>
<td>361</td>
</tr>
</tbody>
</table>

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

3 DIGITS SIGNED

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

**EDIT-RULES:**
NUMERIC

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

**SOURCE:**
CWF

### 71. Carrier NCH Edit Code Count

<table>
<thead>
<tr>
<th>Description</th>
<th>Type</th>
<th>Pack</th>
<th>Start</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUM</td>
<td>NUM</td>
<td>2</td>
<td>362</td>
<td>363</td>
</tr>
</tbody>
</table>

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

2 DIGITS UNSIGNED

DB2 ALIAS: CARR_EDIT_CD_CNT  
SAS ALIAS: CEDCNT  
STANDARD ALIAS: CARR_NCH_EDIT_CD_CNT

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>72. Carrier NCH Patch Code</td>
<td>NUM</td>
<td>2</td>
<td>364</td>
<td>365</td>
<td>Effective with Version H, the count of the number of HCFA patch codes annotated to the carrier claim during the Nearline maintenance process. The purpose of this count is to indicate how many NCH patch trailers are present. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). 2 DIGITS UNSIGNED DB2 ALIAS: CARR_PATCH_CD_CNT SAS ALIAS: CPATCNT STANDARD ALIAS: CARR_NCH_PATCH_CD_CNT</td>
</tr>
<tr>
<td>73. Carrier MCO Period Count</td>
<td>NUM</td>
<td>1</td>
<td>366</td>
<td>366</td>
<td>Effective with Version H, the count of the number of Managed Care Organization (MCO) periods reported on a carrier claim. The purpose of this count is to indicate how many MCO period trailers are present. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 1 DIGIT UNSIGNED</td>
</tr>
</tbody>
</table>
74. Carrier Claim Health PlanID Count

A placeholder field (effective with Version H) for storing the count of the number of Health PlanIDs reported on the carrier claim. The purpose of this count is to indicate how many Health PlanID trailers are present. NOTE: Prior to Version 'I' this field was named:

```
NAME          TYPE  LENGTH BEG  END
---------------------------  ----  ------ ---------  ------------------------------------------------------------
CARR_CLM_PAYERID_CNT.   1 DIGIT UNSIGNED
```

DB2 ALIAS: CARR_MCO_PRD_CNT
SAS ALIAS: CMOCNT
STANDARD ALIAS: CARR_MCO_PRD_CNT

EDIT-RULES:
RANGE: 0 TO 2

SOURCE:
NCH

75. Carrier Claim Demonstration ID Count

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

```
NAME          TYPE  LENGTH BEG  END
---------------------------  ----  ------ ---------  ------------------------------------------------------------
CARR_CLM_HLTH_PLANID_CNT.  1 DIGIT UNSIGNED
```

DB2 ALIAS: CARR_PLANID_CNT
SAS ALIAS: CPLNCNT
STANDARD ALIAS: CARR_CLM_HLTH_PLANID_CNT

EDIT-RULES:
RANGE: 0 TO 3

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

1 DIGIT UNSIGNED

DB2 ALIAS: CARR_DEMO_ID_CNT
SAS ALIAS: CDEMCNT
STANDARD ALIAS: CARR_CLM_DEMO_ID_CNT

EDIT-RULES:
RANGE: 0 TO 5

SOURCE:
NCH

76. Carrier Claim Diagnosis Code Count

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

1 Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

NAME   TYPE LENGTH BEG END CONTENTS
----------------------------------------

77. Carrier Claim Line Count  NUM  2 370 371

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

78. FILLER  CHAR  4 372 375

**** Carrier Claim Variable Group

Variable portion of the carrier claim record for version H of the NCH.

STANDARD ALIAS: CARR_CLM_VAR_GRP

**** NCH Edit Group

GROUP 5

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

OCCURS: UP TO 13 TIMES
DEPENDING ON CARR_NCH_EDIT_CD_CNT

STANDARD ALIAS: NCH_EDIT_GRP

79. NCH Edit Trailer Indicator Code  CHAR  1

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

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

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCH Edit Code</td>
<td>CHAR</td>
<td>4</td>
<td></td>
<td></td>
<td>The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.</td>
</tr>
</tbody>
</table>

**NOTE:** Prior to Version H only the highest priority code was stored. Beginning 11/98 up to 13 edit codes may be present.

**COMMON ALIAS:** QA_ERROR_CODE

**DB2 ALIAS:** NCH_EDIT_CD

**SAS ALIAS:** EDIT_CD

**STANDARD ALIAS:** NCH_EDIT_CD

**TITLE ALIAS:** QA_ERROR_CD

**CODES:**

- E = Edit code trailer present

**SOURCE:**

NCH QA Process

---

#### NCH Patch Group

<table>
<thead>
<tr>
<th>NAME</th>
<th>GROUP</th>
<th>11</th>
<th>OCCURS: UP TO 30 TIMES DEPENDING ON CARR_NCH_PATCH_CD_I_CNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCH Patch Group</td>
<td>GROUP</td>
<td>11</td>
<td></td>
</tr>
</tbody>
</table>

**STANDARD ALIAS:** NCH_PATCH_GRP
81. NCH Patch Trailer Indicator

**CHAR 1**

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

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

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

**CODES:**
P = Patch code trailer present

**SOURCE:**
NCH

82. NCH Patch Code

**CHAR 2**

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

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

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

**CODES:**

---

**NAME** | **TYPE** | **LENGTH** | **BEGIN** | **END** | **CONTENTS**
----------------------------- | ---- | --------- | --------- | --------- | -------------------------------------------------------------

REFER TO: NCH_PATCH_TB
IN THE CODES APPENDIX

**SOURCE:**
NCH
83. NCH Patch Applied Date  NUM  8

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

SOURCE:
NCH

**** MCO Period Group  GROUP 37

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

OCCURS: UP TO 2 TIMES
DEPENDING ON CARR_MCO_PRD_CNT

STANDARD ALIAS: MCO_PRD_GRP

84. NCH MCO Trailer Indicator  CHAR 1

Effective with Version H, the code indicating the presence of a Managed Care Organization (MCO) trailer.

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

COBOL ALIAS: MCO_IND
DB2 ALIAS: MCO_TRLR_IND_CD
SAS ALIAS: MCOIND
### Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Length</th>
<th>BEG</th>
<th>END</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>85. MCO Contract Number</td>
<td>CHAR</td>
<td>5</td>
<td></td>
<td></td>
<td>Effective with Version H, this field represents the plan contract number of the Managed Care Organization (MCO).</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.</td>
</tr>
</tbody>
</table>
|                               |       |        |     |     | DB2 ALIAS: MCO_CNTRCT_NUM  
|                               |       |        |     |     | SAS ALIAS: MCONUM  
|                               |       |        |     |     | STANDARD ALIAS: MCO_CNTRCT_NUM  
|                               |       |        |     |     | TITLE ALIAS: MCO_NUM  
|                               |       |        |     |     | SOURCE: CWF |
| 86. MCO Option Code           | CHAR  | 1      |     |     | Effective with Version H, the code indicating Managed Care Organization (MCO) lock-in enrollment status of the beneficiary. |
|                               |       |        |     |     | NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. |
|                               |       |        |     |     | DB2 ALIAS: MCO_OPTN_CD  
|                               |       |        |     |     | SAS ALIAS: MCOOPTN |
STANDARD ALIAS: MCO_OPTN_CD  
TITLE ALIAS: MCO_OPTION_CD  
CODES: 
****For lock-in beneficiaries**** 
A = HCFA to process all provider bills 
B = MCO to process only in-plan 
C = MCO to process all Part A and Part B bills 

**** For non-lock-in beneficiaries**** 
1 = HCFA to process all provider bills 
2 = MCO to process only in-plan Part A and Part B bills 

SOURCE: 
CWF 

87. MCO Period Effective Date NUM  8 

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

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

8 DIGITS UNSIGNED 

1 

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001 

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DB2 ALIAS: MCO_PRD_EFCTV_DT</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>SAS ALIAS: MCOEFFDT</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: MCO_PRD_EFCTV_DT</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: MCO_PERIOD_EFF_DT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EDIT-RULES: 
YYYYMMDD 

SOURCE: 

88. MCO Period Termination Date  NUM  8

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

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

89. MCO Health PLANID Number  CHAR  14

A placeholder field (effective with Version H) for storing the Health PlanID associated with the Managed Care Organization (MCO). Prior to Version ’I’ this field was named:
MCO_PAYERID_NUM.

DB2 ALIAS: MCO_PLANID_NUM
SAS ALIAS: MCOPLNID
STANDARD ALIAS: MCO_HLTH_PLANID_NUM
TITLE ALIAS: MCO_PLANID

COMMENT:
Prior to Version I this field was named:
MCO_PAYERID_NUM.

SOURCE:
CWF
The number of Health PlanID data trailers is determined by the claim Health PlanID trailer count. Prior to Version 'I' this field was named: CLM_PAYERID_GRP.

<table>
<thead>
<tr>
<th>POSITION</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90. NCH Health PlanID Trailer Indicator Code</td>
<td>CHAR</td>
<td>1</td>
<td></td>
<td></td>
<td>A placeholder field (effective with Version H) for storing the code that indicates the presence of a Health PlanID trailer. NOTE: Prior to Version 'I' this field was named: NCH_PAYERID_TRLR_IND_CD.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: PLANID_TRLR_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: PLANIDIN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: NCH_HLTH_PLANID_TRLR_IND_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CODES:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>I = Health PlanID trailer present</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>COMMENT:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prior to Version I this field was named: NCH_PAYERID_TRLR_IND_CD.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SOURCE:</td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
<td>NCH</td>
</tr>
<tr>
<td></td>
<td>91. Claim Health PlanID Code</td>
<td>CHAR</td>
<td>1</td>
<td></td>
<td></td>
<td>A placeholder field (effective with Version H) for storing the code identifying the type of Health PlanID. Prior to Version 'I' this field was named: CLM_PAYERID_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: CLM_PLANID_CD</td>
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<tr>
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<td></td>
<td>SAS ALIAS: PLANIDCD</td>
</tr>
<tr>
<td>92. Claim Health PlanID Number</td>
<td>CHAR</td>
<td>14</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

A placeholder field (effective with Version H) for storing the Health PlanID number. Prior to Version 'I' this field was named: CLM_PAYERID_NUM.

**DB2 ALIAS: CLM_PLANID_NUM**

**SAS ALIAS: PLANID**

| **** Claim Demonstration Identification Group | GROUP | 18 |

The number of demonstration identification trailers present is determined by the claim demonstration identification trailer count.
93. NCH Demonstration Trailer Indicator Code

CHAR 1

Effective with Version H, the code indicating the presence of a demo trailer.

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

COBOL ALIAS: DEMO_IND
DB2 ALIAS: DEMO_TRLR_IND_CD
SAS ALIAS: DEMOIND
STANDARD ALIAS: NCH_DEMO_TRLR_IND_CD
TITLE ALIAS: DEMO_INDICATOR

CODES:
D = Demo trailer present

SOURCE:
NCH

94. Claim Demonstration Identification Number

CHAR 2

Effective with Version H, the number assigned to identify a demo. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).

NOTE: Prior to Version H, Demo ID was stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4. During the H conversion, this field was populated with data throughout history (as appropriate either by moving ID on Version G or by deriving from specific demo criteria).

01 = Nursing Home Case-Mix and Quality: NHCMQ (RUGS) Demo -- testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a
RUGS indicator and one or more revenue center codes in the 9,000 series.

NOTE1: Effective for SNF claims with NCH weekly process date after 2/8/96 (and service date after 12/31/95) -- beginning 4/97, Demo ID '01' was derived in NCH based on presence of RUGS phase # '2','3' or '4' on incoming claim; since 7/97, CWF has been adding ID to claim.

NOTE2: During the Version H conversion, Demo ID '01' was populated back to NCH weekly process date 2/9/96 based on the RUGS phase indicator (stored in Claim Edit Group, 3rd occurrence, 4th position, in Version G).

02 = National HHA Prospective Payment Demo -- testing PPS for HHAs in 5 states, using two alternate methods of paying HHAs: per visit by type of HHA visit and per episode of HH care.

NOTE1: Effective for HHA claims with NCH weekly process date after 5/31/95 -- beginning 4/97, Demo ID '02' was derived in NCH based on HCFA/CHPP-supplied listing of provider # and start/stop dates of participants.

NOTE2: During the Version H conversion, Demo ID '02' was populated back to NCH weekly process date 6/95 based on the CHPP criteria.

03 = Telemedicine Demo -- testing covering traditionally noncovered physician services for medical consultation furnished via two-way, interactive video systems (i.e. teleconsultation) in 4 states. The claims contain line items
with ‘QQ’ HCPCS code.

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

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

04 = United Mine Workers of America (UMWA) Managed Care Demo -- testing risk sharing for Part A services, paying special capitation rates for all UMWA beneficiaries residing in 13 designated counties in 3 states. Under the demo, UMWA will waive the 3-day qualifying hospital stay for a SNF admission. The claims contain TOB ‘18X’, ‘21X’, ‘28X’ and ‘51X’; condition

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

NOTE1: Effective for all claim types with NCH
weekly process date after 7/31/97 -- CWF adds Demo ID ‘05’ to claim based on the presence of the MCO Plan Contract #.

NOTE2: During the Version H conversion, Demo ID ‘05’ was populated back to NCH weekly process date 8/97 based on the presence of the Choices indicator (stored as an alpha character crosswalked from MCO plan contract # in the Claim Edit Group, 4th occurrence, 2nd position, in Version ‘G’).

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

NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit Date no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID ‘06’ on the claim. The FI adds the ID to the claim based on the presence of DRG ‘106’ or ‘107’ from specific providers for specified time periods; the carrier adds the ID to the claim based on receiving ‘Daily Census List’ from participating hospitals. Demo ID ‘06’ will end once Demo ID ‘07’ is implemented.

NOTE2: During the Version H conversion, any claims where Medicare is the primary payer that were not already identified as Demo ID ‘06’ (stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4, Version G) were annotated based on the following criteria: Inpatient – presence of DRG ‘106’ or ‘107’ and a provider number=220897, 150897, 1

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001
380897, 450897, 110082, 230156 or 360085 for specified service dates; noninstitutional – presence of HCPCS modifier (initial and/or second) = 'Q2' and a carrier number = 00700/31143 00630, 01380, 00900, 01040/00511, 00710, 00623, or 13630 for specified service dates.

07 = Participating Centers of Excellence (PCOE)
Demo -- testing a negotiated all-inclusive pricing arrangement (bundled rates) for high-cost acute care cardiovascular and orthopedic procedures performed in 60-100 premier facilities in the Chicago and San Francisco Regions or by current CABG providers. The inpatient claims will contain a DRG '104', '105', '106', '107', '112', '124', '125', '209', or '471'; the related physician/supplier claims will contain the claim payment denial reason code = 'D'.

NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '07' to claim.

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

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

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

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

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

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
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<tbody>
<tr>
<td>NIH.</td>
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</tr>
</tbody>
</table>

NOTE: Effective for all claim types (except DMERC) with NCH weekly process date after 2/27/98 (and service date after 10/31/97) -- the FI adds Demo ID ’30’ based on the presence of a condition code = EY; the participating physician (not the carrier) adds ID to the noninstitutional claim. DUE TO THE SENSITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO HCFA BUT NOT STORED IN THE NEARLINE FILE (access is restricted to study evaluators only).

31 = VA Pricing Special Processing (SPN) -- not really a demo but special request from VA due to court settlement; not Medicare services but VA inpatient and physician services submitted
to FI 00400 and Carrier 00900 to obtain Medicare pricing -- CWF WILL PROCESS VA CLAIMS ANNOTATED WITH DEMO ID ’31’, BUT WILL NOT TRANSMIT TO HCFA (not in Nearline File).

37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries improve outcomes of care and reduce Medicare expenditures under Part A and Part B. There will be at least 9 Coordinated Care Entities (CCEs). The selected entities will be assigned a provider number specifically for the demonstration services.

NOTE: The demo is on HOLD. The FI and carrier will add Demo ID ’37’ to claim.

38 = Physician Encounter Claims - the purpose of this demo id is to identify the physician encounter claims being processed at the HCFA Data Center (HDC). This number will help EDS in making the claim go through the appropriate processing logic, which differs from that for fee-for-service. **NOT IN NCH -- AVAILABLE IN NMUD.**

NOTE: Effective October, 2000. Demo ids will not be assigned to Inpatient and Outpatient encounter claims.

39 = Centralized Billing of Flu and PPV Claims -- The purpose of this demo is to facilitate the processing carrier, Trailblazers, paying flu and PPV claims based on payment localities. Providers will be giving the shots throughout the country and transmitting the claims to Trailblazers for processing.

NOTE: Effective October, 2000 for carrier claims.

DB2 ALIAS: CLM_DEMO_ID_NUM

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

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</tr>
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<tr>
<td>NAME</td>
</tr>
</tbody>
</table>

1
Effective with Version H, the text field that contains related demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field.

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

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

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

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

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
</table>
| 95. Claim Demonstration Information Text | CHAR 15 | Contains demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field. Note: During the Version H conversion this field was populated with data throughout history. 

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

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

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

<table>
<thead>
<tr>
<th>Alias</th>
<th>Description</th>
</tr>
</thead>
</table>
| DEMONUM     | Contains demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field. Note: During the Version H conversion this field was populated with data throughout history. 

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

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

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

<table>
<thead>
<tr>
<th>Alias</th>
<th>Description</th>
</tr>
</thead>
</table>
| CLM_DEMO_ID_NUM | Contains demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field. Note: During the Version H conversion this field was populated with data throughout history. 

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

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

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

<table>
<thead>
<tr>
<th>Alias</th>
<th>Description</th>
</tr>
</thead>
</table>
| DEMO_ID     | Contains demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field. Note: During the Version H conversion this field was populated with data throughout history. 

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

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

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

<table>
<thead>
<tr>
<th>Alias</th>
<th>Description</th>
</tr>
</thead>
</table>
| DEMOTXT     | Contains demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field. Note: During the Version H conversion this field was populated with data throughout history. 

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

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

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

<table>
<thead>
<tr>
<th>Alias</th>
<th>Description</th>
</tr>
</thead>
</table>
| DEMO_INFO   | Contains demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field. Note: During the Version H conversion this field was populated with data throughout history. 

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

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

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

<table>
<thead>
<tr>
<th>Alias</th>
<th>Description</th>
</tr>
</thead>
</table>
| CLM_DEMO_INFO_TXT | Contains demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field. Note: During the Version H conversion this field was populated with data throughout history. 

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

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

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

<table>
<thead>
<tr>
<th>Alias</th>
<th>Description</th>
</tr>
</thead>
</table>
| CLM_DEMO_INFO_TXT | Contains demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field. Note: During the Version H conversion this field was populated with data throughout history. 

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

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

Demo ID = 03 (Telemedicine demo) -- text field will contain the HCPCS code. If the required HCPCS is not shown then the text field will reflect 'INVALID'.
Demo ID = 04 (UMWA) -- text field will contain W0 denoting that condition code W0 was present. If condition code W0 not present then the text field will reflect 'INVALID'.

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

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

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

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

SOURCE:
CWF
Carrier Claim Diagnosis Group

96. NCH Diagnosis Trailer Indicator Code

- **CHAR** 1
  - Effective with Version H, the code indicating the presence of a diagnosis trailer.
  - NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

- **DB2 ALIAS:** DGNS_TRLR_IND_CD
  - **SAS ALIAS:** DGNSIND
  - **STANDARD ALIAS:** NCH_DGNS_TRLR_IND_CD

- **CODES:**
  - Y = Diagnosis code trailer present

- **SOURCE:**
  - NCH

97. Claim Diagnosis Code

- **CHAR** 5
  - 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.

1

---

**Car...
98. FILLER CHAR 1

**** Carrier Line Item Group GROUP 294

The line item trailer group may occur multiple times in one carrier claim. Up to 13 occurrences may be present.

OCCURS: UP TO 13 TIMES DEPENDING ON CARR_CLM_LINE_CNT

STANDARD ALIAS: CARR_LINE_GRP

99. NCH Line Item Trailer Indicator Code CHAR 1

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

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

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

CODES:
L = Line Item trailer present
Blank = No trailer present

SOURCE:
NCH

100. Carrier Line Performing PIN CHAR 10

Number

The profiling identification number (PIN) of the physician\supplier who performed the service for this line item on the carrier claim
### Carrier Line Performing UPIN Number

**NAME:** Carrier Line Performing UPIN Number  
**TYPE:** CHAR  
**LENGTH:** 6

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

**SOURCE:**  
CWF

**DB2 ALIAS:** LINE_PRFRMG_UPIN  
**SAS ALIAS:** PRF_UPIN  
**STANDARD ALIAS:** CARR_LINE_PRFRMG_UPIN_NUM  
**TITLE ALIAS:** PRFRMG_UPIN

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

**SOURCE:**  
CWF

### Carrier Line Performing NPI Number

**NAME:** Carrier Line Performing NPI Number  
**TYPE:** CHAR  
**LENGTH:** 10

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

**COMMON ALIAS:** PERFORMING_PROVIDER_NPI
103. Carrier Line Performing Group NPI Number

CHAR 10

A placeholder field (effective with Version H) for storing the NPI assigned to a group practice, where the performing physician is part of that group. If the physician is not part of a group, this field will be blank.

104. Carrier Line Provider Type

CHAR 1

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

---

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH BEG END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

CODES:

REFER TO: CARR_LINE_PRVDR_TYPE_TB

IN THE CODES APPENDIX

COMMENT:

Prior to Version H this field was named:
<table>
<thead>
<tr>
<th>Field Name</th>
<th>Type</th>
<th>Length</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>105. Line Provider Tax Number</td>
<td>CHAR</td>
<td>10</td>
<td>Social security number or employee identification number of physician/supplier used to identify to whom payment is made for the line item service on the noninstitutional claim.</td>
</tr>
<tr>
<td>106. Line NCH Provider State Code</td>
<td>CHAR</td>
<td>2</td>
<td>SSA state code where provider facility is located.</td>
</tr>
</tbody>
</table>

**Comment:**
Prior to Version H this field was named: CWFB_PRVDR_TAX_NUM.

**Source:**
CWF

**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

---

1
Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

<table>
<thead>
<tr>
<th>POSITIONS</th>
<th>CONTENTS</th>
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<td>NAME</td>
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<tr>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td>IN THE CODES APPENDIX</td>
<td></td>
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</tbody>
</table>

107. Carrier Line Performing Provider ZIP Code
CHAR 9
The ZIP code of the physician/supplier who performed the Part B service for this line item on the carrier claim (non-DMERC).

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

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

SOURCE:
NCH

108. Line HCFA Provider Specialty Code
CHAR 2
HCFA specialty code used for pricing the line item service on the noninstitutional claim.

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

109. Carrier Line Provider
Specialty Code

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

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

EDIT-RULES:
CARRIER INFORMATION FILE

COMMENT:

1
Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

---------------------------  ----  ------ ---------  ------------------------------------------------------------
NAME              TYPE  LENGTH BEG  END                            CONTENTS

Prior to Version H this field was named:
CWFB_CARR_PRVDR_SPCLTY_CD.

SOURCE:
CWF

110. Line Provider Participating
Indicator Code

Code indicating whether or not a provider is
participating or accepting assignment for this
line item service on the noninstitutional claim.
<table>
<thead>
<tr>
<th>Field Type</th>
<th>Length</th>
<th>Description</th>
<th>DB2 Alias</th>
<th>SAS Alias</th>
<th>Standard Alias</th>
<th>Title Alias</th>
<th>Codes</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Line Reduced Payment Physician Assistant Code</td>
<td>CHAR</td>
<td>1</td>
<td>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.</td>
<td>PRVDR_PRTCPTG_CD</td>
<td>PRTCPTG</td>
<td>LINE_PRVDR_PRTCPTG_IND_CD</td>
<td>PRVDR_PRTCPTG_IND</td>
<td>REFER TO: LINE_PRVDR_PRTCPTG_IND_TB IN THE CODES APPENDIX</td>
</tr>
<tr>
<td>Line Service Count</td>
<td>PACK</td>
<td>2</td>
<td>The count of the total number of services processed for the line item on the non-institutional claim.</td>
<td>PHYSN_ASTNT_CD</td>
<td>ASTNT_CD</td>
<td>CARR_LINE_RDCD_PHYSN_ASTNT_CD</td>
<td>PHYSN_ASTNT_CD</td>
<td>REFER TO: CARR_LINE_RDCD_PHYSN_ASTNT_TB IN THE CODES APPENDIX</td>
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3 DIGITS SIGNED

DB2 ALIAS: SRVC_CNT

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

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<th>NAME</th>
<th>TYPE</th>
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<td>Prior to Version H this field was named:</td>
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</tbody>
</table>

113. Line HCFA Type Service Code  CHAR  1

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: TYPSRVCB
STANDARD ALIAS: LINE_HCFA_TYPE_SRVC_CD
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.
114. Carrier Line Type Service  CHAR  2  
Carrier’s type of service code (usually different from HCFA’s) used for pricing the service reported on the line item on the carrier claim (non-DMERC).

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

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

115. Line Place Of Service Code  CHAR  2  
The code indicating the place of service, as defined in the Medicare Carrier Manual, for this line item on the noninstitutional claim.

1  
Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

<table>
<thead>
<tr>
<th>POSITIONS</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
<td>TYPE</td>
</tr>
</tbody>
</table>

COMMON ALIAS: POS
DB2 ALIAS: LINE_PLC_SRVC_CD
SAS ALIAS: PLCSRVC
STANDARD ALIAS: LINE_PLC_SRVC_CD
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.
<table>
<thead>
<tr>
<th>Field Name</th>
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<tbody>
<tr>
<td>Carrier Line Pricing</td>
<td>CHAR</td>
<td>2</td>
<td>Code denoting the carrier-specific locality used for pricing the service for this line item on the carrier claim (non-DMERC).</td>
</tr>
<tr>
<td>Locality Code</td>
<td></td>
<td></td>
<td>DB2 ALIAS: PRCNG_LCLTY_CD\nSAS ALIAS: LCLTY_CD\nSTANDARD ALIAS: CARR_LINE_PRCNG_LCLTY_CD\nTITLE ALIAS: PRICING_LOCALITY</td>
</tr>
<tr>
<td>Line First Expense Date</td>
<td>NUM</td>
<td>8</td>
<td>Beginning date (1st expense) for this line item service on the noninstitutional claim.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8 DIGITS UNSIGNED\nDB2 ALIAS: LINE_1ST_EXPNS_DT\nSAS ALIAS: EXPNSDT1\nSTANDARD ALIAS: LINE_1ST_EXPNS_DT\nTITLE ALIAS: 1ST_EXPNS_DT</td>
</tr>
</tbody>
</table>

**SOURCE:** CWF

Prior to Version H this field was named: CWFB_CARR_PRCNG_LCLTY_CD.

**SOURCE:** CWF

Prior to Version H this field was named: CWFB_1ST_EXPNS_DT.
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>118. Line Last Expense Date</td>
<td>NUM</td>
<td>8</td>
<td></td>
<td></td>
<td>The ending date (last expense) for the line item service on the noninstitutional claim.</td>
</tr>
<tr>
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<td>8 DIGITS UNSIGNED</td>
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<td>COBOL ALIAS: LST_EXP_DT</td>
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<td>DB2 ALIAS: LINE_LAST_EXPNS_DT</td>
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<td>SAS ALIAS: EXPNSDT2</td>
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<td>STANDARD ALIAS: LINE_LAST_EXPNS_DT</td>
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<td>TITLE ALIAS: LAST_EXPNS_DT</td>
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<td>EDIT-RULES: YYYymmdd</td>
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<td></td>
<td>COMMENT: Prior to Version H this field was named: CWF_LAST_EXPNS_DT.</td>
</tr>
<tr>
<td>119. Line HCPCS Code</td>
<td>CHAR</td>
<td>5</td>
<td></td>
<td></td>
<td>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:</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>DB2 ALIAS: LINE_HCPCS_CD</td>
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<td>SAS ALIAS: HCPCS_CD</td>
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<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: LINE_HCPCS_CD</td>
</tr>
</tbody>
</table>
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 noninstitutional: LINE).

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

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

1 Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HCFA/AMA agreement. Any other use violates the AMA copyright.</td>
</tr>
</tbody>
</table>

Level II
Includes codes and descriptors copyrighted by the American Dental Association’s Current Dental Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.
Level III
Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not represented in the level I or level II codes.

120. Line HCPCS Initial Modifier CHAR 2
A first modifier to the HCPCS procedure code to enable a more specific procedure identification for the line item service on the noninstitutional claim.

DB2 ALIAS: HCPCS_1ST_MDFR_CD
SAS ALIAS: MDFR_CD1
STANDARD ALIAS: LINE_HCPCS_INITL_MDFR_CD
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 noninstitutional: LINE).

SOURCE:
CWF

121. Line HCPCS Second Modifier CHAR 2
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.

Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

POSITIONS
NAME TYPE LENGTH BEG END CONTENTS
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<thead>
<tr>
<th>Field Name</th>
<th>Alias</th>
<th>Type</th>
<th>Length</th>
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</thead>
<tbody>
<tr>
<td>Line NCH BETOS Code</td>
<td>DB2 ALIAS: HCPCS_2ND_MDFR_CD</td>
<td>CHAR</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: MDFR_CD2</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: LINE_HCPCS_2ND_MDFR_CD</td>
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<td>TITLE ALIAS: SECOND_MODIFIER</td>
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<td>COMMENT:</td>
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<td></td>
<td>Prior to Version H this field was named: HCPCS_2ND_MDFR_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV_CNTR and noninstitutional: LINE).</td>
<td></td>
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<tr>
<td></td>
<td>CWF</td>
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<tr>
<td></td>
<td>Effective with Version H, the Berenson-Eggers type of service (BETOS) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services. This field is included as a line item on the noninstitutional claim.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).</td>
<td></td>
<td></td>
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<td>DB2 ALIAS: LINE_NCH_BETOS_CD</td>
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<td>SAS ALIAS: BETOS</td>
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<td>STANDARD ALIAS: LINE_NCH_BETOS_CD</td>
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</tbody>
</table>
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

123. Line IDE Number  CHAR  7

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

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

DB2 ALIAS: LINE_IDE_NUM
SAS ALIAS: LINE_IDE
124. Line National Drug Code  CHAR  11

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

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
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<tr>
<td>LINE_NATL_DRUG_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NDC_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SOURCE:
CWF

125. Line NCH Payment Amount  PACK  6

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.

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LINE_NCH_PMT_AMT</td>
<td>PACK</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>LINEPMT</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>LINE_NCH_PMT_AMT</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>LINEPMT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9.2 DIGITS SIGNED

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

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

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

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

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

9.2 DIGITS SIGNED

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

SOURCE:
CWF

126. Line Beneficiary Payment Amount

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

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

9.2 DIGITS SIGNED

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

SOURCE:
CWF

127. Line Provider Payment Amount
128. Line Beneficiary Part B Deductible Amount

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

9.2 DIGITS SIGNED

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

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

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

129. Line Beneficiary Primary Payer Code

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

DB2 ALIAS: LINE_PRMRY_PYR_CD
SAS ALIAS: LPRPAYCD
STANDARD ALIAS: LINE_BENE_PRMRY_PYR_CD
Title Alias: PRIMARY_PAYER_CD

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

130. Line Beneficiary Primary Payer Paid Amount

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: LPRPDAMT
Standard Alias: LINE_BENE_PRMRY_PYR_PD_AMT
Title Alias: PRMRY_PYR_PD

Edit-Rules:
$$$$$$$$$CC

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

Source:
CWF
131. Line Coinsurance Amount  PACK  6  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: COINAMT
STANDARD ALIAS: LINE_COINSRNC_AMT
TITLE ALIAS: COINSRNC_AMT

SOURCE:
CWF

132. Carrier Line Psychiatric, Occupational Therapy, Physical Therapy Limit Amount  PACK  6  For type of service psychiatric, occupational therapy or physical therapy, the amount of allowed charges applied toward the limit cap for this line item service on the noninstitutional claim.

9.2 DIGITS SIGNED

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

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

SOURCE:
CWF

133. Line Interest Amount  PACK  6  Amount of interest to be paid for this line item service on the noninstitutional claim.
**NOTE: This is not included in the line item NCH payment (reimbursement) amount.

9.2 DIGITS SIGNED

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

134. Line Primary Payer Allowed Charge Amount

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

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

9.2 DIGITS SIGNED

DB2 ALIAS: PRMRY_PYR_ALOW_AMT
SAS ALIAS: PRPYALOW
STANDARD ALIAS: LINE_PRMRY_PYR_ALOW_CHRG_AMT
TITLE ALIAS: PRMRY_PYR_ALOW_CHRG
### 135. Line 10% Penalty Reduction Amount

**Pack**: 6

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

9.2 DIGITS SIGNED

**DB2 Alias**: TENPCT_PNLTY_AMT  
**SAS Alias**: PNLTYAMT  
**Standard Alias**: LINE_10PCT_PNLTY_RDCTN_AMT  
**Title Alias**: TENPCT_PNLTY

**Source**:  
CWF

### 136. Carrier Line Blood Deductible Pints Quantity

**Pack**: 2

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

3 DIGITS SIGNED

**DB2 Alias**: LINE_BLOOD_DDCTBL  
**SAS Alias**: LBLD_DED  
**Standard Alias**: CARR_LINE_BLOOD_DDCTBL_QTY  
**Title Alias**: BLOOD_DDCTBL

**Source**:  
CWF

---

<table>
<thead>
<tr>
<th>Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NAME</strong></td>
</tr>
<tr>
<td>-----------</td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Field Description</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>137. Line Submitted Charge Amount</td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td>138. Line Allowed Charge Amount</td>
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<td></td>
</tr>
</tbody>
</table>
139. Carrier Line Clinical Lab Number

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

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

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

SOURCE:
CWF

140. Carrier Line Clinical Lab Charge Amount

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

9.2 DIGITS SIGNED

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

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

COMMENT:
Prior to Version H this field was named:
141. Line Processing Indicator Code

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CWFB_CLNCL_LAB_CHRG_AMT</td>
<td>CHAR</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

SOURCE:
CWF

DB2 ALIAS: LINE_PRCSG_IND_CD
SAS ALIAS: PRCNGIND
STANDARD ALIAS: LINE_PRCSG_IND_CD
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:
Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

142. Line Payment 80%/100% Code

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CWFB_CLNCL_LAB_CHRG_AMT</td>
<td>CHAR</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

COMMON ALIAS: REIMBURSEMENT_IND
DB2 ALIAS: LINE_PMT_80_100_CD
SAS ALIAS: PMTINDSW
STANDARD ALIAS: LINE_PMT_80_100_CD
TITLE ALIAS: REIMBURSEMENT_IND
143. Line Service Deductible Indicator Switch

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

144. Line Payment Indicator Code

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

DB2 ALIAS: LINE_PMT_IND_CD
SAS ALIAS: PMTINDCD
STANDARD ALIAS: LINE_PMT_IND_CD
TITLE ALIAS: PMT_IND
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>REFER TO: LINE_PMT_IND_TB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IN THE CODES APPENDIX</td>
</tr>
<tr>
<td>COMMENT:</td>
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<td>Prior to Version H this field was named: CWFB_PMT_IND_CD.</td>
</tr>
<tr>
<td>SOURCE:</td>
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<td></td>
<td></td>
<td></td>
<td>CWF</td>
</tr>
<tr>
<td>145. Carrier Line</td>
<td>PACK</td>
<td>2</td>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Miles/Time/Units/Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 DIGITS SIGNED</td>
</tr>
<tr>
<td>DB2 ALIAS: LINE_MTUS_CNT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: MTUS_CNT</td>
</tr>
<tr>
<td>STANDARD ALIAS: CARR_LINE_MTUS_CNT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TITLE ALIAS: MTUS_CNT</td>
</tr>
<tr>
<td>EDIT-RULES:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>For CARR_LINE_MTUS_IND_CD equal to 2 (anesthesia time units) there is one implied decimal point.</td>
</tr>
<tr>
<td>COMMENT:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prior to Version H this field was named: CWFB_MTUS_CNT.</td>
</tr>
<tr>
<td>SOURCE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CWF</td>
</tr>
</tbody>
</table>
146. **Carrier Line**  
**Miles/Time/Units/Services Indicator Code**  

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

<table>
<thead>
<tr>
<th>POSITIONS</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMENT:</td>
<td>Prior to Version H this field was named: CWFB_MTUS_IND_CD.</td>
<td></td>
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<td>SOURCE:</td>
<td>CWF</td>
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<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

147. **Line Diagnosis Code**  

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

<table>
<thead>
<tr>
<th>POSITIONS</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMENT:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>SOURCE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ICD-9-CM

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

SOURCE:
CWF

148. FILLER
CHAR    1

149. Carrier Line Anesthesia Base Unit Count
PACK    2
The base number of units assigned to the line item anesthesia procedure on the carrier claim (non-DMERC).
3 DIGITS SIGNED

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

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

SOURCE:
CWF

150. Carrier Line CLIA Alert Indicator Code
CHAR    1
Effective with Version G, the alert code (resulting from CLIA editing) added by CWF as a line item on the carrier claim (non-DMERC).

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

CODES:
1
Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001
(Effective 9/92 but not stored until 10/93)
0 = No Alert
1 = 77X9
2 = 77XA
3 = 77X5
4 = 77X6
5 = 77X7
6 = 77X8
7 = 77XB

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

SOURCE:
CWF

151. Line Additional Claim Documentation Indicator Code
CHAR 1

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

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

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

CODES:
REFER TO: LINE_ADDTNL_CLM_DCMTN_IND_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CWFB_ADDTNL_CLM_DCMTN_IND_CD.
### Carrier Line DME Coverage Period Start Date

**NUM** 8

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

**8 DIGITS UNSIGNED**

DB2 ALIAS: DME_CVRG_STRT_DT
SAS ALIAS: DMEST_DT

---

**NAME** | **TYPE** | **LENGTH** | **BEG** | **END** | **CONTENTS**
--- | --- | --- | --- | --- | ---
STANDARD ALIAS: CARR_LINE_DME_CVRG_PRD_STRT_DT
TITLE ALIAS: DME_CVRG_START_DT

EDIT-RULES:
YYYYMMDD

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

SOURCE:
CWF

LIMITATIONS:
When the revised DME processing was implemented (phased in between 10/93-6/94), this field was not included on the new DMERC claim; it is being reported on the certificate of medical necessity (CMN) transaction. HCFA does not receive CMN transaction from CWF.
153. Line DME Purchase Price  PACK  6  Effective 5/92, the amount representing the lower of fee schedule for purchase of new or used DME, or actual charge. In case of rental DME, this amount represents the purchase cap; rental payments can only be made until the cap is met. This line item field is applicable to non-institutional claims involving DME, prosthetic, orthotic and supply items, immunosuppressive drugs, pen, ESRD and oxygen items referred to as DMEPOS.

9.2 DIGITS SIGNED

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

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

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

SOURCE:
CWF

154. Carrier Line DME Medical Necessity Month Count  PACK  2  Effective 5/92 through 6/94, as line item on the carrier claim (non-DMERC), the count determined by the carrier showing the length of need (medical necessity for DME in months from the start date through the determined period of need. This field is applicable to line items involving

<table>
<thead>
<tr>
<th>POSITION</th>
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<tbody>
<tr>
<td>NAME</td>
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<tr>
<td>TYPE</td>
</tr>
<tr>
<td>LENGTH</td>
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<tr>
<td>BEG</td>
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<tr>
<td>END</td>
</tr>
<tr>
<td>CONTENTS</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>DME, prosthetic, orthotic and supply items, immuno-</td>
</tr>
</tbody>
</table>
suppressive drugs, pen, ESRD and oxygen items referred to as DMEPOS).

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

3 DIGITS SIGNED

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

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

SOURCE:
CWF

LIMITATIONS:
When the revised DME processing was implemented (phased in between 10/93-6/94), this field was not included on the new DMERC claim; it is being reported on the certificate of medical necessity (CMN) transaction. HCFA does not receive CMN transaction from CWF.

155. FILLER CHAR 50

156. End of Record Code CHAR 3

Effective with Version ‘I’, the code used to identify the end of a record/segment or the end of the claim.

DB2 ALIAS: END_REC_CD
SAS ALIAS: EOR
STANDARD ALIAS: END_REC_CD
TITLE ALIAS: END_OF_REC
CODES:
EOR = End of Record/Segment
EOC= End of Claim

COMMENT:
Prior to Version I this field was named:
END_REC_CNSTNT.

SOURCE:
NCH

BENE_IDENT_TB
----------------
Beneficiary Identification Code (BIC) Table

Social Security Administration:

A  = Primary claimant
B  = Aged wife, age 62 or over (1st
    claimant)
B1 = Aged husband, age 62 or over (1st
    claimant)
B2 = Young wife, with a child in her care
    (1st claimant)
B3 = Aged wife (2nd claimant)
B4 = Aged husband (2nd claimant)
B5 = Young wife (2nd claimant)
B6 = Divorced wife, age 62 or over (1st
    claimant)
B7 = Young wife (3rd claimant)
B8 = Aged wife (3rd claimant)
B9 = Divorced wife (2nd claimant)
BA = Aged wife (4th claimant)
BD = Aged wife (5th claimant)
BG = Aged husband (3rd claimant)
BH = Aged husband (4th claimant)
BJ = Aged husband (5th claimant)
BK = Young wife (4th claimant)
BL = Young wife (5th claimant)
BN = Divorced wife (3rd claimant)
BP = Divorced wife (4th claimant)
BQ = Divorced wife (5th claimant)
BR = Divorced husband (1st claimant)
BT = Divorced husband (2nd claimant)
BW = Young husband (2nd claimant)
BY = Young husband (1st claimant)
C1-C9, CA-CZ = Child (includes minor, student or disabled child)
D = Aged widow, 60 or over (1st claimant)
D1 = Aged widower, age 60 or over (1st claimant)
D2 = Aged widow (2nd claimant)
D3 = Aged widower (2nd claimant)
D4 = Widow (remarried after attainment of age 60) (1st claimant)
D5 = Widower (remarried after attainment of age 60) (1st claimant)
D6 = Surviving divorced wife, age 60 or over (1st claimant)
D7 = Surviving divorced wife (2nd claimant)
D8 = Aged widow (3rd claimant)
D9 = Remarried widow (2nd claimant)
DA = Remarried widow (3rd claimant)
DD = Aged widow (4th claimant)
DG = Aged widow (5th claimant)
DH = Aged widower (3rd claimant)
DJ = Aged widower (4th claimant)
DK = Aged widower (5th claimant)
DL = Remarried widow (4th claimant)
DM = Surviving divorced husband (2nd claimant)
DN = Remarried widow (5th claimant)

1  BENE_IDENT_TB
---

Beneficiary Identification Code (BIC) Table

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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F8</td>
<td>Second alleged mother</td>
</tr>
<tr>
<td>J1</td>
<td>Primary prouty entitled to HIB</td>
</tr>
<tr>
<td>J2</td>
<td>Primary prouty entitled to HIB</td>
</tr>
<tr>
<td>J3</td>
<td>Primary prouty not entitled to HIB</td>
</tr>
<tr>
<td>J4</td>
<td>Primary prouty not entitled to HIB</td>
</tr>
<tr>
<td>K1</td>
<td>Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)</td>
</tr>
<tr>
<td>K2</td>
<td>Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)</td>
</tr>
<tr>
<td>K3</td>
<td>Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)</td>
</tr>
<tr>
<td>K4</td>
<td>Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)</td>
</tr>
<tr>
<td>K5</td>
<td>Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)</td>
</tr>
<tr>
<td>K6</td>
<td>Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)</td>
</tr>
<tr>
<td>K7</td>
<td>Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)</td>
</tr>
<tr>
<td>K8</td>
<td>Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)</td>
</tr>
<tr>
<td>K9</td>
<td>Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)</td>
</tr>
<tr>
<td>KA</td>
<td>Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)</td>
</tr>
<tr>
<td>KB</td>
<td>Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)</td>
</tr>
<tr>
<td>KC</td>
<td>Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)</td>
</tr>
</tbody>
</table>
KD = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (4th claimant)
KE = Prouty wife entitled to HIB (over 2 Q.C. (4th claimant)
KF = Prouty wife not entitled to HIB (less than 3 Q.C.) (4th claimant)
KG = Prouty wife not entitled to HIB (over 2 Q.C.) (4th claimant)
KH = Prouty wife entitled to HIB (less than 3 Q.C.) (5th claimant)
KJ = Prouty wife entitled to HIB (over 2 Q.C.) (5th claimant)
KL = Prouty wife not entitled to HIB (less than 3 Q.C.) (5th claimant)
KM = Prouty wife not entitled to HIB (over 2 Q.C.) (5th claimant)
M = Uninsured—not qualified for deemed HIB
M1 = Uninsured—qualified but refused HIB
T = Uninsured—entitled to HIB under deemed or renal provisions
TA = MQGE (primary claimant)
TB = MQGE aged spouse (first claimant)
TC = MQGE disabled adult child (first claimant)
TD = MQGE aged widow(er) (first claimant)
TE = MQGE young widow(er) (first claimant)
TF = MQGE parent (male)
TG = MQGE aged spouse (second claimant)
TH = MQGE aged spouse (third claimant)
TJ = MQGE aged spouse (fourth claimant)
TK = MQGE aged spouse (fifth claimant)
TL = MQGE aged widow(er) (second claimant)
TM = MQGE aged widow(er) (third claimant)
TN = MQGE aged widow(er) (fourth claimant)
TP = MQGE aged widow(er) (fifth claimant)
TQ = MQGE parent (female)
TR = MQGE young widow(er) (second claimant)
TS = MQGE young widow(er) (third claimant)
TT = MQGE young widow(er) (fourth claimant)
TU = MQGE young widow(er) (fifth claimant)
TV = MQGE disabled widow(er) fifth claimant
TW = MQGE disabled widow(er) first claimant
TX = MQGE disabled widow(er) second claimant
TY = MQGE disabled widow(er) third claimant
TZ = MQGE disabled widow(er) fourth claimant
T2-T9 = Disabled child (second to ninth claimant)
W = Disabled widow, age 50 or over (1st claimant)
W1 = Disabled widower, age 50 or over (1st claimant)
W2 = Disabled widow (2nd claimant)
W3 = Disabled widower (2nd claimant)
W4 = Disabled widow (3rd claimant)
W5 = Disabled widower (3rd claimant)
W6 = Disabled surviving divorced wife (1st claimant)
W7 = Disabled surviving divorced wife (2nd claimant)
W8 = Disabled surviving divorced wife (3rd claimant)
W9 = Disabled widow (4th claimant)
WB = Disabled widower (4th claimant)
WC = Disabled surviving divorced wife (4th claimant)
WF = Disabled widow (5th claimant)
WG = Disabled widower (5th claimant)
WJ = Disabled surviving divorced wife (5th claimant)
WR = Disabled surviving divorced husband (1st claimant)
WT = Disabled surviving divorced husband (2nd claimant)

Railroad Retirement Board:

NOTE:
Employee: a Medicare beneficiary who is still working or a worker who died before retirement
Annuitant: a person who retired under the railroad retirement act on or
after 03/01/37
Pensioner: a person who retired prior to
03/01/37 and was included in the
railroad retirement act

<table>
<thead>
<tr>
<th>BENE_IDENT_TB</th>
<th>Beneficiary Identification Code (BIC) Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Retirement - employee or annuitant</td>
</tr>
<tr>
<td>80</td>
<td>RR pensioner (age or disability)</td>
</tr>
<tr>
<td>14</td>
<td>Spouse of RR employee or annuitant</td>
</tr>
<tr>
<td></td>
<td>(husband or wife)</td>
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<tr>
<td>84</td>
<td>Spouse of RR pensioner</td>
</tr>
<tr>
<td>43</td>
<td>Child of RR employee</td>
</tr>
<tr>
<td>13</td>
<td>Child of RR annuitant</td>
</tr>
<tr>
<td>17</td>
<td>Disabled adult child of RR annuitant</td>
</tr>
<tr>
<td>46</td>
<td>Widow/widower of RR employee</td>
</tr>
<tr>
<td>16</td>
<td>Widow/widower of RR annuitant</td>
</tr>
<tr>
<td>86</td>
<td>Widow/widower of RR pensioner</td>
</tr>
<tr>
<td>43</td>
<td>Widow of employee with a child in her care</td>
</tr>
<tr>
<td>13</td>
<td>Widow of annuitant with a child in her care</td>
</tr>
<tr>
<td>83</td>
<td>Widow of pensioner with a child in her care</td>
</tr>
<tr>
<td>45</td>
<td>Parent of employee</td>
</tr>
<tr>
<td>15</td>
<td>Parent of annuitant</td>
</tr>
<tr>
<td>85</td>
<td>Parent of pensioner</td>
</tr>
<tr>
<td>11</td>
<td>Survivor joint annuitant</td>
</tr>
<tr>
<td></td>
<td>(reduced benefits taken to insure benefits for surviving spouse)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>BENE_PRMRY_PYR_TB</th>
<th>Beneficiary Primary Payer Table</th>
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</thead>
<tbody>
<tr>
<td>1</td>
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</tr>
<tr>
<td>A</td>
<td>Working aged bene/spouse with employer group health plan (EGHP)</td>
</tr>
<tr>
<td>B</td>
<td>End stage renal disease (ESRD) beneficiary in the 18 month coordination period with an employer group health plan</td>
</tr>
<tr>
<td>C</td>
<td>Conditional payment by Medicare; future reimbursement expected</td>
</tr>
<tr>
<td>D</td>
<td>Automobile no-fault (eff. 4/97; Prior to 3/94, also included any liability</td>
</tr>
</tbody>
</table>
insurance
E = Workers’ compensation
F = Public Health Service or other federal agency (other than Dept. of Veterans Affairs)
G = Working disabled bene (under age 65 with LGHP)
H = Black Lung
I = Dept. of Veterans Affairs
J = Any liability insurance (eff. 3/94 - 3/97)
L = Any liability insurance (eff. 4/97)
M = Override code: EGHP services involved (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)
N = Override code: non-EGHP services involved (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)
BLANK = Medicare is primary payer (not sure of effective date: in use 1/91, if not earlier)
T = MSP cost avoided - IEQ contractor (eff. 7/96 carrier claims only)
U = MSP cost avoided - HMO rate cell adjustment contractor (eff. 7/96 carrier claims only)
V = MSP cost avoided - litigation settlement contractor (eff. 7/96 carrier claims only)
X = MSP cost avoided override code (eff. 12/90 for carrier claims and 10/93 for
FI claims; obsoleted for all claim types 7/1/96)

***Prior to 12/90***

Y = Other secondary payer investigation shows Medicare as primary payer

Z = Medicare is primary payer

NOTE: Values C, M, N, Y, Z and BLANK indicate Medicare is primary payer.
(values Z and Y were used prior to 12/90. BLANK was suppose to be effective after 12/90, but may have been used prior to that date.)

<table>
<thead>
<tr>
<th></th>
<th>BENE_PRMRY_PYR_TB</th>
<th>Beneficiary Primary Payer Table</th>
</tr>
</thead>
<tbody>
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<td>1</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>BETOS_TB</th>
<th>BETOS Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

M1A = Office visits - new
M1B = Office visits - established
M2A = Hospital visit - initial
M2B = Hospital visit - subsequent
M2C = Hospital visit - critical care
M3 = Emergency room visit
M4A = Home visit
M4B = Nursing home visit
M5A = Specialist - pathology
M5B = Specialist - psychiatry
M5C = Specialist - ophthalmology
M5D = Specialist - other
M6 = Consultations
P0 = Anesthesia
P1A = Major procedure - breast
P1B = Major procedure - colectomy
P1C = Major procedure - cholecystectomy
P1D = Major procedure - turp
P1E = Major procedure - hysterectomy
P1F = Major procedure - explor/decompr/excisdisc
P1G = Major procedure - Other
P2A = Major procedure, cardiovascular-CABG
P2B = Major procedure, cardiovascular-Aneurysm repair
P2C = Major Procedure, cardiovascular-Thromboendarterectomy
P2D = Major procedure, cardiovascular-Coronary angioplasty (PTCA)
P2E = Major procedure, cardiovascular-Pacemaker insertion
P2F = Major procedure, cardiovascular-Other
P3A = Major procedure, orthopedic - Hip fracture repair
P3B = Major procedure, orthopedic - Hip replacement
P3C = Major procedure, orthopedic - Knee replacement
P3D = Major procedure, orthopedic - other
P4A = Eye procedure - corneal transplant
P4B = Eye procedure - cataract removal/lens insertion
P4C = Eye procedure - retinal detachment
P4D = Eye procedure - treatment
P4E = Eye procedure - other
P5A = Ambulatory procedures - skin
P5B = Ambulatory procedures - musculoskeletal
P5C = Ambulatory procedures - inguinal hernia repair
P5D = Ambulatory procedures - lithotripsy
P5E = Ambulatory procedures - other
P6A = Minor procedures - skin
P6B = Minor procedures - musculoskeletal
P6C = Minor procedures - other (Medicare fee schedule)
P6D = Minor procedures - other (non-Medicare fee schedule)
P7A = Oncology - radiation therapy
P7B = Oncology - other
P8A = Endoscopy - arthroscopy
P8B = Endoscopy - upper gastrointestinal
P8C = Endoscopy - sigmoidoscopy
P8D = Endoscopy - colonoscopy
P8E = Endoscopy - cystoscopy
P8F = Endoscopy - bronchoscopy
P8G = Endoscopy - laparoscopic cholecystectomy
P8H = Endoscopy - laryngoscopy
P8I = Endoscopy - other
P9A = Dialysis services

BETOS Table

I1A = Standard imaging - chest
I1B = Standard imaging - musculoskeletal
I1C = Standard imaging - breast
I1D = Standard imaging - contrast gastrointestinal
I1E = Standard imaging - nuclear medicine
I1F = Standard imaging - other
I2A = Advanced imaging - CAT: head
I2B = Advanced imaging - CAT: other
I2C = Advanced imaging - MRI: brain
I2D = Advanced imaging - MRI: other
I3A = Echography - eye
I3B = Echography - abdomen/pelvis
I3C = Echography - heart
I3D = Echography - carotid arteries
I3E = Echography - prostate, transrectal
I3F = Echography - other
I4A = Imaging/procedure - heart including cardiac catheter
I4B = Imaging/procedure - other
T1A = Lab tests - routine venipuncture (non Medicare fee schedule)
T1B = Lab tests - automated general profiles
T1C = Lab tests - urinalysis
T1D = Lab tests - blood counts
T1E = Lab tests - glucose
T1F = Lab tests - bacterial cultures
T1G = Lab tests - other (Medicare fee schedule)
T1H = Lab tests - other (non-Medicare fee schedule)
T2A = Other tests - electrocardiograms
T2B = Other tests - cardiovascular stress tests
T2C = Other tests - EKG monitoring
T2D = Other tests - other
D1A = Medical/surgical supplies
D1B = Hospital beds
D1C = Oxygen and supplies
D1D = Wheelchairs
D1E = Other DME
D1F = Orthotic devices
O1A = Ambulance
O1B = Chiropractic
O1C = Enteral and parenteral
O1D = Chemotherapy
O1E = Other drugs
O1F = Vision, hearing and speech services
O1G = Influenza immunization
Y1 = Other - Medicare fee schedule
Y2 = Other - non-Medicare fee schedule
Z1 = Local codes
Z2 = Undefined codes

1  CARR_CLM_PMT_DNL_TB                      Carrier Claim Payment Denial Table
--------------------------------------------
0 = Denied
1 = Physician/supplier
2 = Beneficiary
3 = Both physician/supplier and beneficiary
4 = Hospital (hospital based physicians)
5 = Both hospital and beneficiary
6 = Group practice prepayment plan
7 = Other entries (e.g. Employer, union)
8 = Federally funded
9 = PA service
A = Beneficiary under limitation of liability
B = Physician/supplier under limitation of liability
D = Denied due to demonstration involvement (eff. 5/97)
E = MSP cost avoided IRS/SSA/HCPA Data Match (eff. 7/3/00)
F = MSP cost avoided HMO Rate Cell (eff. 7/3/00)
G = MSP cost avoided Litigation Settlement (eff. 7/3/00)
H = MSP cost avoided Employer Voluntary Reporting (eff. 7/3/00)
J = MSP cost avoided Insurer Voluntary Reporting (eff. 7/3/00)
K = MSP cost avoided Initial Enrollment Questionnaire (eff. 7/3/00)
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided - (Contractor #88888) voluntary agreement (eff. 1/98)
T = MSP cost avoided - IEQ contractor
    (eff. 7/96) (obsolete 6/30/00)
U = MSP cost avoided - HMO rate cell
    adjustment (eff. 7/96) (obsolete 6/30/00)
V = MSP cost avoided - litigation
    settlement (eff. 7/96) (obsolete 6/30/00)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data
    match project (obsolete 6/30/00)

1  CARR_LINE_PRVDR_TYPE_TB
-------------------------------
Carrier Line Provider Type Table
-------------------------------

For Physician/Supplier (RIC O) Claims:

0 = Clinics, groups, associations,
    partnerships, or other entities
1 = Physicians or suppliers reporting as
    solo practitioners
2 = Suppliers (other than sole proprietorship)
3 = Institutional provider
4 = Independent laboratories
5 = Clinics (multiple specialties)
6 = Groups (single specialty)
7 = Other entities

For DMERC (RIC M) Claims - PRIOR TO VERSION H:

0 = Clinics, groups, associations,
    partnerships, or other entities
    for whom the carrier’s own ID number
    has been assigned.
1 = Physicians or suppliers billing as
    solo practitioners for whom SSN’s are
    shown in the physician ID code field.
2 = Physicians or suppliers billing as
    solo practitioners for whom the carrier’s
    own physician ID code is shown.
3 = Suppliers (other than sole proprietorship)
    for whom EI numbers are used in coding the
    ID field.
4 = Suppliers (other than sole proprietorship) for whom the carrier’s own code has been shown.

5 = Institutional providers and independent laboratories for whom EI numbers are used in coding the ID field.

6 = Institutional providers and independent laboratories for whom the carrier’s own ID number is shown.

7 = Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field.

8 = Other entities for whom EI numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.

<table>
<thead>
<tr>
<th>BLANK = Adjustment situation (where CLM_DISP_CD equal 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = N/A</td>
</tr>
<tr>
<td>1 = 65%</td>
</tr>
<tr>
<td>A) Physician assistants assisting in surgery</td>
</tr>
<tr>
<td>B) Nurse midwives</td>
</tr>
<tr>
<td>2 = 75%</td>
</tr>
<tr>
<td>A) Physician assistants performing services in a hospital (other than assisting surgery)</td>
</tr>
<tr>
<td>B) Nurse practitioners and clinical nurse specialists performing services in rural areas</td>
</tr>
<tr>
<td>C) Clinical social worker services</td>
</tr>
<tr>
<td>3 = 85%</td>
</tr>
<tr>
<td>A) Physician assistant services for other than assisting surgery</td>
</tr>
<tr>
<td>B) Nurse practitioners services</td>
</tr>
</tbody>
</table>

1CARR_LINE_RDCD_PHYSN_ASTNT_TB  Carrier Line Part B Reduced Physician Assistant Table

1CARR_NUM_TB  Carrier Number Table
00510 = Alabama BS (eff. 1983)
00511 = Georgia - Alabama BS (eff. 1998)
00512 = Mississippi - Alabama BS (eff. 2000)
00520 = Arkansas BS (eff. 1983)
00521 = New Mexico - Arkansas BS (eff. 1998)
00522 = Oklahoma - Arkansas BS (eff. 1998)
00523 = Missouri - Arkansas BS (eff. 1999)
00528 = Louisiana - Arkansas BS (eff. 1984)
00542 = California BS (eff. 1983; term. 1996)
00550 = Colorado BS (eff. 1983; term. 1994)
00570 = Delaware - Pennsylvania BS (eff. 1983; term. 1997)
00580 = District of Columbia - Pennsylvania BS (eff. 1983; term. 1997)
00590 = Florida BS (eff. 1983)
00591 = Connecticut - Florida BS (eff. 2000)
00621 = Illinois BS - HCSC (eff. 1983; term. 1998)
00630 = Indiana - Administar (eff. 1983)
00635 = DMERC-B (Administar Federal, Inc.) (eff. 1993)
00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)
00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)
00650 = Kansas BS (eff. 1983)
00655 = Nebraska - Kansas BS (eff. 1988)
00660 = Kentucky - Administar (eff. 1983)
00690 = Maryland BS (eff. 1983; term. 1994)
00700 = Massachusetts BS (eff. 1983; term. 1997)
00710 = Michigan BS (eff. 1983; term. 1994)
00720 = Minnesota BS (eff. 1983; term. 1995)
00740 = Missouri - BS Kansas City (eff. 1983)
00751 = Montana BS (eff. 1983)
00770 = New Hampshire/Vermont Physician Services (eff. 1983; term. 1984)
00780 = New Hampshire/Vermont - Massachusettes BS (eff. 1985; term. 1997)
00801 = New York - Western BS (eff. 1983)
00803 = New York - Empire BS (eff. 1983)
<table>
<thead>
<tr>
<th>CARR_NUM_TB</th>
<th>Carrier Number Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>0005</td>
<td>New Jersey - Empire BS (eff. 3/99)</td>
</tr>
<tr>
<td>0011</td>
<td>DMERC (A) - Western New York BS (eff. 2000)</td>
</tr>
<tr>
<td>0020</td>
<td>North Dakota - North Dakota BS (eff. 1983)</td>
</tr>
<tr>
<td>0024</td>
<td>Colorado - North Dakota BS (eff. 1995)</td>
</tr>
<tr>
<td>0025</td>
<td>Wyoming - North Dakota BS (eff. 1990)</td>
</tr>
<tr>
<td>0026</td>
<td>Iowa - North Dakota BS (eff. 1999)</td>
</tr>
<tr>
<td>0031</td>
<td>Alaska - North Dakota BS (eff. 1998)</td>
</tr>
<tr>
<td>0032</td>
<td>Arizona - North Dakota BS (eff. 1998)</td>
</tr>
<tr>
<td>0033</td>
<td>Hawaii - North Dakota BS (eff. 1998)</td>
</tr>
<tr>
<td>0034</td>
<td>Nevada - North Dakota BS (eff. 1998)</td>
</tr>
<tr>
<td>0035</td>
<td>Oregon - North Dakota BS (eff. 1998)</td>
</tr>
<tr>
<td>0036</td>
<td>Washington - North Dakota BS (eff. 1998)</td>
</tr>
<tr>
<td>0060</td>
<td>New Jersey - Pennsylvania BS (eff. 1988; term. 1999)</td>
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<tr>
<td>0065</td>
<td>Pennsylvania BS (eff. 1983)</td>
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<tr>
<td>0070</td>
<td>Rhode Island BS (eff. 1983)</td>
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<tr>
<td>0080</td>
<td>South Carolina BS (eff. 1983)</td>
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<tr>
<td>0082</td>
<td>RRB - South Carolina PGBA (eff. 2000)</td>
</tr>
<tr>
<td>0085</td>
<td>DMERC C - Palmetto (eff. 1993)</td>
</tr>
<tr>
<td>0090</td>
<td>Texas BS (eff. 1983)</td>
</tr>
<tr>
<td>0091</td>
<td>Maryland - Texas BS (eff. 1995)</td>
</tr>
<tr>
<td>0092</td>
<td>Delaware - Texas BS (eff. 1998)</td>
</tr>
<tr>
<td>0093</td>
<td>District of Columbia - Texas BS (eff. 1998)</td>
</tr>
<tr>
<td>0094</td>
<td>Virginia - Texas BS (eff. 2000)</td>
</tr>
<tr>
<td>00910</td>
<td>Utah BS (eff. 1983)</td>
</tr>
<tr>
<td>00951</td>
<td>Wisconsin - Wisconsin Phy Svc (eff. 1983)</td>
</tr>
<tr>
<td>00952</td>
<td>Illinois - Wisconsin Phy Svc (eff. 1999)</td>
</tr>
<tr>
<td>00953</td>
<td>Michigan - Wisconsin Phy Svc (eff. 1999)</td>
</tr>
<tr>
<td>00954</td>
<td>Minnesota - Wisconsin Phy Svc (eff. 2000)</td>
</tr>
<tr>
<td>00973</td>
<td>Triple-S, Inc. - Puerto Rico (eff. 1983)</td>
</tr>
<tr>
<td>00974</td>
<td>Triple-S, Inc. - Virgin Islands</td>
</tr>
<tr>
<td>01020</td>
<td>Alaska - AETNA (eff. 1983; term. 1997)</td>
</tr>
<tr>
<td>01030</td>
<td>Arizona - AETNA (eff. 1983; term. 1997)</td>
</tr>
<tr>
<td>01040</td>
<td>Georgia - AETNA (eff. 1988; term. 1997)</td>
</tr>
<tr>
<td>01120</td>
<td>Hawai - AETNA (eff. 1983; term. 1997)</td>
</tr>
<tr>
<td>01290</td>
<td>Nevada - AETNA (eff. 1983; term. 1997)</td>
</tr>
<tr>
<td>01360</td>
<td>New Mexico - AETNA (eff. 1986; term. 1997)</td>
</tr>
<tr>
<td>01370</td>
<td>Oklahoma - AETNA (eff. 1983; term. 1997)</td>
</tr>
<tr>
<td>01380</td>
<td>Oregon - AETNA (eff. 1983; term. 1997)</td>
</tr>
<tr>
<td>CARR_NUM_TB</td>
<td>Carrier Number Table</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>31146</td>
<td>So. California - NHIC (eff. 2000)</td>
</tr>
</tbody>
</table>
CLM_DISP_TB

Claim Disposition Table

01 = Debit accepted
02 = Debit accepted (automatic adjustment)
     applicable through 4/4/93
03 = Cancel accepted
61 = *Conversion code: debit accepted
62 = *Conversion code: debit accepted
     (automatic adjustment)
63 = *Conversion code: cancel accepted

*Used only during conversion period:
    1/1/91 - 2/21/91

CTGRY_EQTBL_BENE_IDENT_TB

Category Equatable Beneficiary Identification Code (BIC) Table

NCH BIC          SSA Categories
------          ------------
A = A;J1;J2;J3;J4;M;M1;T;TA
B = B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6;
    TB(F);TD(F);TE(F);TW(F)
B1 = B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M)
    TD(M);TE(M);TW(M)
B3 = B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2
    W7;TG(F);TL(F);TR(F);TX(F)
B4 = B4;B7;BW;D3;DM;DP;E6;E9;W3;WT;TG(M)
    TL(M);TR(M);TX(M)
B8 = B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4
    W8;TH(F);TM(F);TS(F);TX(F)
BA = BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9
    WC;TJ(F);TN(F);TT(F);TZ(F)
BD = BD;BL;BO;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WF
    WJ;TK(F);TP(F);TU(F);TV(F)
BG = BG;DH;DQ;DS;EF;EJ;W5;TH(M);TM(M);TS(M)
    TY(M)
BH = BH;DJ;DR;DX;EG;EK;WB;TJ(M);TN(M);TT(M)
    T2(M)
BJ = BJ;DK;DT;DZ;EH;EM;WG;TK(M);TP (M);TU (M)
TV (M)
C1 = C1;TC
C2 = C2;T2
C3 = C3;T3
C4 = C4;T4
C5 = C5;T5
C6 = C6;T6
C7 = C7;T7
C8 = C8;T8
C9 = C9;T9
F1 = F1;TF
F2 = F2;TQ
F3-F8 = Equatable only to itself (e.g., F3 IS
equatable to F3)
CA-CZ = Equatable only to itself. (e.g., CA is
only equatable to CA)

---------------------------------------
RRB Categories

  10 = 10
  11 = 11
  13 = 13;17
  14 = 14;16
  15 = 15
  43 = 43
  45 = 45
  46 = 46
  80 = 80
  83 = 83
  84 = 84;86
  85 = 85

1 GEO_SSA_STATE_TB State Table
-----------------------------

  01 = Alabama
  02 = Alaska
  03 = Arizona
  04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
<table>
<thead>
<tr>
<th>State Code</th>
<th>State Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>Utah</td>
</tr>
<tr>
<td>47</td>
<td>Vermont</td>
</tr>
<tr>
<td>48</td>
<td>Virgin Islands</td>
</tr>
<tr>
<td>49</td>
<td>Virginia</td>
</tr>
<tr>
<td>50</td>
<td>Washington</td>
</tr>
<tr>
<td>51</td>
<td>West Virginia</td>
</tr>
<tr>
<td>52</td>
<td>Wisconsin</td>
</tr>
<tr>
<td>53</td>
<td>Wyoming</td>
</tr>
<tr>
<td>54</td>
<td>Africa</td>
</tr>
<tr>
<td>55</td>
<td>Asia</td>
</tr>
<tr>
<td>56</td>
<td>Canada &amp; Islands</td>
</tr>
<tr>
<td>57</td>
<td>Central America and West Indies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region Code</th>
<th>Region Name</th>
</tr>
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<tbody>
<tr>
<td>58</td>
<td>Europe</td>
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<tr>
<td>59</td>
<td>Mexico</td>
</tr>
<tr>
<td>60</td>
<td>Oceania</td>
</tr>
<tr>
<td>61</td>
<td>Philippines</td>
</tr>
<tr>
<td>62</td>
<td>South America</td>
</tr>
<tr>
<td>63</td>
<td>U.S. Possessions</td>
</tr>
<tr>
<td>64</td>
<td>American Samoa</td>
</tr>
<tr>
<td>65</td>
<td>Guam</td>
</tr>
<tr>
<td>66</td>
<td>Saipan</td>
</tr>
<tr>
<td>97</td>
<td>Northern Marianas</td>
</tr>
<tr>
<td>98</td>
<td>Guam</td>
</tr>
<tr>
<td>99</td>
<td>With 000 county code is American Samoa; otherwise unknown</td>
</tr>
</tbody>
</table>

**Prior to 5/92**

<table>
<thead>
<tr>
<th>Specialty Code</th>
<th>Specialty Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>General practice</td>
</tr>
<tr>
<td>02</td>
<td>General surgery</td>
</tr>
<tr>
<td>03</td>
<td>Allergy (revised 10/91 to mean allergy/immunology)</td>
</tr>
<tr>
<td>04</td>
<td>Otology, laryngology, rhinology (revised 10/91 to mean otolaryngology)</td>
</tr>
</tbody>
</table>
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 (include 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).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>Medical supply company with C.P.O. certification (certified prosthetist - orthotist - certified by American Board for Certification in Prosthetics and Orthotics).</td>
</tr>
<tr>
<td>54</td>
<td>Medical supply company not included in 51, 52, or 53.</td>
</tr>
<tr>
<td>55</td>
<td>Individual certified orthotist</td>
</tr>
<tr>
<td>56</td>
<td>Individual certified prosthetist</td>
</tr>
<tr>
<td>57</td>
<td>Individual certified prosthetist - orthotist</td>
</tr>
<tr>
<td>58</td>
<td>Individuals not included in 55, 56 or 57</td>
</tr>
<tr>
<td>59</td>
<td>Ambulance service supplier (e.g. private ambulance companies, funeral homes, etc.)</td>
</tr>
<tr>
<td>60</td>
<td>Public health or welfare agencies (federal, state, and local)</td>
</tr>
<tr>
<td>61</td>
<td>Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities)</td>
</tr>
<tr>
<td>62</td>
<td>Psychologist--billing independently</td>
</tr>
<tr>
<td>63</td>
<td>Portable X-ray supplier--billing independently (revised 10/91 to mean portable X-ray supplier)</td>
</tr>
<tr>
<td>64</td>
<td>Audiologist (billing independently)</td>
</tr>
<tr>
<td>65</td>
<td>Physical therapist (independent practice)</td>
</tr>
<tr>
<td>66</td>
<td>Rheumatology (added 10/91)</td>
</tr>
<tr>
<td>67</td>
<td>Occupational therapist--independent practice</td>
</tr>
<tr>
<td>68</td>
<td>Clinical psychologist</td>
</tr>
<tr>
<td>69</td>
<td>Independent laboratory--billing independently (revised 10/91 to mean independent clinical laboratory -- billing independently)</td>
</tr>
<tr>
<td>70</td>
<td>Clinic or other group practice, except Group Practice Prepayment Plan (GPPP)</td>
</tr>
<tr>
<td>71</td>
<td>Group Practice Prepayment Plan - diagnostic X-ray (do not use after 1/92)</td>
</tr>
</tbody>
</table>
72 = Group Practice Prepayment Plan - diagnostic laboratory (do not use after 1/92)
73 = Group Practice Prepayment Plan - physiotherapy (do not use after 1/92)
74 = Group Practice Prepayment Plan - occupational therapy (do not use after 1/92)
75 = Group Practice Prepayment Plan - other medical care (do not use after 1/92)
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)
80 = Clinical social worker (1991)
81 = Critical care-intensivists (added 10/91)
82 = Ophthalmology, cataracts specialty (added 10/91; used only until 5/92)
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 psychiatric services (revised 10/91 to mean unknown supplier/provider)

**Effective 5/92**

00 = Carrier wide
<table>
<thead>
<tr>
<th>Code</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>General practice</td>
</tr>
<tr>
<td>02</td>
<td>General surgery</td>
</tr>
<tr>
<td>03</td>
<td>Allergy/immunology</td>
</tr>
<tr>
<td>04</td>
<td>Otolaryngology</td>
</tr>
<tr>
<td>05</td>
<td>Anesthesiology</td>
</tr>
<tr>
<td>06</td>
<td>Cardiology</td>
</tr>
<tr>
<td>07</td>
<td>Dermatology</td>
</tr>
<tr>
<td>08</td>
<td>Family practice</td>
</tr>
<tr>
<td>09</td>
<td>Gynecology (osteopaths only)</td>
</tr>
<tr>
<td></td>
<td>(discontinued 5/92 use code 16)</td>
</tr>
<tr>
<td>10</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>11</td>
<td>Internal medicine</td>
</tr>
<tr>
<td>12</td>
<td>Osteopathic manipulative therapy</td>
</tr>
<tr>
<td>13</td>
<td>Neurology</td>
</tr>
<tr>
<td>14</td>
<td>Neurosurgery</td>
</tr>
<tr>
<td>15</td>
<td>Obstetrics (osteopaths only)</td>
</tr>
<tr>
<td></td>
<td>(discontinued 5/92 use code 16)</td>
</tr>
<tr>
<td>16</td>
<td>Obstetrics/gynecology</td>
</tr>
<tr>
<td>17</td>
<td>Ophthalmology, otology, laryngology, rhinology (osteopaths only)</td>
</tr>
<tr>
<td></td>
<td>(discontinued 5/92 use codes 18 or 04 depending on percentage of practice)</td>
</tr>
<tr>
<td>18</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>19</td>
<td>Oral surgery (dentists only)</td>
</tr>
<tr>
<td>20</td>
<td>Orthopedic surgery</td>
</tr>
<tr>
<td>21</td>
<td>Pathologic anatomy, clinical pathology (osteopaths only)</td>
</tr>
<tr>
<td></td>
<td>(discontinued 5/92 use code 22)</td>
</tr>
<tr>
<td>22</td>
<td>Pathology</td>
</tr>
<tr>
<td>23</td>
<td>Peripheral vascular disease, medical or surgical (osteopaths only)</td>
</tr>
<tr>
<td></td>
<td>(discontinued 5/92 use code 76)</td>
</tr>
<tr>
<td>24</td>
<td>Plastic and reconstructive surgery</td>
</tr>
<tr>
<td>25</td>
<td>Physical medicine and rehabilitation</td>
</tr>
<tr>
<td>26</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>27</td>
<td>Psychiatry, neurology (osteopaths only) (discontinued 5/92 use code 86)</td>
</tr>
<tr>
<td>28</td>
<td>Colorectal surgery (formerly</td>
</tr>
</tbody>
</table>
proctology)

29 = Pulmonary disease
30 = Diagnostic radiology
31 = Roentgenology, radiology (osteopaths only) (discontinued 5/92 use code 30)
32 = Radiation therapy (osteopaths only)
     (discontinued 5/92 use code 92)
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry (revised 10/93 to mean optometrist)
42 = Certified nurse midwife (eff 1/87)
43 = Crna, anesthesia assistant
     (eff 1/87)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology (eff 5/92)
47 = Independent Diagnostic Testing Facility (IDTF) (eff. 6/98)
48 = Podiatry
49 = Ambulatory surgical center
     (formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics)
52 = Medical supply company with certified prosthetist
     (certified by American Board for Certification In Prosthetics And Orthotics)
53 = Medical supply company with
certified prosthetist-orthotist
(certified by American Board for
Certification in Prosthetics
and Orthotics)

54 = Medical supply company not included
in 51, 52, or 53. (Revised 10/93
to mean medical supply company for DMERC)

55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-
orthotist

58 = Individuals not included in 55, 56,
or 57 (revised 10/93 to mean medical
supply company with registered
pharmacist)

59 = Ambulance service supplier, e.g.,
private ambulance companies, funeral
homes, etc.

60 = Public health or welfare agencies
(federal, state, and local)

61 = Voluntary health or charitable
agencies (e.g., National Cancer
Society, National Heart Association,
Catholic Charities)

62 = Psychologist (billing independently)
63 = Portable X-ray supplier
64 = Audiologist (billing independently)
65 = Physical therapist (independently
practicing)

66 = Rheumatology (eff 5/92)

Note: during 93/94 DMERC also used this
to mean medical supply company with
respiratory therapist

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 be assigned after 5/92)  
76 = Peripheral vascular disease  
    (eff 5/92)  
77 = Vascular surgery (eff 5/92)  
78 = Cardiac surgery (eff 5/92)  
79 = Addiction medicine (eff 5/92)  
80 = Licensed clinical social worker  
81 = Critical care (intensivists)  
    (eff 5/92)  
82 = Hematology (eff 5/92)  
83 = Hematology/oncology (eff 5/92)  
84 = Preventive medicine (eff 5/92)  
85 = Maxillofacial surgery (eff 5/92)  
86 = Neuropsychiatry (eff 5/92)  
87 = All other suppliers (e.g. drug and  
    department stores)  
    (note: DMERC used 87 to mean department store from 10/93  
     through 9/94; recoded eff 10/94 to A7;  
     NCH cross-walked DMERC reported 87 to A7.  
88 = Unknown supplier/provider specialty  
    (note: DMERC used 87 to mean grocery  
     store from 10/93 - 9/94; recoded eff  
     10/94 to A8; NCH cross-walked DMERC  
     reported 88 to A8.  
89 = Certified clinical nurse specialist  
90 = Medical oncology (eff 5/92)  
91 = Surgical oncology (eff 5/92)  
92 = Radiation oncology (eff 5/92)  
93 = Emergency medicine (eff 5/92)  
94 = Interventional radiology (eff 5/92)  
95 = Independent physiological  
    laboratory (eff 5/92)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96</td>
<td>Optician (eff 10/93)</td>
</tr>
<tr>
<td>97</td>
<td>Physician assistant (eff 5/92)</td>
</tr>
<tr>
<td>98</td>
<td>Gynecologist/oncologist (eff 10/94)</td>
</tr>
<tr>
<td>99</td>
<td>Unknown physician specialty</td>
</tr>
<tr>
<td>A0</td>
<td>Hospital (eff 10/93) (DMERCs only)</td>
</tr>
<tr>
<td>A1</td>
<td>SNF (eff 10/93) (DMERCs only)</td>
</tr>
<tr>
<td>A2</td>
<td>Intermediate care nursing facility (eff 10/93) (DMERCs only)</td>
</tr>
<tr>
<td>A3</td>
<td>Nursing facility, other (eff 10/93) (DMERCs only)</td>
</tr>
<tr>
<td>A4</td>
<td>HHA (eff 10/93) (DMERCs only)</td>
</tr>
<tr>
<td>A5</td>
<td>Pharmacy (eff 10/93) (DMERCs only)</td>
</tr>
<tr>
<td>A6</td>
<td>Medical supply company with respiratory therapist (eff 10/93) (DMERCs only)</td>
</tr>
<tr>
<td>A7</td>
<td>Department store (for DMERC use: eff 10/94, but cross-walked from code 87 eff 10/93)</td>
</tr>
<tr>
<td>A8</td>
<td>Grocery store (for DMERC use: eff 10/94, but cross-walked from code 88 eff 10/93)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>HCFA_PRVDR_SPCLTY_TB (HCFA Provider Specialty Table)</td>
</tr>
<tr>
<td>2</td>
<td>HCFA_TYPE_SRVC_TB (HCFA Type of Service Table)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical care</td>
</tr>
<tr>
<td>2</td>
<td>Surgery</td>
</tr>
<tr>
<td>3</td>
<td>Consultation</td>
</tr>
<tr>
<td>4</td>
<td>Diagnostic radiology</td>
</tr>
<tr>
<td>5</td>
<td>Diagnostic laboratory</td>
</tr>
<tr>
<td>6</td>
<td>Therapeutic radiology</td>
</tr>
<tr>
<td>7</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>8</td>
<td>Assistant at surgery</td>
</tr>
<tr>
<td>9</td>
<td>Other medical items or services</td>
</tr>
<tr>
<td>0</td>
<td>Whole blood only eff 01/96, whole blood or packed red cells before 01/96</td>
</tr>
<tr>
<td>A</td>
<td>Used durable medical equipment (DME)</td>
</tr>
<tr>
<td>B</td>
<td>High risk screening mammography (obsolete 1/1/98)</td>
</tr>
</tbody>
</table>
C = Low risk screening mammography (obsolete 1/1/98)
D = Ambulance (eff 04/95)
E = Enteral/parenteral nutrients/supplies (eff 04/95)
F = Ambulatory surgical center (facility usage for surgical services)
G = Immunosuppressive drugs
H = Hospice services (discontinued 01/95)
I = Purchase of DME (installment basis) (discontinued 04/95)
J = Diabetic shoes (eff 04/95)
K = Hearing items and services (eff 04/95)
L = ESRD supplies (eff 04/95) (renal supplier in the home before 04/95)
M = Monthly capitation payment for dialysis
N = Kidney donor
P = Lump sum purchase of DME, prosthetics, orthotics
Q = Vision items or services
R = Rental of DME
S = Surgical dressings or other medical supplies (eff 04/95)
T = Psychological therapy (term. 12/31/97) outpatient mental health limitation (eff. 1/1/98)
U = Occupational therapy
V = Pneumococcal/flu vaccine (eff 01/96), Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95), Pneumococcal only before 04/95
W = Physical therapy
Y = Second opinion on elective surgery (obsoleted 1/97)
Z = Third opinion on elective surgery (obsoleted 1/97)

1 LINE_ADDTNL_CLM_DCMTN_IND_TB Line Additional Claim Documentation Indicator Table
   0 = No additional documentation
   1 = Additional documentation submitted for non-DME EMC claim
2 = CMN/prescription/other documentation submitted which justifies medical necessity
3 = Prior authorization obtained and approved
4 = Prior authorization requested but not approved
5 = CMN/prescription/other documentation submitted but did not justify medical necessity
6 = CMN/prescription/other documentation submitted and approved after prior authorization rejected
7 = Recertification CMN/prescription/other documentation

<table>
<thead>
<tr>
<th>1</th>
<th>LINE_PLC_SRVC_TB</th>
<th>Line Place Of Service Table</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior To 1/92</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 = Office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 = Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 = Inpatient hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 = SNF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 = Outpatient hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 = Independent lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 = Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 = Independent kidney disease treatment center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 = Ambulatory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A = Ambulance service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H = Hospice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M = Mental health, rural mental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N = Nursing home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R = Rural codes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Effective 1/92**

| 11 = Office |
| 12 = Home |
| 21 = Inpatient hospital |
| 22 = Outpatient hospital |
| 23 = Emergency room - hospital |
| 24 = Ambulatory surgical center |
25 = Birthing center
26 = Military treatment facility
31 = Skilled nursing facility
32 = Nursing facility
33 = Custodial care facility
34 = Hospice
35 = Adult living care facilities (ALCF)
     (eff. NYD - added 12/3/97)
41 = Ambulance - land
42 = Ambulance - air or water
50 = Federally qualified health centers
     (eff. 10/1/93)
51 = Inpatient psychiatric facility
52 = Psychiatric facility partial hospitalization
53 = Community mental health center
54 = Intermediate care facility/mentally retarded
55 = Residential substance abuse treatment facility
56 = Psychiatric residential treatment center
60 = Mass immunizations center (eff. 9/1/97)
61 = Comprehensive inpatient rehabilitation facility
62 = Comprehensive outpatient rehabilitation facility
65 = End stage renal disease treatment facility
71 = State or local public health clinic
72 = Rural health clinic
81 = Independent laboratory

1       LINE_PLC_SRVC_TB                             Line Place Of Service Table
         ---------------------------------------------
99 = Other unlisted facility

1       LINE_PMT_IND_TB                             Line Payment Indicator Table
         ---------------------------------------------
1 = Actual charge
2 = Customary charge
3 = Prevailing charge (adjusted, unadjusted
4 = Other (ASC fees, radiology and outpatient limits, and non-payment because of denial.
5 = Lab fee schedule
6 = Physician fee schedule - full fee schedule amount
7 = Physician fee schedule - transition
8 = Clinical psychologist fee schedule
9 = DME and prosthetics/orthotics fee schedules (eff. 4/97)

A = Allowed
B = Benefits exhausted
C = Noncovered care
D = Denied (existed prior to 1991; from BMAD)
I = Invalid data
L = CLIA (eff 9/92)
M = Multiple submittal--duplicate line item
N = Medically unnecessary
O = Other
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided (contractor #88888) - voluntary agreement (eff. 1/98)
R = Reprocessed--adjustments based on subsequent reprocessing of claim
S = Secondary payer
T = MSP cost avoided - IEQ contractor (eff. 7/76)
U = MSP cost avoided - HMO rate cell adjustment (eff. 7/96)
V = MSP cost avoided - litigation settlement (eff. 7/96)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data match project
Z = Bundled test, no payment
(eff. 1/1/98)

LINE_PRVDR_PRTCPTG_IND_TB  
Line Provider Participating Indicator Table

1 = Participating
2 = All or some covered and allowed expenses applied to deductible Participating
3 = Assignment accepted/non-participating
4 = Assignment not accepted/non-participating
5 = Assignment accepted but all or some covered and allowed expenses applied to deductible Non-participating.
6 = Assignment not accepted and all covered and allowed expenses applied to deductible non-participating.
7 = Participating provider not accepting assignment.

NCH_CLM_TYPE_TB  
NCH Claim Type Table

10 = HHA claim
20 = Non swing bed SNF claim
30 = Swing bed SNF claim
40 = Outpatient claim
41 = Outpatient 'Full-Encounter' claim (available in NMUD)
42 = Outpatient 'Abbreviated-Encounter' claim (available in NMUD)
50 = Hospice claim
60 = Inpatient claim
61 = Inpatient 'Full-Encounter' claim
62 = Inpatient 'Abbreviated-Encounter' claim (available in NMUD)
71 = RIC O local carrier non-DMEPOS claim
72 = RIC O local carrier DMEPOS claim
73 = Physician 'Full-Encounter' claim (available in NMUD)
81 = RIC M DMERC non-DMEPOS claim
82 = RIC M DMERC DMERPOS claim

NCH_EDIT_TABLE

- A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
- A000 = (C) REIMB > $100,000 OR UNITS > 150
- A002 = (C) CLAIM IDENTIFIER (CAN)
- A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
- A004 = (C) PATIENT SURNAME BLANK
- A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
- A006 = (C) DATE OF BIRTH IS NOT NUMERIC
- A007 = (C) INVALID GENDER (0, 1, 2)
- A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
- A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
- A1X1 = (C) PERCENT ALLOWED INDICATOR
- A1X2 = (C) DT>97273, DGI=7611, DG<>103,163,1589
- A1X3 = (C) DT>96365, DIAG=V725
- A1X4 = (C) INVALID DIAGNOSTIC CODES
- C050 = (U) HOSPICE - SPELL VALUE INVALID
- D102 = (C) DME DATE OF BIRTH INVALID
- D2X2 = (C) DME SCREEN SAVINGS INVALID
- D2X3 = (C) DME SCREEN RESULT INVALID
- D2X4 = (C) DME DECISION IND INVALID
- D2X5 = (C) DME WAIVER OF PROV LIAB INVALID
- D3X1 = (C) DME NATIONAL DRUG CODE INVALID
- D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID
- D4X2 = (C) DME OUT OF DMERC SERVICE AREA
- D4X3 = (C) DME STATE CODE INVALID
- D5X1 = (C) TOS INVALID FOR DME HCPCS
- D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING
- D5X3 = (C) DME INVALID USE OF MS MODIFIER
- D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED
- D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS
- D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID
- D6X1 = (C) DME SUPPLIER NUMBER MISSING
- D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
- D919 = (C) CAPPED/PEN PUMPS, NUM OF SRVCS > 1
- D921 = (C) SHOE HCPCS W/O MOD RT, LT REQ U=2/4/6
- XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
- Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1
Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
Y003 = (C) HCPCS R0075/UNITS=SERVICES
Y010 = (C) TOB=13X/14X AND T.C.>$7,500
Y011 = (C) INP CLAIM/REIM > $75,000
Z001 = (C) RVNU 820-859 REQ COND CODE 71-76
Z002 = (C) CC M2 PRESENT/REIMB > $150,000
Z003 = (C) CC M2 PRESENT/UNITS > 150
Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX
Z005 = (C) REIMB>99999 AND REIMB<150000
Z006 = (C) UNITS>99 AND UNITS<150
Z237 = (E) HOSPICE OVERLAP - DATE ZERO
0011 = (C) ACTION CODE INVALID
0013 = (C) CABG/PCOE AND INVALID ADMIT DATE
0014 = (C) DEMO NUM NOT=01-06,08,15,31
0015 = (C) ESRD PLAN BUT DEMO ID NOT = 15
0016 = (C) INVALID VA CLAIM
0017 = (C) DEMO=31,TOB<>11 OR SPEC<>08
0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
0020 = (C) CANCEL ONLY CODE INVALID
0021 = (C) DEMO COUNT > 1
0301 = (C) INVALID HI CLAIM NUMBER

1 NCH_EDIT_TB
   NCH EDIT TABLE
   ---------------
0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK
04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)
04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
0401 = (C) BILL TYPE/PROVIDER INVALID
0402 = (C) BILL TYPE/REV CODE/PROVR RANGE
0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092
0407 = (C) RESPITE CARE BILL TYPE 34X, NO REV 66
0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974
0410 = (C) IMMUNO DRUG OCCR-36, NO REV 25 OR 636
0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES
0413 = (C) CABG/PCOE BUT TOB = HHA, OUT, HOS
0414 = (C) VALU CD 61, MSA AMOUNT MISSING
0415 = (C) HOME HEALTH INCORRECT ALPHA RIC
05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE
05X5 = (C) UPIN REQUIRED FOR DME HCPCS
0501 = (C) UNIQUE PHY IDEN. (UPIN) BLANK
0502 = (C) UNIQUE PHY IDEN. (UPIN) INVALID
0601 = (C) GENDER INVALID
0701 = (C) CONTRACTOR INVALID CARRIER/ETC
0702 = (C) PROVIDER NUMBER INCONSISTANT
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
0704 = (C) INVALID CONT FOR CABG DEMO
0705 = (C) INVALID CONT FOR PCOE DEMO
0901 = (C) INVALID DISP CODE OF 02
0902 = (C) INVALID DISP CODE OF SPACES
0903 = (C) INVALID DISP CODE
1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE
13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
1301 = (C) LINE COUNT NOT NUMERIC OR > 13
1302 = (C) RECORD LENGTH INVALID
1401 = (C) INVALID MEDICARE STATUS CODE
1501 = (C) ADMIT DATE/ENTRY CODE INVALID
1502 = (C) ADMIT DATE > STAY FROM DATE
1503 = (C) ADMIT DATE INVALID WITH THRU DATE
1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
1505 = (C) HCPCS W SERVICE DATES > 09-30-94
1601 = (C) INVESTIGATION IND INVALID
1701 = (C) SPLIT IND INVALID
1801 = (C) PAY-DENY CODE INVALID
1802 = (C) HEADER AMT AND NOT DENIED CLAIM
1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME
1901 = (C) AB CROSSOVER IND INVALID
2001 = (C) HOSPICE OVERRIDE INVALID
2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
2102 = (C) FROM/THRU DATE OR KRON/PAT STAT
2201 = (C) FROM/THRU DATE OR HCPCS YR INVAL
2202 = (C) STAY-FROM DATE > THRU-DATE
2203 = (C) THRU DATE INVALID
2204 = (C) FROM DATE BEFORE EFFECTIVE DATE
2205 = (C) DATE YEARS DIFFERENT ON OUTPAT
2207 = (C) MAMMOGRAPHY BEFORE 1991
2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID
2302 = (C) COVERED DAYS INVALID OR INCONSIST
2303 = (C) COST REPORT DAYS > ACCOMIDATION
2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL
2305 = (C) UTIL DAYS = INCONSISTENCIES
2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT
2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09

NCH_EDIT_TB NCH EDIT TABLE
2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
2401 = (C) NON-UTIL DAYS INVALID
2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL
2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
2504 = (C) COINSURANCE AMOUNT EXCESSIVE
2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT
2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST
2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR
2508 = (C) COINSURANCE DAYS INVALID FOR TRAN
2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
2602 = (C) LR-DYS, NO VAL 08,10/PD/DEN>CUR+27
2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
2604 = (C) PPS BILL, NO DAY OUTLIER
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
28XA = (C) UTIL DAYS > FROM TO BENEF EXH
28XB = (C) BENEFITS EXH DATE > FROM DATE
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN = (C) INVALID OCC CODE
28XO = (C) BENE EXH DATE OUTSIDE SERVICE DATES
28X1 = (C) OCCUR DATE INVALID
28X2 = (C) OCCUR = 20 AND TRANS = 4
28X3 = (C) OCCUR 20 DATE < ADMIT DATE
28X4 = (C) OCCUR 20 DATE > ADMIT + 12
28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM
28X6 = (C) OCCUR 20 DATE < BENE EXH DATE
28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
28X8 = (C) OCCUR 22 DATE < FROM OR > THRU
28X9 = (C) UTIL > FROM - THRU LESS NCOV
33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)
33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)
33X3 = (C) QS DAYS/ADMISSION ARE INVALID
33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)
33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE
33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33X7</td>
<td>TOB&lt;&gt;18/21/28/51, COND=WO</td>
</tr>
<tr>
<td>33X8</td>
<td>TOB=18/21/28/51, CO=WO, ADM DT&lt;97001</td>
</tr>
<tr>
<td>33X9</td>
<td>TOB=32X SPAN 70 OR OCCR BO PRESENT</td>
</tr>
<tr>
<td>34X2</td>
<td>DEMO ID = 04 AND COND WO NOT SHOWN</td>
</tr>
<tr>
<td>3401</td>
<td>DEMO ID = 04 AND RIC NOT = 1</td>
</tr>
<tr>
<td>35X1</td>
<td>60, 61, 66 &amp; NON-PPS / 65 &amp; PPS</td>
</tr>
<tr>
<td>35X2</td>
<td>COND = 60 OR 61 AND NO VALU 17</td>
</tr>
<tr>
<td>35X3</td>
<td>PRO APPROVAL COND C3, C7 REQ SPAN M0</td>
</tr>
<tr>
<td>36X1</td>
<td>SURG DATE &lt; STAY FROM/ &gt; STAY THRU</td>
</tr>
<tr>
<td>3701</td>
<td>ASSIGN CODE INVALID</td>
</tr>
<tr>
<td>3705</td>
<td>1ST CHAR OF IDE# IS NOT ALPHA</td>
</tr>
<tr>
<td>3706</td>
<td>INVALID IDE NUMBER - NOT IN FILE</td>
</tr>
<tr>
<td>3710</td>
<td>NUM OF IDE# &gt; REV 0624</td>
</tr>
<tr>
<td>3715</td>
<td>NUM OF IDE# &lt; REV 0624</td>
</tr>
<tr>
<td>3720</td>
<td>IDE AND LINE ITEM NUMBER &gt; 2</td>
</tr>
<tr>
<td>3801</td>
<td>AMT BENE PD INVALID</td>
</tr>
<tr>
<td>4001</td>
<td>BLOOD PINTS FURNISHED INVALID</td>
</tr>
<tr>
<td>4002</td>
<td>BLOOD FURNISHED/REPLACED INVALID</td>
</tr>
<tr>
<td>4003</td>
<td>BLOOD FURNISHED/VERIFIED/DEDUCT</td>
</tr>
<tr>
<td>4201</td>
<td>BLOOD PINTS UNREPLACED INVALID</td>
</tr>
<tr>
<td>4202</td>
<td>BLOOD PINTS UNREPLACED/BLOOD DED</td>
</tr>
<tr>
<td>4203</td>
<td>INVALID CPO PROVIDER NUMBER</td>
</tr>
<tr>
<td>4301</td>
<td>BLOOD DEDUCTIBLE INVALID</td>
</tr>
<tr>
<td>4302</td>
<td>BLOOD DEDUCT/FURNISHED PINTS</td>
</tr>
<tr>
<td>4303</td>
<td>BLOOD DEDUCT &gt; UNREPLACED BLOOD</td>
</tr>
<tr>
<td>4304</td>
<td>BLOOD DEDUCT &gt; 3 - REPLACED</td>
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<tr>
<td>4501</td>
<td>PRIMARY DIAGNOSIS INVALID</td>
</tr>
<tr>
<td>46XA</td>
<td>MSP VET AND VET AT MEDICARE</td>
</tr>
<tr>
<td>46XB</td>
<td>MULTIPLE COIN VALU CODES (A2, B2, C2)</td>
</tr>
<tr>
<td>46XC</td>
<td>COIN VALUE (A2, B2, C2) ON INP/SNF</td>
</tr>
<tr>
<td>46XG</td>
<td>VALU CODE 20 INVALID</td>
</tr>
<tr>
<td>46XN</td>
<td>VALUE CODE 37, 38, 39 INVALID</td>
</tr>
<tr>
<td>46XO</td>
<td>VALUE CDE 38&gt;0/VAL CDE 06 MISSNG</td>
</tr>
<tr>
<td>46XP</td>
<td>BLD UNREP VS REV CDS AND/OR UNITS</td>
</tr>
<tr>
<td>46XQ</td>
<td>VALUE CDE 37=39 AND 38 IS PRESENT</td>
</tr>
<tr>
<td>46XR</td>
<td>BLD FIELDS VS REV CDE 380, 381, 382</td>
</tr>
<tr>
<td>46XS</td>
<td>VALU CODE 39, AND 37 IS NOT PRESENT</td>
</tr>
<tr>
<td>46XT</td>
<td>CABG/PCOE, VC&lt;&gt;Y1, Y2, Y3, Y4, VA NOT&gt;0</td>
</tr>
<tr>
<td>46X1</td>
<td>VALUE AMOUNT INVALID</td>
</tr>
</tbody>
</table>
46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61
46X7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
46X9 = (C) DEMO ID=03, REQUIRED HCPCS NOT SHOWN
4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
4601 = (C) CABG/PCOE, MSP CODE PRESENT
4602 = (C) DEMO ID = 03 AND RIC NOT=6,7
4901 = (C) PCOE/CABG, DEN CD NOT D
50X1 = (C) RVCD=54, TOB<>13, 23, 32, 33, 34, 83, 85
50X2 = (C) REV CD=054X, MOD NOT = QM, QN
5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
51XA = (C) HCPCS EYEWARE & REV CODE NOT 274
51XC = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51XD = (C) HCPCS REQUIRES UNITS > ZERO
51XE = (C) HCPCS REQUIRES REVENUE CODE 636
51XF = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51XG = (C) HCPCS REQUIRES DIAG OF HEMOPHILLIA
51XH = (C) TOB 21X/P82=2/3/4; REV CD<9001,>9044
51XI = (C) TOB 21X/P82<>2/3/4; REV CD>8999<9045
51XJ = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
51XK = (C) REV CODE<9041,>9045,RC<>4/234
51XM = (C) HHA RC DATE OF SRVC MISSING
51XQ = (C) NO RC 0636 OR DTE INVALID
51XR = (C) DEMO ID=01, RIC NOT=2
51XS = (C) DEMO ID=01, RUGS<>2,3,4 OR BILL<>21
51X0 = (C) REV CENTER CODE INVALID
51X1 = (C) REV CODE CHECK

1 NCH_EDIT_TB
---------------- NCH EDIT TABLE

51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
51X3 = (C) UNITS MUST BE > 0
51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR
51X5 = (C) REVENUE NON-COVERED > TOTAL CHARGE
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
51X9 = (C) HCPCS/REV CODE/BILL TYPE
5100 = (U) TRANSITION SPELL / SNF
5160 = (U) LATE CHG HSP BILL STAY DAYS > 0
5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT
5169 = (U) PROVIDER NE TO WORK PROVIDER
5177 = (U) PROVIDER NE TO WORK PROVIDER
5178 = (U) HOSPICE BILL THRU < DOLBA
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
5200 = (E) ENTITLEMENT EFFECTIVE DATE
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
5203 = (U) HOSPICE TRAILER ERROR
5204 = (U) HOSPICE START DATE ERROR
5205 = (U) HOSPICE DATE DISCREPANCY
5206 = (U) HOSPICE DATE DISCREPANCY
5207 = (U) HOSPICE THRU > TERM DATE 2ND
5208 = (U) HOSPICE PERIOD NUMBER BLANK
5209 = (U) HOSPICE DATE DISCREPANCY
5210 = (E) ENTITLEMENT FRM/TRU/END DATES
5211 = (E) ENTITLEMENT DATE DEATH/THRU
5212 = (E) ENTITLEMENT DATE DEATH/THRU
5213 = (E) ENTITLEMENT DATE DEATH MBR
5220 = (E) ENTITLEMENT FROM/EFF DATES
5225 = (E) ENT INP PPS SPAN 70 DATES
5232 = (E) ENTL HMO NO HMO OVERRIDE CDE
5233 = (E) ENTITLEMENT HMO PERIODS
5234 = (E) ENTITLEMENT HMO NUMBER NEEDED
5235 = (E) ENTITLEMENT HMO HOSP+NO CC07
5236 = (E) ENTITLEMENT HMO HOSP + CC07
5237 = (E) ENTITLEMENT HOSP OVERLAP
5238 = (U) HOSPICE CLAIM OVERLAP > 90
5239 = (U) HOSPICE CLAIM OVERLAP > 60
5242 = (E) HOSP OVERLAP NO OVD NO DEMO
5240 = (U) HOSPICE DAYS STAY+USED > 90
5241 = (U) HOSPICE DAYS STAY+USED > 60
5242 = (C) INVALID CARRIER FOR RRB
5243 = (C) HMO=90091,INVALID SERVICE DTE
5244 = (E) DEMO CABG/PCOE MISSING ENTL
5245 = (C) INVALID CARRIER FOR NON RRB
525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO
5260 = (U) HOSPICE DOEBA/DOLBA
5255 = (U) HOSPICE DAYS USED
5256 = (U) HOSPICE DAYS USED > 999
526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0
526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0
527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0
527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
5299 = (U) HOSPICE PERIOD NUMBER ERROR
1         NCH_EDIT_TB                                       NCH EDIT TABLE
-----------                                       --------------
5320 = (U) BILL > DOEBA AND IND-1 = 2
5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
5355 = (U) HOSPICE DAYS USED SECONDARY
5378 = (C) SERVICE DATE < AGE 50
5399 = (U) HOSPICE PERIOD NUM MATCH
5410 = (U) INPAT DEDUCTABLE
5425 = (U) PART B DEDUCTABLE CHECK
5430 = (U) PART B DEDUCTABLE CHECK
5450 = (U) PART B COMPARE MED EXPENSE
5460 = (U) PART B COMPARE MED EXPENSE
5499 = (U) MED EXPENSE TRAILER MISSING
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS
5510 = (U) COIN DAYS/SNF COIN DAYS
5515 = (U) FULL DAYS/COIN DAYS
5516 = (U) SNF FULL DAYS/SNF COIN DAYS
5520 = (U) LIFE RESERVE DAYS
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS
5540 = (U) HH VISITS NE AFT PT B TRLR
5550 = (E) SNF LESS THAN PT A EFF DATE
5600 = (D) LOGICAL DUPE, COVERED
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123
5602 = (D) LOGICAL DUPE, PANDE C, E OR I
5603 = (D) LOGICAL DUPE, COVERED
5605 = (D) POSS DUPE, OUTPAT REIMB
5606 = (D) POSS DUPE, HOME HEALTH COVERED U
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>61X3</td>
<td>(C) Pay process ind/allowed charges</td>
</tr>
<tr>
<td>61X4</td>
<td>(C) Rate missing or non-numeric</td>
</tr>
<tr>
<td>6100</td>
<td>(C) Rev 0001 not present on claim</td>
</tr>
<tr>
<td>6101</td>
<td>(C) Rev computed charges not=total</td>
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<tr>
<td>6102</td>
<td>(C) Rev computed non-covered/non-cov</td>
</tr>
<tr>
<td>6103</td>
<td>(C) Rev total charges &lt; primary payer</td>
</tr>
<tr>
<td>62XA</td>
<td>(C) Psych ot pt/reim/type</td>
</tr>
<tr>
<td>62X1</td>
<td>(C) DME/date/100% or inval reim ind</td>
</tr>
<tr>
<td>62X6</td>
<td>(C) Rad path/place/type/date/ded</td>
</tr>
<tr>
<td>62X8</td>
<td>(C) Kidney dono/type/100%</td>
</tr>
<tr>
<td>62X9</td>
<td>(C) Pneum vaccine/type/100%</td>
</tr>
<tr>
<td>6201</td>
<td>(C) Total deduct &gt; charges/non- cov</td>
</tr>
<tr>
<td>6203</td>
<td>(U) Hospice adjustment period/date</td>
</tr>
<tr>
<td>6204</td>
<td>(U) Hospice adjustment thru&gt;dolba</td>
</tr>
<tr>
<td>6260</td>
<td>(U) Hospice adjustment stay days</td>
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<tr>
<td>6261</td>
<td>(U) Hospice adjustment days used</td>
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<td>6265</td>
<td>(U) Hospice adjustment days used</td>
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<tr>
<td>6269</td>
<td>(U) Hospice adjustment period# (main)</td>
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<tr>
<td>63X1</td>
<td>(C) Deduct ind invalid</td>
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<tr>
<td>63X2</td>
<td>(C) Ded/hcfa coins in pcoe/cabg</td>
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<tr>
<td>6356</td>
<td>(U) Hospice adjustment secondary days</td>
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<tr>
<td>6369</td>
<td>(U) Hospice adjustment period# (second)</td>
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<td>64X1</td>
<td>(C) Provider ind invalid</td>
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<td>6430</td>
<td>(U) Part B deductible check</td>
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<td>65X1</td>
<td>(C) Payscreen ind invalid</td>
</tr>
<tr>
<td>66??</td>
<td>(D) Poss dupe, cr/db, doc-id</td>
</tr>
<tr>
<td>66XX</td>
<td>(D) Poss dupe, cr/db, doc-id</td>
</tr>
<tr>
<td>66X1</td>
<td>(C) Units amount invalid</td>
</tr>
<tr>
<td>66X2</td>
<td>(C) Units ind &gt; 0; amt not valid</td>
</tr>
<tr>
<td>66X3</td>
<td>(C) Units ind = 0; amt &gt; 0</td>
</tr>
<tr>
<td>66X4</td>
<td>(C) Mt indicator/amount</td>
</tr>
<tr>
<td>6600</td>
<td>(U) Adjustment bill full days</td>
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<tr>
<td>6610</td>
<td>(U) Adjustment bill coin days</td>
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<tr>
<td>6620</td>
<td>(U) Adjustment bill life reserve</td>
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<tr>
<td>6630</td>
<td>(U) Adjustment bill life psych dys</td>
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<tr>
<td>67X1</td>
<td>(C) Units indicator invalid</td>
</tr>
<tr>
<td>67X2</td>
<td>(C) Chg allowed &gt; 0; units ind = 0</td>
</tr>
<tr>
<td>67X3</td>
<td>(C) Tos/hcpcs=anest, mtu ind not = 2</td>
</tr>
<tr>
<td>67X4</td>
<td>(C) Hcpcs = ambulance, mtu ind not = 1</td>
</tr>
<tr>
<td>67X6</td>
<td>(C) Invalid proc for mt ind 2, anest</td>
</tr>
<tr>
<td>67X7</td>
<td>(C) Invalid units ind with tos of blood</td>
</tr>
<tr>
<td>67X8</td>
<td>(C) Invalid proc for mt ind 4, oxygen</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>6700</td>
<td>(U) ADJUSTMENT BILL FULL/SNF DAYS</td>
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<tr>
<td>6710</td>
<td>(U) ADJUSTMENT BILL COIN/SNF DAYS</td>
</tr>
<tr>
<td>68X1</td>
<td>(C) INVALID HCPCS CODE</td>
</tr>
<tr>
<td>68X2</td>
<td>(C) MAMMOGRAPHY/DATE/PROC NOT 76092</td>
</tr>
<tr>
<td>68X3</td>
<td>(C) TYPE OF SERVICE = G /PROC CODE</td>
</tr>
<tr>
<td>68X4</td>
<td>(C) HCPCS NOT VALID FOR SERVICE DATE</td>
</tr>
<tr>
<td>68X5</td>
<td>(C) MODIFIER NOT VALID FOR HCPCS, ETC</td>
</tr>
<tr>
<td>68X6</td>
<td>(C) TYPE SERVICE INVALID FOR HCPCS, ETC</td>
</tr>
<tr>
<td>68X7</td>
<td>(C) ZX MOD REQ FOR THER SHOES/INS/MOD.</td>
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<tr>
<td>68X8</td>
<td>(C) LINE ITEM INCORRECT OR DATE INVAL.</td>
</tr>
<tr>
<td>69XA</td>
<td>(C) MODIFIER NOT VALID FOR HCPCS/GLOBAL</td>
</tr>
<tr>
<td>69X3</td>
<td>(C) PROC CODE MOD = LL / TYPE = R</td>
</tr>
<tr>
<td>69X6</td>
<td>(C) PROC CODE MOD/NOT CAPPED</td>
</tr>
<tr>
<td>69X8</td>
<td>(C) SPEC CODE NURSE PRACT, MOD INVAL</td>
</tr>
<tr>
<td>6901</td>
<td>(C) KRON IND AND UTIL DYS EQUALS ZERO</td>
</tr>
<tr>
<td>6902</td>
<td>(C) KRON IND AND NO-PAY CODE B OR N</td>
</tr>
<tr>
<td>6903</td>
<td>(C) KRON IND AND INPATIENT DEDUCT = 0</td>
</tr>
<tr>
<td>6904</td>
<td>(C) KRON IND AND TRANS CODE IS 4</td>
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<tr>
<td>6910</td>
<td>(C) REV CODES ON HOME HEALTH</td>
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<tr>
<td>6911</td>
<td>(C) REV CODE 274 ON OUTPAT AND HH ONLY</td>
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<tr>
<td>6912</td>
<td>(C) REV CODE INVAL FOR PROSTH AND ORTHO</td>
</tr>
<tr>
<td>6913</td>
<td>(C) REV CODE INVAL FOR OXYGEN</td>
</tr>
<tr>
<td>6914</td>
<td>(C) REV CODE INVAL FOR DME</td>
</tr>
<tr>
<td>6915</td>
<td>(C) PURCHASE OF RENT DME INVAL ON DATES</td>
</tr>
<tr>
<td>6916</td>
<td>(C) PURCHASE OF RENT DME INVAL ON DATES</td>
</tr>
<tr>
<td>6917</td>
<td>(C) PURCHASE OF LIFT CHAIR INVAL &gt; 91000</td>
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<tr>
<td>6918</td>
<td>(C) HCPCS INVALID ON DATE RANGES</td>
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<td>6919</td>
<td>(C) DME OXYGEN ON HH INVAL BEFORE 7/1/89</td>
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<td>6920</td>
<td>(C) HCPCS INVAL ON REV 270/BILL 32-33</td>
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<td>6921</td>
<td>(C) HCPCS ON REV CODE 272 BILL TYPE 83X</td>
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<tr>
<td>6922</td>
<td>(C) HCPCS ON BILL TYPE 83X -NOT REV 274</td>
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<tr>
<td>6923</td>
<td>(C) RENTAL OF DME CUSTOMIZE AND REV 291</td>
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<td>6924</td>
<td>(C) INVAL MODIFIER FOR CAPPED RENTAL</td>
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<tr>
<td>6925</td>
<td>(C) HCPCS ALLOWED ON BILL TYPES 32X-34X</td>
</tr>
<tr>
<td>6929</td>
<td>(U) ADJUSTMENT BILL LIFE RESERVE</td>
</tr>
<tr>
<td>6930</td>
<td>(U) ADJUSTMENT BILL LIFE PSYCH DYS</td>
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<tr>
<td>7000</td>
<td>(U) INVALID DOEBA/DOLBA</td>
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<tr>
<td>7002</td>
<td>(U) LESS THAN 60/61 BETWEEN SPELLS</td>
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<tr>
<td>7010</td>
<td>(E) TOB 85X/ELECTN PRD: COND CD 07 REQD</td>
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</table>
71X1 = (C) SUBMITTED CHARGES INVALID
71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG
72X1 = (C) ALLOWED CHGS INVALID
72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
72X3 = (C) DENIED LINE/ALLOWED CHARGES
73X1 = (C) SS NUMBER INVALID
73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING
74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT
76X1 = (C) PL OF SER INVALID ON MAMMOGRAPHY BILL
77X1 = (C) PLACE OF SERVICE INVALID
77X2 = (C) PHYS THERAPY/PLACE
77X3 = (C) PHYS THERAPY/SPECIALTY/TYP
77X4 = (C) ASC/TYP/PLACE/REIMB IND/DED IND
77X6 = (C) TOS=F, PL OF SER NOT = 24
7701 = (C) INCORRECT MODIFIER
7777 = (D) POSS DUPE, PART B DOC-ID
78XA = (C) MAMMOGRAPHY BEFORE 1991
78X1 = (C) THRU DATE INVALID
78X3 = (C) FROM DATE GREATER THAN THRU DATE
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY
78X5 = (C) FROM DATE > PAID DATE/TYP/100%
78X7 = (C) LAB EDIT/TYP/100%/FROM DATE
79X3 = (C) THRU DATE>RECD DATE/NOT DENIED
79X4 = (C) THRU DATE>PAID DATE/NOT DENIED
8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90
8028 = (E) NO ENTITLEMENT
8029 = (U) HH BEFORE PERIOD NOT PRESENT
8030 = (U) HH BILL VISITS > PT A REMAINING
8031 = (U) HH PT A REMAINING > 0
8032 = (U) HH DOLBA+59 NOT GT FROM-DATE
8050 = (U) HH QUALIFYING INDICATOR = 1
8051 = (U) HH # VISITS NE AFT PT B APPLIED
8052 = (U) HH # VISITS NE AFT TRAILER
8053 = (U) HH BENEFIT PERIOD NOT PRESENT
8054 = (U) HH DOEBA/DOLBA NOT > 0
8060 = (U) HH QUALIFYING INDICATOR NE 1
8061 = (U) HH DATE NE DOLBA IN AFT TRLR
8062 = (U) HH NE PT-A VISITS REMAINING
81X1 = (C) NUM OF SERVICES INVALID
83X1 = (C) DIAGNOSIS INVALID
8301 = (C) HCPCS/GENDER DIAGNOSIS
8302 = (C) HCPCS G0101 V-CODE/SEX CODE
8304 = (C) BILL TYPE INVALID FOR G0123/4
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
84X2 = (C) INVALID DME START DATE
84X3 = (C) INVALID DME START DATE W/HCPCS
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
84X5 = (C) HCPCS CODE WITH INV DIAG CODE
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD
9000 = (U) DOEBA/DOLBA CALC
9005 = (U) FULL/COINS HOSP DAYS CALC
9010 = (U) FULL/COINS SNF DAYS CALC
9015 = (U) LIFE RESERVE DAYS CALC
9020 = (U) LIFE PSYCH DAYS CALC
9030 = (U) INPAT DEDUCTIBLE CALC
9040 = (U) DATA INDICATOR 1 SET
9050 = (U) DATA INDICATOR 2 SET
91X1 = (C) PATIENT REIMB/PAY-DENY CODE
92X1 = (C) PATIENT REIMB INVALID
92X2 = (C) PROVIDER REIMB INVALID
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
92X7 = (C) REIMB/PAY-DENY INCONSISTANT
9201 = (C) UPIN REF NAME OR INITIAL MISSING
9202 = (C) UPIN REF FIRST 3 CHAR INVALID
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
93X1 = (C) CASH DEDUCTIBLE INVALID
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
93X4 = (C) FROM DATE/CASH DEDUCTIBLE
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
9300 = (C) UPIN OTHER, NOT PRESENT
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
94A1 = (C) NON-COVERED FROM DATE INVALID
94A2 = (C) NON-COVERED FROM > THRU DATE
94A3 = (C) NON-COVERED THRU DATE INVALID
94A4 = (C) NON-COVERED THRU DATE > ADMIT
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
94C1 = (C) PR-PSYCH DAYS INVALID
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
94F1 = (C) REIMBURSEMENT AMOUNT INVALID
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
94G1 = (C) NO-PAY CODE INVALID
1
NCH_EDIT_TB
-----------
94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
94G4 = (C) NO PAY CODE = R & REIMB PRESENT
94X1 = (C) BLOOD LIMIT INVALID
94X2 = (C) TYPE/BLOOD DEDUCTIBLE
94X3 = (C) TYPE/DATE/LIMIT AMOUNT
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
9401 = (C) BLOOD DEDUCTIBLE AMT > 3
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
9404 = (C) INVALID GENDER CODE ON PRO-PAY
9407 = (C) INVALID DRG NUMBER
9408 = (C) INVALID DRG NUMBER (GLOBAL)
9409 = (C) HCFA DRG<>DRG ON BILL
9410 = (C) CABG/PCOE,INVALID DRG
95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
95X2 = (C) MSP AMOUNT APPLIED INVALID
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
95X5 = (C) MSP CODE = G/DATE BEFORE 1987
95X6 = (C) MSP CODE = X AND NOT AVOIDED
95X7 = (C) MSP CODE VALID, CABG/PCOE
96X1 = (C) OTHER AMOUNTS INVALID
96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB
97X1 = (C) OTHER AMOUNTS INDICATOR INVALID
97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0
98X1 = (C) COINSURANCE INVALID
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
99XX = (D) FOSS DUPE, PART B DOC-ID
1 NCH_NEAR_LINE_RIC_TB

NCH Near-Line Record Identification Code Table

O = Part B physician/supplier claim record (processed by local carriers; can include DMEPOS services)

V = Part A institutional claim record (inpatient (IP), skilled nursing facility (SNF), christian science (CS), home health agency (HHA), or hospice)

W = Part B institutional claim record (outpatient (OP), HHA)

U = Both Part A and B institutional home health agency (HHA) claim records -- due to HHPPS and HHA A/B split. (effective 10/00)

M = Part B DMEPOS claim record (processed by DME Regional Carrier) (effective 10/93)
NCH Patch Table

01 = RRB Category Equatable BIC - changed (all claim types) -- applied during the Nearline 'G' conversion to claims with NCH weekly process date before 3/91. Prior to Version 'H', patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 2.

02 = Claim Transaction Code made consistent with NCH payment/edit RIC code (OP and HHA) -- effective 3/94, CWFMQA began patch. During 'H' conversion, patch applied to claims with NCH weekly process date prior to 3/94. Prior to version 'H', patch indicator stored in redefined Claim Edit Group, 4th occurrence, position 1.

03 = Garbage/nonnumeric Claim Total Charge Amount set to zeroes (Instnl) -- during the Version 'G' conversion, error occurred in the derivation of this field where the claim was missing revenue center code = '0001'. In 1994, patch was applied to the OP and HHA SAFs only. (This SAF patch indicator was stored in the redefined Claim Edit Group, 4th occurrence, position 2). During the 'H' conversion, patch applied to Nearline claims where garbage or nonnumeric values.

04 = Incorrect bene residence SSA standard county code '999' changed (all claim types) -- applied during the Nearline 'G' conversion and ongoing through 4/21/94, calling EQSTZIP routine to claims with NCH weekly process date prior to 4/22/94. Prior to Version 'H' patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 4.

05 = Wrong century bene birth date corrected (all claim types) -- applied during Nearline 'H' conversion to all history where century
greater than 1700 and less than 1850; if century less than 1700, zeroes moved.

06 = Inconsistent CWF bene medicare status code made consistent with age (all claim types) --
applied during Nearline 'H' conversion to all history and patched ongoing. Bene age is
calculated to determine the correct value; if greater than 64, 1st position MSC = '1';
if less than 65, 1st position MSC = '2'.

07 = Missing CWF bene medicare status code derived (all claim types) -- applied during Nearline
'H' conversion to all history and patched ongoing, except claims with unknown DOB and/
or Claim From Date='0' (left blank). Bene age is calculated to determine missing value;
if greater than 64, MSC='10'; if less than 65, MSC = '20'.

08 = Invalid NCH primary payer code set to blanks (Instnl) -- applied during Version 'H'
conversion to claims with NCH weekly process date 10/1/93-10/30/95, where MSP values =

1     NCH_PATCH_TB
     ------------
     NCH Patch Table

invalid '0', '1', '2', '3' or '4' (caused by erroneous logic in HCFA program code,
which was corrected on 11/1/95).

09 = Zero CWF claim accretion date replaced with NCH weekly process date (all claim types)

-- applied during Version 'H' conversion to Instnl and DMERC claims; applied during
Version 'G' conversion to non-institutional (non-DMERC) claims. Prior to Version 'H',
patch indicator stored in redefined claim edit group, 3rd occurrence, position 1.

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

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

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

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

1  NCH_STATE_SGMT_TB  NCH State Segment Table
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01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
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55 = Asia
56 = Canada
57 = Central America & West Indies
58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = US Possessions
97 = Saipan - MP
98 = Guam
99 = American Samoa