All Clinical Labs claims are carrier claims

The Clinical Lab HCPCS specified in the Clinical Lab Fee Schedule is used to determine which claims are Clinical Lab claims and will be included in the Clinical Lab File. Any claim that contains any line item with a clinical lab HCPCS code is put into the file.

VARIABLES BLANKED FOR CONFIDENTIALITY REASONS

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

BENEFICIARY CLAIM ACCOUNT NUMBER
BENEFICIARY MAILING CONTACT ZIP CODE
BENEFICIARY NCH STATE SEGMENT NEAR-LINE CODE
BENEFICIARY RESIDENCE SSA STANDARD COUNTY CODE
CARRIER CLAIM REFERRING PHYSICIAN NPI NUMBER
CARRIER CLAIM REFERRING PIN 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 SURNAME
CLAIM ATTENDING PHYSICIAN UPIN NUMBER
CLAIM OPERATING PHYSICIAN GIVEN NAME
CLAIM OPERATING PHYSICIAN MIDDLE INITIAL NAME
CLAIM OPERATING PHYSICIAN SURNAME
CLAIM OPERATING PHYSICIAN UPIN NUMBER
CLAIM OTHER PHYSICIAN GIVAN NAME
CLAIM OTHER PHYSICIAN IDENTIFICATION NUMBER
CLAIM OTHER PHYSICIAN MIDDLE INITIAL NAME
CLAIM OTHER PHYSICIAN SURNAME
CLAIM OTHER PHYSICIAN UPIN NUMBER
CLAIM PATIENT 1ST INITIAL GIVEN NAME
CLAIM PATIENT 1ST INITIAL MIDDLE NAME
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
<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></td>
<td>**** Carrier Claim Record</td>
<td>REC</td>
<td>VAR</td>
<td></td>
<td></td>
<td>Carrier claim record (other than DMERC) for version I of the NCH.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: CARR_CLM_REC SYSTEM ALIAS: UTLCARRI</td>
</tr>
<tr>
<td></td>
<td>**** Carrier Claim Fixed Group</td>
<td>GROUP</td>
<td>375</td>
<td>1</td>
<td>375</td>
<td>Fixed portion of the carrier claim record for version I of the NCH.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: CARR_CLM_FIX_GRP</td>
</tr>
<tr>
<td></td>
<td>**** Claim Record Identification Group</td>
<td>GROUP</td>
<td>8</td>
<td>1</td>
<td>8</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: CLM_REC_IDENT_GRP</td>
</tr>
<tr>
<td>1. Record Length Count</td>
<td>PACK</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td></td>
<td>Effective with Version H, the count (in bytes) of the length of the claim record.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).</td>
</tr>
</tbody>
</table>

5 DIGITS SIGNED

DB2 ALIAS: REC_LENGTH_CNT
SAS ALIAS: REC_LEN
STANDARD ALIAS: REC_LENGTH_CNT
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>Source: NCH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The code indicating the record version of the Nearline file</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>where the institutional, carrier or DMERC claims data are stored.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: NCH_REC_VRSN_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: REC_LVL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: NCH_NEAR_LINE_REC_VRSN_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TITLE ALIAS: NCH_VERSION</td>
</tr>
<tr>
<td>CODES:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A = Record format as of January 1991</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>B = Record format as of April 1991</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C = Record format as of May 1991</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D = Record format as of January 1992</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>E = Record format as of March 1992</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>F = Record format as of May 1992</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>G = Record format as of October 1993</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>H = Record format as of September 1998</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>I = Record format as of July 2000</td>
</tr>
</tbody>
</table>

COMMENT:
1

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

Prior to Version H this field was named: CLM_NEAR_LINE_REC_VRSN_CD.

SOURCE:
NCH

3. NCH Near Line Record 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>Source: NCH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A code defining the type of claim record being processed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>COMMON ALIAS: RIC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: NEAR_LINE_RIC_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: RIC_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: NCH_NEAR_LINE_RIC_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TITLE ALIAS: RIC</td>
</tr>
<tr>
<td>CODES:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>REFER TO: NCH_NEAR_LINE_RIC_TB</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IN THE CODES APPENDIX</td>
</tr>
</tbody>
</table>

COMMENT:
Prior to Version H this field was named: RIC_CD.
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
7 = Durable Medical Equipment

SOURCE:
NCH QA PROCESS

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 through-out history (back to service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.

DB2 ALIAS: NCH_CLM_TYPE_CD
SAS ALIAS: CLM_TYPE
STANDARD ALIAS: 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

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

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


CLM_FREQ_CD

DERIVATION RULES:

SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
2. PMT_EDIT_RIC_CD EQUAL 'F'
3. CLM_TRANS_CD EQUAL '5'

SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y' OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y' OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT '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 = '2', '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:

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLM_NEAR_LINE_RIC_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLM_TRANS_CD</td>
<td></td>
<td></td>
<td></td>
<td></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.  CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET:

1.  FI_NUM = 80881
2.  CLM_FAC_TYPE_CD = '1'; CLM_SRVRC_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>Name</th>
<th>Type</th>
<th>Length</th>
<th>Begin</th>
<th>End</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier/DMERC Claim Link Group</td>
<td>GROUP</td>
<td>125</td>
<td>9</td>
<td>133</td>
<td>Effective with Version ‘I’, this group was added to the carrier and DMERC records to keep fields common across all record types in the same position. Due to OP PPS, several fields on the Institutional record had to be moved to a link group so those same fields had to be moved on the carrier records eventhough OP PPS only affects institutional claims. STANDARD ALIAS: CARR_DMERC_CLM_LINK_GRP</td>
</tr>
<tr>
<td>Claim Locator Number Group</td>
<td>GROUP</td>
<td>11</td>
<td>9</td>
<td>19</td>
<td>This number uniquely identifies the beneficiary in the NCH Nearline. COMMON ALIAS: HIC STANDARD ALIAS: CLM_LCTR_NUM_GRP TITLE ALIAS: HICAN</td>
</tr>
<tr>
<td>Beneficiary Claim Account Number</td>
<td>CHAR</td>
<td>9</td>
<td>9</td>
<td>17</td>
<td>The number identifying the primary beneficiary under the SSA or RRB programs submitted.</td>
</tr>
</tbody>
</table>
7. NCH Category Equatable

Beneficiary Identification Code

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

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

<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>COMMON ALIAS: NCH_BASECATEGORY_BIC</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>DB2 ALIAS: CTGRY_EQTBL_BIC</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: EQ_BIC</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: NCH_CTGRY_EQTBL_BIC_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: EQUATED_BIC</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

COMMON ALIAS: BIC
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

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

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>POSITIONS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CODES:
REFER TO: NCH_STATE_SGMT_TB
IN THE CODES APPENDIX

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

SOURCE:
NCH

CHAR  2  23  24  The SSA standard state code of a beneficiary’s residence.

DA3 ALIAS: SSA_STANDARD_STATE_CODE
DB2 ALIAS: BENE_SSA_STATE_CD
SAS ALIAS: STATE_CD
STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD
TITLE ALIAS: BENE_STATE_CD

EDIT-RULES:
OPTIONAL: MAY BE BLANK

CODES:
REFER TO: GEO_SSA_STATE_TB
IN THE CODES APPENDIX

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

SOURCE:
SSA/EDB

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:

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></td>
<td>----</td>
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<td>-----</td>
<td>-----</td>
<td>----------</td>
</tr>
<tr>
<td>YYYYMMD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
12. Claim Through Date  
NUM 8 33 40  
The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').

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

8 DIGITS UNSIGNED  
DB2 ALIAS: CLM_THRU_DT  
SAS ALIAS: THRU_DT  
STANDARD ALIAS: CLM_THRU_DT  
TITLE ALIAS: THRU_DATE  
EDIT-RULES:  
YYYYMMDD  
SOURCE: CWF

13. NCH Weekly Claim Processing Date  
NUM 8 41 48  
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.

8 DIGITS UNSIGNED  
DB2 ALIAS: NCH_WKLY_PROC_DT  
SAS ALIAS: WKLY_DT  
STANDARD ALIAS: NCH_WKLY_PROC_DT  
TITLE ALIAS: NCH_PROCESS_DT  
EDIT-RULES:  
YYYYMMDD  
COMMENT:  
Prior to Version H this field was named: HCFA_CLM_PROC_DT.  
SOURCE: NCH

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.

<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 DIGITS UNSIGNED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DB2 ALIAS: CWF_CLM_ACRTN_DT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: ACRTN_DT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: CWF_CLM_ACRTN_DT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: ACCRETION_DT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDIT-RULES: YYYYMMDD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOURCE: CWF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.**

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 by HCFA's CWFMQA system (used for internal editing purposes).
Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

Note: 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
SAS ALIAS: LINK_NUM
STANDARD ALIAS: NCH_SGMT_LINK_NUM
TITLE ALIAS: LINK_NUM

SOURCE:
NCH

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

POSITIONS
NAME          TYPE LENGTH BEG END CONTENTS
---------------------------  ----  ------ ---------  ------------------------------------------------------------
For institutional claims, the count for claims prior to 7/00 will be 1 or 2 (1 if 45 or less revenue center lines on a claim and 2 if more than 45 revenue center lines on a claim). For noninstitutional claims, the count will always be 1.

2 DIGITS UNSIGNED

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

SOURCE:
CWF

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
### 22. Claim Total Line Count

<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>Source: CWF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

### 23. Claim Segment Line Count

<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>Source: CWF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.
### Carrier/DMERC Claim Common Group

**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

<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</td>
</tr>
</tbody>
</table>
of the claim record.

DB2 ALIAS: CLM_DISP_CD
SAS ALIAS: DISP_CD
STANDARD ALIAS: CLM_DISP_CD
TITLE ALIAS: DISPOSITION_CD

CODES:
   REFER TO: CLM_DISP_TB
   IN THE CODES APPENDIX

SOURCE:
CWF

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
<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>30. Beneficiary Residence SSA</td>
<td>CHAR</td>
<td>3</td>
<td>146</td>
<td>148</td>
<td>The SSA standard county code of a beneficiary’s residence.</td>
</tr>
<tr>
<td>Standard County Code</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>H = BIC submitted by CWF = HA, HB or HC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>blank = No HA, HB or HC BIC present</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>NCH QA Process</td>
</tr>
<tr>
<td>31. Carrier Claim Receipt Date</td>
<td>NUM</td>
<td>8</td>
<td>149</td>
<td>156</td>
<td>The date the carrier receives the non-institutional claim.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>EDIT-RULES:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Optional: May be blank</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>SSA/EDB</td>
</tr>
<tr>
<td>32. Carrier Claim Scheduled</td>
<td>NUM</td>
<td>8</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>
</tbody>
</table>
**Note: This date is considered to be the date paid since no additional information as to the actual payment date is available.

8 DIGITS UNSIGNED

DB2 ALIAS: CARR_SCHLD_PMT_DT
SAS ALIAS: SCHLD_DT
STANDARD ALIAS: CARR_CLM_SCHLD_PMT_DT
TITLE ALIAS: SCHLD_PMT_DT

EDIT-RULES:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAME</td>
<td>TYPE</td>
<td>LENGTH</td>
<td>BEG</td>
</tr>
<tr>
<td>---------------</td>
<td>------</td>
<td>--------</td>
<td>-----</td>
</tr>
<tr>
<td>YYYYMMDD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

SOURCE:
CWF

33. CWF Forwarded Date   NUM   8   165  172  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.

8 DIGITS UNSIGNED

DB2 ALIAS: CWF_FRWRD_DT
SAS ALIAS: FRWRD_DT
STANDARD ALIAS: CWF_FRWRD_DT
TITLE ALIAS: FORWARD_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

34. Carrier Number   CHAR   5   173  177  The identification number assigned by HCFA to a carrier authorized to process claims from a physician or supplier.

DB2 ALIAS: CARR_NUM
<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>FILLER</td>
<td>CHAR</td>
<td>8</td>
<td>178</td>
<td>185</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>
<tr>
<td>CWF Transmission Batch</td>
<td>CHAR</td>
<td>4</td>
<td>186</td>
<td>189</td>
<td>The ZIP code of the mailing address where the beneficiary may be contacted.</td>
</tr>
</tbody>
</table>

SOURCE:
CWF

```
35. FILLER CHAR 8 178 185
36. CWF Transmission Batch Number CHAR 4 186 189
```

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

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


   DA3 ALIAS: RACE_CODE
   DB2 ALIAS: BENE_RACE_CD
   SAS ALIAS: RACE
   STANDARD ALIAS: BENE_RACE_CD
   SYSTEM ALIAS: LTRACE
   TITLE ALIAS: RACE_CD

   CODES:
   0 = Unknown

   1 = White
   2 = Black
   3 = Other
   4 = Asian
   5 = Hispanic
   6 = North American Native

   SOURCE:
   SSA

1

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

40. Beneficiary Birth Date  NUM  8 201 208  The beneficiary’s date of birth.

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

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

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.
### 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</td>
<td>CHAR</td>
<td>1</td>
<td>218</td>
<td>218</td>
<td>The first initial of the Medicare patient’s middle name as reported by the provider on the claim.</td>
</tr>
<tr>
<td>Middle Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

<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>45. Beneficiary CWF Location Code</td>
<td>CHAR</td>
<td>1</td>
<td>219</td>
<td>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>
</tr>
</tbody>
</table>

**COMMON ALIAS:** PATIENT_GIVEN_NAME  
**SOURCE:** CWF  
**CODES:**  
B = Mid-Atlantic
<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>46. Claim Principal Diagnosis</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>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer.</td>
</tr>
<tr>
<td>DB2 ALIAS: PRNCPAL_DGNS_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ál: PDGNS_CD</td>
</tr>
<tr>
<td>SAS ALIAS: PDGNS_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD</td>
</tr>
<tr>
<td>EDIT-RULES:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>SOURCE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CWF</td>
</tr>
<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>DB2 ALIAS: CARR_PMT_DNL_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: PMTDNLCD</td>
</tr>
<tr>
<td>STANDARD ALIAS: CARR_CLM_PMT_DNL_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CODES: REFER TO: CARR_CLM_PMT_DNL_TB IN THE CODES APPENDIX</td>
</tr>
</tbody>
</table>
49. Claim Excepted/Nonexcepted Medical Treatment Code

CHAR  1  227  227

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.

SOURCE:
CWF

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

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).

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

<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>SOURCE:</td>
<td>CWF</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LIMITATIONS: Prior to 4/6/93, on inpatient, outpatient, and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>51. Carrier Claim Primary Payer Paid Amount</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>52. FILLER</td>
<td>Char 9.2 DIGITS SIGNED</td>
<td>SOURCE: CWF</td>
</tr>
</tbody>
</table>
| 53. Carrier Claim Referring UPIN Number | The unique physician identification number (UPIN) of the physician who referred the beneficiary to the physician who performed the Part B services. | COMMON ALIAS: REFERRING_PHYSICIAN_UPIN  
DB2 ALIAS: CARR_RFRG_UPIN_NUM  
SAS ALIAS: RFR_UPIN  
STANDARD ALIAS: CARR_CLM_RFRG_UPIN_NUM  
TITLE ALIAS: REFERRING_PHYSICIAN_UPIN  
COMMENT: Prior to Version H this field was named: CWFB_CLM_RFRG_UPIN_NUM.  
SOURCE: |
<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Length</th>
<th>Positions</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Claim Referring Physician NPI Number</td>
<td>CHAR</td>
<td>10</td>
<td>247-256</td>
<td>A placeholder field (effective with Version H) for storing the NPI assigned to the referring physician.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>COMMON ALIAS: REFERRING_PHYSICIAN_NPI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: RFRG_PHYSN_NPI_NUM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: RFR_NPI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: CARR_CLM_RFRG_PHYSN_NPI_NUM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TITLE ALIAS: RFRG_PHYSN_NPI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SOURCE: CWF</td>
</tr>
<tr>
<td>Carrier Claim Provider Assignment Indicator Switch</td>
<td>CHAR</td>
<td>1</td>
<td>257-257</td>
<td>A switch indicating whether or not the provider accepts assignment for the noninstitutional claim.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: PRVDR_ASGNMT_SW</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: ASGMNTCD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: CARR_CLM_PRVDR_ASGNMT_IND_SW</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TITLE ALIAS: ASSIGNMENT_SW</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>CODES:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A = Assigned claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N = Non-assigned claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>COMMENT: Prior to Version H this field was named: CWF_CLM_PRVDR_ASGNMT_IND_SW.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SOURCE: CWF</td>
</tr>
<tr>
<td>NCH Claim Provider Payment Amount</td>
<td>PACK</td>
<td>6</td>
<td>258-263</td>
<td>Effective with Version H, the total payments made to the provider for this claim (sum of line item provider payment amounts.)</td>
</tr>
<tr>
<td></td>
<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 zeroes in this field.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9.2 DIGITS SIGNED</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: NCH_PRVDR_PMT_AMT</td>
</tr>
</tbody>
</table>
Effective with Version H, the total payments made to the beneficiary for this claim (sum of line payment amounts to the beneficiary.)

<table>
<thead>
<tr>
<th>POSITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
</tr>
<tr>
<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 zeroes in this field.</td>
</tr>
<tr>
<td>9.2 DIGITS SIGNED</td>
</tr>
<tr>
<td>DB2 ALIAS: NCH_BENE_PMT_AMT</td>
</tr>
<tr>
<td>SAS ALIAS: BENE_PMT</td>
</tr>
<tr>
<td>STANDARD ALIAS: NCH_CLM_BENE_PMT_AMT</td>
</tr>
<tr>
<td>TITLE ALIAS: BENE_PMT</td>
</tr>
<tr>
<td>SOURCE: NCH QA Process</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>POSITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
</tr>
<tr>
<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 zeroes in this field.</td>
</tr>
<tr>
<td>9.2 DIGITS SIGNED</td>
</tr>
<tr>
<td>DB2 ALIAS: CARR_BENE_PD_AMT</td>
</tr>
<tr>
<td>SAS ALIAS: BENEPAYED</td>
</tr>
<tr>
<td>STANDARD ALIAS: CARR_CLM_BENE_PD_AMT</td>
</tr>
<tr>
<td>TITLE ALIAS: BENE_PD_AMT</td>
</tr>
<tr>
<td>SOURCE: CWF</td>
</tr>
</tbody>
</table>

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

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

9.2 DIGITS SIGNED

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

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

SOURCE:
NCH QA Process

<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>
</table>
| 60       | NCH Carrier Claim Allowed Charge Amount | PACK | 6      | 282  | 287  | Effective with Version H, the total allowed charges on the claim (the sum of line item allowed charges).

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

9.2 DIGITS SIGNED

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

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

SOURCE:
NCH QA Process

<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>
</table>
| 61       | Carrier Claim Deductible Applied Amount | PACK | 6      | 288  | 293  | Effective with Version H, the amount of the cash deductible as submitted on the claim.

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

9.2 DIGITS SIGNED

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

SOURCE:
CWF

<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 HCPCS Year Code</td>
<td>NUM</td>
<td>1</td>
<td>294</td>
<td>294</td>
<td></td>
</tr>
</tbody>
</table>

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

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

SOURCE:
CWF

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>Carrier Claim MCO Override Indicator Code</td>
<td>CHAR</td>
<td>1</td>
<td>295</td>
<td>295</td>
<td></td>
</tr>
</tbody>
</table>

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

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

DB2 ALIAS: MCO_OVRRD_IND_CD
SAS ALIAS: MCOOVRRD
STANDARD ALIAS: CARR_CLM_MCO_OVRRD_IND_CD
TITLE ALIAS: MCO OVERRIDE
CODES:
0 = No Investigation
1 = MCO Investigation does not apply to this claim.

SOURCE:
CWF

64. Carrier Claim Hospice Override Indicator Code
CHAR 1 296 296
Effective with Version H, the code used to indicate whether or not an Hospice investigation applies to the claim (used for internal CWFMQA editing purposes).

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

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

CODES:
0 = No Investigation
1 = Hospice investigation shown not applicable to this claim.

SOURCE:
CWF

65. FILLER
CHAR 31 297 327

**** Carrier Specific Group
GROUP 34 328 361
This group identifies those fields specific to the carrier claim record.

STANDARD ALIAS: CARR_SPECFC_GRP

66. Carrier Claim Referring PIN Number
CHAR 14 328 341
Carrier-assigned identification (profiling) number of the physician who referred the 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>
</tr>
</thead>
<tbody>
<tr>
<td>beneficiary to the physician that performed the Part B services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMMON ALIAS: REFERRING_PHYSICIAN_PIN
DB2 ALIAS: CARR_RFRG_PIN_NUM
SAS ALIAS: RFR_PRFL
67. Care Plan Oversight (CPO) Provider Number

| CHAR | 6 | 342 | 347 |

Effective with NCH weekly process date 3/7/97, the Medicare provider number of the HHA or Hospice rendering Medicare covered services during period the physician is providing care plan oversight. 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-DMERC processed carrier claim.

NOTE: On the Version G format, this field is stored as a redefinition of the NEAR_LINE_ORGNL_BENE_CAN_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.

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

| CHAR | 10 | 348 | 357 |

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
<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>69. Claim Blood Pints Furnished</td>
<td>PACK</td>
<td>2</td>
<td>358</td>
<td>359</td>
<td>Number of whole pints of blood furnished to the beneficiary, as reported on the carrier claim (non-DMERC).</td>
</tr>
<tr>
<td>Quantity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 DIGITS SIGNED</td>
</tr>
<tr>
<td>DB2 ALIAS: BLOOD_PT_FRNSH_QTY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: BLDFRNSH</td>
</tr>
<tr>
<td>STANDARD ALIAS: CLM_BLOOD_PT_FRNSH_QTY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TITLE ALIAS: BLOOD_PINTS_FURNISHED</td>
</tr>
<tr>
<td>EDIT-RULES:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NUMERIC</td>
</tr>
<tr>
<td>COMMENT:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prior to Version H this field was stored in a blood trailer. Version H eliminated the blood trailer.</td>
</tr>
<tr>
<td>SOURCE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CWF</td>
</tr>
<tr>
<td>70. Claim Blood Deductible</td>
<td>PACK</td>
<td>2</td>
<td>360</td>
<td>361</td>
<td>The quantity of blood pints applied (blood deductible) as reported on the carrier claim (non-DMERC).</td>
</tr>
<tr>
<td>Pints Quantity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 DIGITS SIGNED</td>
</tr>
<tr>
<td>DB2 ALIAS: BLOOD_DDCTBL_PT</td>
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<td></td>
<td></td>
<td>SAS ALIAS: BLD_DED</td>
</tr>
<tr>
<td>STANDARD ALIAS: CLM_BLOOD_DDCTBL_PT_QTY</td>
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<td></td>
<td></td>
<td></td>
<td>TITLE ALIAS: BLOOD_PINTS_DEDUCTIBLE</td>
</tr>
<tr>
<td>EDIT-RULES:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NUMERIC</td>
</tr>
<tr>
<td>COMMENT:</td>
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<td></td>
<td>Prior to Version H this field was stored in a blood trailer. Version H eliminated the blood trailer.</td>
</tr>
<tr>
<td>SOURCE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CWF</td>
</tr>
<tr>
<td>71. Carrier NCH Edit Code Count</td>
<td>NUM</td>
<td>2</td>
<td>362</td>
<td>363</td>
<td>The count of the number of edit codes annotated to the carrier claim during</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

<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>
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<td>COMMENT:</td>
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<tr>
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<td></td>
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<td>Prior to Version H this field was named:</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>CLM_EDIT_CD_CNT.</td>
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<td>SOURCE:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>NCH</td>
</tr>
</tbody>
</table>

72. Carrier NCH Patch Code Count

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

SOURCE:
NCH

<table>
<thead>
<tr>
<th>POSITION</th>
<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>
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<td>Prior to Version H this field was named:</td>
</tr>
<tr>
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<td>CLM_EDIT_CD_CNT.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NCH</td>
</tr>
</tbody>
</table>

73. Carrier MCO Period Count

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.
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:

```
CARR_CLM_PAYERID_CNT.
```

1 DIGIT UNSIGNED

DB2 ALIAS: CARR_MCO_PRD_CNT
SAS ALIAS: CMCOCNT
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.

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

```
CARR_DEMO_ID_CNT
```

1 DIGIT UNSIGNED

DB2 ALIAS: CARR_MCO_PRD_CNT
SAS ALIAS: CMCOCNT
STANDARD ALIAS: CARR_MCO_PRD_CNT

EDIT-RULES:
RANGE: 0 TO 3

SOURCE:
NCH
**76. Carrier Claim Diagnosis Code Count**

<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Length</th>
<th>Begin</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUM</td>
<td>1</td>
<td>369</td>
<td>369</td>
<td></td>
</tr>
</tbody>
</table>

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

1 DIGIT UNSIGNED

**DB2 ALIAS:** CARR_DGNS_CD_CNT  
**SAS ALIAS:** CDGNCNT  
**STANDARD ALIAS:** CARR_CLM_DGNS_CD_CNT

**EDIT-RULES:**
**RANGE:** 0 TO 4

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

**SOURCE:**
NCH

---

**1**

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

---

**77. Carrier Claim Line Count**

<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Length</th>
<th>Begin</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUM</td>
<td>2</td>
<td>370</td>
<td>371</td>
<td></td>
</tr>
</tbody>
</table>

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:
78. FILLER

** Carrier Claim Variable Group

Group

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

STANDARD ALIAS: CARR_CLM_VAR_GRP

**** NCH Edit Group

Group

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

OCCURS: UP TO 13 TIMES

Source: CWFB CLAIMS

79. NCH Edit Trailer Indicator

Code

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

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

DB2 ALIAS: EDIT_TRLR_IND_CD

SAS ALIAS: EDITIND

STANDARD ALIAS: NCH_EDIT_TRLR_IND_CD

CODES:

E = Edit code trailer present

SOURCE:

NCH QA Process

80. NCH Edit Code

Code

The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.

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

COMMON ALIAS: QA_ERROR_CODE
**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:
<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>83. NCH Patch Applied Date</td>
<td>NUM</td>
<td>8</td>
<td></td>
<td></td>
<td>Effective with Version H, the date the NCH patch was applied to the claim.</td>
</tr>
<tr>
<td>8 DIGITS UNSIGNED</td>
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<td></td>
<td></td>
<td></td>
<td>8 DIGITS UNSIGNED</td>
</tr>
</tbody>
</table>
|                               |       |        |     |     | 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.                                                                                                  |
| Code                          |       |        |     |     | 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_TLR_IND_CD  
|                               |       |        |     |     | SAS ALIAS: MCOIND  
|                               |       |        |     |     | STANDARD ALIAS: NCH_MCO_TLR_IND_CD  
| Refer to: NCH_PATCH_TB        |       |        |     |     | IN THE CODES APPENDIX  
| Source: NCH                  |       |        |     |     |  
|
### 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>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>NOTE:</strong> 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>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: MCO_CNTRCT_NUM</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: MCONUM</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: MCO_CNTRCT_NUM</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>TITLE ALIAS: MCO_NUM</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td>SOURCE: CWF</td>
</tr>
</tbody>
</table>

| 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

<table>
<thead>
<tr>
<th>NAME</th>
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<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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<tr>
<td>SAS ALIAS: MCOEFFDT</td>
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<tr>
<td>STANDARD ALIAS: MCO_PRD_EFCTV_DT</td>
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<td></td>
<td>CWF</td>
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</tr>
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</table>

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

<table>
<thead>
<tr>
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<th>TYPE</th>
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<th>BEG</th>
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</tr>
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<tbody>
<tr>
<td>DB2 ALIAS: MCO_PRD_TRMNTN_DT</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: MCOTRMDT</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td>STANDARD ALIAS: MCO_PRD_TRMNTN_DT</td>
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<td></td>
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<tr>
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<td>SOURCE:</td>
<td></td>
<td>CWF</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

**** Claim Health PlanID Group  GROUP  16

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.

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>90. NCH Health PlanID Trailer Indicator Code</td>
<td>CHAR</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

DB2 ALIAS: PLANID_TRLR_CD
SAS ALIAS: PLANIDIN
STANDARD ALIAS: NCH_HLTH_PLANID_TRLR_IND_CD
CODES:
I = Health PlanID trailer present
### 91. Claim Health PlanID Code

**CHAR** 1

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

**DB2 ALIAS:** CLM_PLANID_CD  
**SAS ALIAS:** PLANIDCD  
**STANDARD ALIAS:** CLM_HLTH_PLANID_CD  
**TITLE ALIAS:** PLANID_TYPE

**CODES:**  
1 = Medicare Secondary Payer  
2 = Medicaid  
3 = Medigap  
4 = Supplemental Insurer  
5 = Managed Care Organization

### 92. Claim Health PlanID Number

**CHAR** 14

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

---

**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>
|      |      |        |     |     | STANDARD ALIAS: CLM_HLTH_PLANID_NUM  
|      |      |        |     |     | TITLE ALIAS: PLANID |

**COMMENT:**  
Prior to Version I this field was named: CLM_PAYERID_NUM.

**SOURCE:**  
CWF
** Claim Demonstration Identification Group

GROUP 18

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

OCCURS: UP TO 5 TIMES
DEPENDING ON CARR_CLM_DEMO_ID_CNT

STANDARD ALIAS: CLM_DEMO_ID_GRP

<table>
<thead>
<tr>
<th>Field Description</th>
<th>Data Type</th>
<th>Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>93. NCH Demonstration Trailer Indicator Code</td>
<td>CHAR</td>
<td>1</td>
</tr>
<tr>
<td>Effective with Version H, the code indicating the presence of a demo trailer.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Field Description</th>
<th>Data Type</th>
<th>Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>94. Claim Demonstration Identification Number</td>
<td>CHAR</td>
<td>2</td>
</tr>
<tr>
<td>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).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

POSITIONS
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

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

<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>
</tr>
<tr>
<td>BEG</td>
</tr>
<tr>
<td>END</td>
</tr>
<tr>
<td>CONTENTS</td>
</tr>
</tbody>
</table>

code = W0; claim MCO paid switch = not ’0’; and MCO contract # = ’90091’.

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

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

NOTE1: Effective for all claim types with NCH weekly process date after 7/31/97 -- CWF adds Demo ID ’05’ to claim based on the presences 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, or 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

1

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

<table>
<thead>
<tr>
<th>POSITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>NIH.</td>
</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

<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>95. Claim Demonstration Information Text</td>
<td>CHAR</td>
<td>15</td>
<td></td>
<td></td>
<td>Effective with Version H, the text field that contains related demo information. For example,</td>
</tr>
</tbody>
</table>
A claim involving a CHOICES demo id ‘05’ would contain the MCO plan contract number in the first five positions of this text field.

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

DB2 ALIAS: CLM_DEMO_INFO_TXT
SAS ALIAS: DEMOTXT
STANDARD ALIAS: CLM_DEMO_INFO_TXT
TITLE ALIAS: DEMO_INFO

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

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

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

Demo ID = 04 (UMWA) -- text field will contain W0 denoting that condition code W0 was present. If condition code W0 not present then the text field will reflect ’INVALID’.

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

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

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

03/16/2001
reflect 'INVALID CHOICES PLAN NUMBER'. When
CHOICES plan number not present, text will re-
fect '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

<table>
<thead>
<tr>
<th>**** Carrier Claim Diagnosis Group</th>
<th>GROUP 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>96. NCH Diagnosis Trailer</td>
<td>CHAR 1</td>
</tr>
<tr>
<td>Indicator Code</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>97. Claim Diagnosis Code</th>
<th>CHAR 5</th>
</tr>
</thead>
</table>

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.

### Position 98: Filler

**Name:** Carrier Line Item Group  
**Type:** CHAR  
**Length:** 1  
**Positions:**  

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**

### Position 99: NCH Line Item Trailer Indicator Code

**Name:** Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001  
**Contents:**

Prior to Version H this field was named: CLM_OTHR_DGNS_CD.

**DB2 ALIAS:** CLM_DGNS_CD  
**SAS ALIAS:** DGNS_CD  
**STANDARD ALIAS:** CLM_DGNS_CD  
**TITLE ALIAS:** DIAGNOSIS

**EDIT-RULES:**

ICD-9-CM

**COMMENT:**

Prior to Version H this field was named: CLM_OTHR_DGNS_CD.

**CODES:**

L = Line Item trailer present  
Blank = No trailer present

**SOURCE:**
100. Carrier Line Performing PIN  CHAR  10  The profiling identification number (PIN) of the
Number physician\supplier who performed the service
for this line item on the carrier claim
(non-DMERC).

COMMON ALIAS: PHYSICIAN/SUPPLIER_PROVIDER_NUM
DB2 ALIAS: LINE_PRFRMG_PIN
SAS ALIAS: PRF_PRFL
STANDARD ALIAS: CARR_LINE_PRFRMG_PIN_NUM
TITLE ALIAS: PRFRMG_PIN

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

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>SOURCE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 101. Carrier Line Performing UPIN Number  CHAR  6  The unique physician identification number
Number (UPIN) of the physician who performed the service
for this line item on the carrier claim (non-DMERC).

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

102. Carrier Line Performing NPI  CHAR  10  A placeholder field (effective with Version H)
Number for storing the NPI assigned to the performing
provider.

COMMON ALIAS: PERFORMING_PROVIDER_NPI
DB2 ALIAS: LINE_PRFRMG_NPI
SAS ALIAS: PRFNPI
STANDARD ALIAS: CARR_LINE_PRFRMG_NPI_NUM
TITLE ALIAS: PRFRMG_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.

<table>
<thead>
<tr>
<th>DB2 ALIAS: PRFRMG_GRP_NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAS ALIAS: PRGRPNPI</td>
</tr>
<tr>
<td>STANDARD ALIAS: CARR_LINE_PRFRMG_GRP_NPI_NUM</td>
</tr>
<tr>
<td>TITLE ALIAS: PRFRMG_GROUP_NPI</td>
</tr>
</tbody>
</table>

SOURCE: CWF

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).

<table>
<thead>
<tr>
<th>DB2 ALIAS: LINE_PRVDR_TYPE_CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAS ALIAS: PRV_TYPE</td>
</tr>
<tr>
<td>STANDARD ALIAS: CARR_LINE_PRVDR_TYPE_CD</td>
</tr>
<tr>
<td>TITLE ALIAS: PRVDR_TYPE</td>
</tr>
</tbody>
</table>

SOURCE: CWF

105. Line Provider Tax Number CHAR 10

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.

<table>
<thead>
<tr>
<th>DB2 ALIAS: LINE_PRVDR_TAX_NUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAS ALIAS: TAX_NUM</td>
</tr>
</tbody>
</table>

SOURCE: CWF
106. Line NCH Provider State Code CHAR 2

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

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

DB2 ALIAS: LINE_PRVDR_STATE
SAS ALIAS: PRVSTATE
STANDARD ALIAS: LINE_NCH_PRVDR_STATE_CD
TITLE ALIAS: PRVDR_STATE

DERIVATION:
DERIVED_FROM:
  CARR_LINE_PRFRMG_PRVDR_ZIP_CD

DERIVATION RULES:

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

CODES: REFER TO: GEO_SSA_STATE_TB

IN THE CODES APPENDIX

1

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

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

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

SOURCE:
NCH

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
108. Line HCFA Provider Specialty Code

CHAR  2
HCFA specialty code used for pricing the line item service on the noninstitutional claim.

SOURCE:
CWF

109. Carrier Line Provider Specialty Code

CHAR  2
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).

SOURCE:
CWF

1
Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001
<table>
<thead>
<tr>
<th>Field</th>
<th>Type</th>
<th>Length</th>
<th>Description</th>
<th>Alias</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Line Provider Participating Indicator Code</strong></td>
<td>CHAR</td>
<td>1</td>
<td>Code indicating whether or not a provider is participating or accepting assignment for this line item service on the noninstitutional claim.</td>
<td>PRVDR_PRTCPTG_CD</td>
</tr>
<tr>
<td><strong>Carrier Line Reduced Payment Physician Assistant Code</strong></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>PHYSN_ASTNT_CD</td>
</tr>
<tr>
<td><strong>Line Service Count</strong></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></td>
</tr>
</tbody>
</table>
### 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>BEGIN</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SAS ALIAS: SRVC_CNT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: LINE_SRVC_CNT</td>
</tr>
<tr>
<td></td>
<td>COMMENT:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prior to Version H this field was named: CWFB_SRVC_CNT.</td>
</tr>
<tr>
<td></td>
<td>SOURCE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CWF</td>
</tr>
</tbody>
</table>

**113. Line HCFA Type Service Code**

<table>
<thead>
<tr>
<th>CHAR</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td></td>
</tr>
</tbody>
</table>

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.

**SOURCE:**
CWF

**114. Carrier Line Type Service Code**

<table>
<thead>
<tr>
<th>CHAR</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td></td>
</tr>
</tbody>
</table>

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).
### 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.

<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>
</table>

**SOURCE:**
CWF

### 116. Carrier Line Pricing Locality Code

**CHAR 2**

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

**SOURCE:**
CWF
Prior to Version H this field was named: CWFB_CARR_PRCNG_LCLTY_CD.

SOURCE: CWF

### 117. Line First Expense Date

<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 First Expense Date</td>
<td>NUM</td>
<td>8</td>
<td></td>
<td></td>
<td>Beginning date (1st expense) for this line item service on the noninstitutional claim.</td>
</tr>
</tbody>
</table>

8 DIGITS UNSIGNED

DB2 ALIAS: LINE_1ST_EXPNS_DT
SAS ALIAS: EXPNSDT1
STANDARD ALIAS: LINE_1ST_EXPNS_DT
TITLE ALIAS: 1ST_EXPNS_DT

EDIT-RULES: YYYYMMDD

COMMENT: Prior to Version H this field was named: CWFB_1ST_EXPNS_DT.

### 118. Line Last Expense Date

<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 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>
</tbody>
</table>

8 DIGITS UNSIGNED

COBOL ALIAS: LST_EXP_DT
DB2 ALIAS: LINE_LAST_EXPNS_DT
SAS ALIAS: EXPNSDT2
STANDARD ALIAS: LINE_LAST_EXPNS_DT
TITLE ALIAS: LAST_EXPNS_DT

EDIT-RULES: YYYYMMDD

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

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

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

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

**Level II**
- Includes codes and descriptors copyrighted by the American Dental Association’s Current Dental Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting...
of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

Level III
Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not represented in the level I or level II codes.

120. Line HCPCS Initial Modifier  CHAR  2
Code
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
Code
A second modifier to the HCPCS procedure code to make it more specific than the first modifier code to identify the line item procedures for this claim.

DB2 ALIAS: HCPCS_2ND_MDFR_CD
SAS ALIAS: MDFR_CD2
STANDARD ALIAS: LINE_HCPCS_2ND_MDFR_CD
TITLE ALIAS: SECOND_MODIFIER

EDIT-RULES:
CARRIER INFORMATION FILE

COMMENT:
Prior to Version H this field was named: HCPCS_2ND_MDFR_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV_CNTR and noninstitutional: LINE).

SOURCE:
CWF

122. Line NCH BETOS Code CHAR 3

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

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

DB2 ALIAS: LINE_NCH_BETOS_CD
SAS ALIAS: BETOS
STANDARD ALIAS: LINE_NCH_BETOS_CD
SYSTEM ALIAS: LTBETOS
TITLE ALIAS: BETOS

DERIVATION:
DERIVED FROM:
   LINE_HCPCS_CD
   LINE_HCPCS_INITL_MDFR_CD
   LINE_HCPCS_2ND_MDFR_CD
   HCPCS MASTER FILE

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

CODES:
   REFER TO: BETOS_TB
   IN THE CODES APPENDIX

SOURCE:
NCH
<table>
<thead>
<tr>
<th>Line</th>
<th>Name</th>
<th>Type</th>
<th>Length</th>
<th>Begin</th>
<th>End</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>123.</td>
<td>Line IDE Number</td>
<td>CHAR</td>
<td>7</td>
<td></td>
<td></td>
<td>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.)</td>
</tr>
</tbody>
</table>
|       |                                         |      |        |       |     | DB2 ALIAS: LINE_IDE_NUM  
SAS ALIAS: LINE_IDE  
STANDARD ALIAS: LINE_IDE_NUM  
TITLE ALIAS: IDE_NUMBER  
SOURCE: CWF |
| 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.                                                                                                                                                                                                 | DB2 ALIAS: LINE_NATL_DRUG_CD  
SAS ALIAS: NDC_CD  
STANDARD ALIAS: LINE_NATL_DRUG_CD  
TITLE ALIAS: NDC_CD  
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.

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

126. Line Beneficiary Payment
Amount

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

127. Line Provider Payment
Amount

Effective with Version H, the payment made to the provider for the line item service on the noninstitutional claim.
### 128. Line Beneficiary Part B Deductible Amount

**TYPE**: PACK  
**LENGTH**: 6

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

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

**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

**TYPE**: CHAR  
**LENGTH**: 1

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

**SOURCE**:  
CWF
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

131. Line Coinsurance Amount  

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

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

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

1 Carrier Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001
COMMENT:
Prior to Version H this field was named: CWFB_INTRST_AMT and the field size was S9(5)V99.

SOURCE:
CWF

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

SOURCE:
CWF

135. Line 10% Penalty Reduction Amount

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

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
<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>137. Line Submitted Charge Amount</td>
<td>PACK</td>
<td>6</td>
<td></td>
<td></td>
<td>The amount of submitted charges for the line item service on the noninstitutional claim. 9.2 DIGITS SIGNED</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: LINE_SBMT_CHRG_AMT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: LSBMTCHG</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: LINE_SBMT_CHRG_AMT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TITLE ALIAS: SBMT_CHRG</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>EDIT-RULES: $$$$$$$$$$$CC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>COMMENT: Prior to Version H this field was named: CWFB_LINE_BLOOD_DDCTBL_QTY.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SOURCE: CWF</td>
</tr>
<tr>
<td><strong>NOTE:</strong> The allowed charge is determined by the lower of three charges: prevailing, customary or actual. 9.2 DIGITS SIGNED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 138. Line Allowed Charge Amount         | PACK | 6      |     |     | The amount of allowed charges for the line item service on the noninstitutional claim. This charge is used to compute pay to providers or reimbursement to beneficiaries. **NOTE:** The allowed charge is determined by the lower of three charges: prevailing, customary or actual. 9.2 DIGITS SIGNED |
|                                          |      |        |     |     | DB2 ALIAS: LINE_ALOW_CHRG_AMT                                            |
|                                          |      |        |     |     | SAS ALIAS: LALOWCHG                                                      |
|                                          |      |        |     |     | STANDARD ALIAS: LINE_ALOW_CHRG_AMT                                       |
### Carrier Line Clinical Lab Number

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Type</th>
<th>Length</th>
<th>Begin</th>
<th>End</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>139</td>
<td>Carrier Line Clinical Lab</td>
<td>CHAR</td>
<td>10</td>
<td>5</td>
<td>14</td>
<td>The identification number assigned to the clinical laboratory providing services for the line item on the carrier claim (non-DMERC).</td>
</tr>
</tbody>
</table>

- **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

### Carrier Line Clinical Lab Charge Amount

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Type</th>
<th>Length</th>
<th>Begin</th>
<th>End</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>140</td>
<td>Carrier Line Clinical Lab</td>
<td>PACK</td>
<td>6</td>
<td>5</td>
<td>10</td>
<td>Fee schedule charge amount applied for the line item clinical laboratory service on the carrier claim (non-DMERC).</td>
</tr>
</tbody>
</table>

- **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: CWFB_CLNCL_LAB_CHRG_AMT and the field size was S9(5)V99.
## 141. Line Processing Indicator

**CHAR** 1

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

**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.

### Positions

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

## 142. Line Payment 80%/100% Code

**CHAR** 1

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

**COMMON ALIAS:** REIMBURSEMENT_IND  
**DB2 ALIAS:** LINE_PMT_80_100_CD  
**SAS ALIAS:** PMTINDSW  
**STANDARD ALIAS:** LINE_PMT_80_100_CD  
**TITLE ALIAS:** REINBURSEMENT_IND

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

**COMMENT:**
Prior to Version H this field was named: CWFB_PMT_80_100_CD.
143. Line Service Deductible Indicator Switch CHAR 1

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 CHAR 1

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

CODES:

SOURCE:
CWF

145. Carrier Line Miles/Time/Units/Services Count PACK 2

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

3 DIGITS SIGNED

DB2 ALIAS: LINE_MTUS_CNT
SAS ALIAS: MTUS_CNT
STANDARD ALIAS: CARR_LINE_MTUS_CNT
TITLE ALIAS: MTUS_CNT

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

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

SOURCE:
CWF

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).

DB2 ALIAS: LINE_MTUS_IND_CD
SAS ALIAS: MTUS_IND
STANDARD ALIAS: CARR_LINE_MTUS_IND_CD
TITLE ALIAS: MTUS_IND

CODES:
0 = Values reported as zero (no allowed activities)
1 = Transportation (ambulance) miles
2 = Anesthesia time units
3 = Services
4 = Oxygen units
5 = Units of blood
6 = Anesthesia base and time units (prior to 1991; from BMAD)
147. Line Diagnosis Code  CHAR  5
The ICD-9-CM code indicating the diagnosis supporting this line item procedure/service on the noninstitutional claim.

DB2 ALIAS: LINE_DGNS_CD
SAS ALIAS: LINEDGNS
STANDARD ALIAS: LINE_DGNS_CD
TITLE ALIAS: DGNS_CD

EDIT-RULES:
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

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>(Effective 9/92 but not stored until 10/93)</td>
<td>0 = No Alert</td>
<td>CHAR</td>
<td>1</td>
<td></td>
<td></td>
<td>(Effective 9/92 but not stored until 10/93)</td>
</tr>
<tr>
<td>0 = No Alert</td>
<td>1 = 77X9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0 = No Alert</td>
</tr>
<tr>
<td>2 = 77XA</td>
<td>3 = 77X5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 = 77X9</td>
</tr>
<tr>
<td>4 = 77X6</td>
<td>5 = 77X7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 = 77XA</td>
</tr>
<tr>
<td>6 = 77X8</td>
<td>7 = 77XB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 = 77X5</td>
</tr>
<tr>
<td></td>
<td>COMMENT:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prior to Version H this field was named:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CWFB_CLIA_ALERT_IND_CD.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>SOURCE:</td>
<td>CWF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**151. Line Additional Claim Code**

- **Name**: Line Additional Claim Document Indication
- **Type**: CHAR
- **Length**: 1
- **BEG**: 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.

**SOURCE**: CWF

**152. Carrier Line DME Coverage Period Start Date**

- **Name**: Carrier Line DME Coverage Period Start Date
- **Type**: NUM
- **Length**: 8
- **BEG**: Effective 5/92 through 6/94, as line item on the carrier claim (non-DMERC), the date durable medical

**SOURCE**: CWF
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

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>STAND</td>
<td>arde ALIAS: CARR_LINE_DME_CVRG_PRD_STRT_DT</td>
<td>----</td>
<td>------</td>
<td>----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>TITLE</td>
<td>ALIAS: DME_CVRG_START_DT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 receivee CMN transaction from CWF.

153. Line DME Purchase Price

Amount

153. Line DME Purchase Price

Amount

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
### Carrier Line DME Medical Necessity Month Count

**Position**
- **NAME**: Carrier Line DME Medical Necessity Month Count
- **PACK**: 2
- **BEG**: 2
- **END**: 4
- **CONTENT**: 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>NAME</th>
<th>POSITION</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DME, prosthetic, orthotic and supply items, immunosuppressive drugs, pen, ESRD and oxygen items referred to as DMEPOS).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

**Aliases**
- **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

---

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

1 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)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B9</td>
<td>Divorced wife (2nd claimant)</td>
</tr>
<tr>
<td>BA</td>
<td>Aged wife (4th claimant)</td>
</tr>
<tr>
<td>BD</td>
<td>Aged wife (5th claimant)</td>
</tr>
<tr>
<td>BG</td>
<td>Aged husband (3rd claimant)</td>
</tr>
<tr>
<td>BH</td>
<td>Aged husband (4th claimant)</td>
</tr>
<tr>
<td>BJ</td>
<td>Aged husband (5th claimant)</td>
</tr>
<tr>
<td>BK</td>
<td>Young wife (4th claimant)</td>
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<tr>
<td>BL</td>
<td>Young wife (5th claimant)</td>
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<td>BN</td>
<td>Divorced wife (3rd claimant)</td>
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<td>BP</td>
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<td>BQ</td>
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<tr>
<td>BR</td>
<td>Divorced husband (1st claimant)</td>
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<tr>
<td>BT</td>
<td>Divorced husband (2nd claimant)</td>
</tr>
<tr>
<td>BW</td>
<td>Young husband (2nd claimant)</td>
</tr>
<tr>
<td>BY</td>
<td>Young husband (1st claimant)</td>
</tr>
<tr>
<td>C1-C9,CA-CZ</td>
<td>Child (includes minor, student or disabled child)</td>
</tr>
<tr>
<td>D</td>
<td>Aged widow, 60 or over (1st claimant)</td>
</tr>
<tr>
<td>D1</td>
<td>Aged widower, age 60 or over (1st claimant)</td>
</tr>
<tr>
<td>D2</td>
<td>Aged widow (2nd claimant)</td>
</tr>
<tr>
<td>D3</td>
<td>Aged widower (2nd claimant)</td>
</tr>
<tr>
<td>D4</td>
<td>Widow (remarried after attainment of age 60) (1st claimant)</td>
</tr>
<tr>
<td>D5</td>
<td>Widower (remarried after attainment of age 60) (1st claimant)</td>
</tr>
<tr>
<td>D6</td>
<td>Surviving divorced wife, age 60 or over (1st claimant)</td>
</tr>
<tr>
<td>D7</td>
<td>Surviving divorced wife (2nd claimant)</td>
</tr>
<tr>
<td>D8</td>
<td>Aged widow (3rd claimant)</td>
</tr>
<tr>
<td>D9</td>
<td>Remarried widow (2nd claimant)</td>
</tr>
<tr>
<td>DA</td>
<td>Remarried widow (3rd claimant)</td>
</tr>
<tr>
<td>DD</td>
<td>Aged widow (4th claimant)</td>
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<tr>
<td>DG</td>
<td>Aged widow (5th claimant)</td>
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<tr>
<td>DH</td>
<td>Aged widower (3rd claimant)</td>
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<tr>
<td>DJ</td>
<td>Aged widower (4th claimant)</td>
</tr>
<tr>
<td>DK</td>
<td>Aged widower (5th claimant)</td>
</tr>
<tr>
<td>DL</td>
<td>Remarried widow (4th claimant)</td>
</tr>
<tr>
<td>DM</td>
<td>Surviving divorced husband (2nd claimant)</td>
</tr>
<tr>
<td>DN</td>
<td>Remarried widow (5th claimant)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>DP</td>
<td>Remarried widower (2nd claimant)</td>
</tr>
<tr>
<td>DQ</td>
<td>Remarried widower (3rd claimant)</td>
</tr>
<tr>
<td>DR</td>
<td>Remarried widower (4th claimant)</td>
</tr>
<tr>
<td>DS</td>
<td>Surviving divorced husband (3rd claimant)</td>
</tr>
<tr>
<td>DT</td>
<td>Remarried widower (5th claimant)</td>
</tr>
<tr>
<td>DV</td>
<td>Surviving divorced wife (3rd claimant)</td>
</tr>
</tbody>
</table>
DW = Surviving divorced wife (4th claimant)
DX = Surviving divorced husband (4th claimant)
DY = Surviving divorced wife (5th claimant)
DZ = Surviving divorced husband (5th claimant)
E = Mother (widow) (1st claimant)
E1 = Surviving divorced mother (1st claimant)
E2 = Mother (widow) (2nd claimant)
E3 = Surviving divorced mother (2nd claimant)
E4 = Father (widower) (1st claimant)
E5 = Surviving divorced father (widower) (1st claimant)
E6 = Father (widower) (2nd claimant)
E7 = Mother (widow) (3rd claimant)
E8 = Mother (widow) (4th claimant)
E9 = Surviving divorced father (widower) (2nd claimant)
EA = Mother (widow) (5th claimant)
EB = Surviving divorced mother (3rd claimant)
EC = Surviving divorced mother (4th claimant)
ED = Surviving divorced mother (5th claimant)
EF = Father (widower) (3rd claimant)
EG = Father (widower) (4th claimant)
EH = Father (widower) (5th claimant)
EJ = Surviving divorced father (3rd claimant)
EK = Surviving divorced father (4th claimant)
EM = Surviving divorced father (5th claimant)
F1 = Father
F2 = Mother
F3 = Stepfather
F4 = Stepmother
F5 = Adopting father
F6 = Adopting mother
F7 = Second alleged father
F8 = Second alleged mother
J1 = Primary prouty entitled to HIB (less than 3 Q.C.) (general fund)
J2 = Primary prouty entitled to HIB (over 2 Q.C.) (RSI trust fund)
J3 = Primary prouty not entitled to HIB (less than 3 Q.C.) (general fund)
J4 = Primary prouty not entitled to HIB
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<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>
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<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>
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<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>
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<tr>
<td>KB</td>
<td>Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)</td>
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<td>Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)</td>
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<td>KD</td>
<td>Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (4th claimant)</td>
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<td>KE</td>
<td>Prouty wife entitled to HIB (over 2 Q.C.) (4th claimant)</td>
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<td>KF</td>
<td>Prouty wife not entitled to HIB (less than 3 Q.C.) (4th claimant)</td>
</tr>
<tr>
<td>KG</td>
<td>Prouty wife not entitled to HIB (over 2 Q.C.) (4th claimant)</td>
</tr>
<tr>
<td>KH</td>
<td>Prouty wife entitled to HIB (less than 3 Q.C.) (5th claimant)</td>
</tr>
<tr>
<td>KJ</td>
<td>Prouty wife entitled to HIB (over 2 Q.C.) (5th claimant)</td>
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<tr>
<td>KL</td>
<td>Prouty wife not entitled to HIB (less than 3 Q.C.) (5th claimant)</td>
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<tr>
<td>KM</td>
<td>Prouty wife not entitled to HIB (over 2 Q.C.) (5th claimant)</td>
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<tr>
<td>M</td>
<td>Uninsured—not qualified for deemed HIB</td>
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<td>Description</td>
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<tr>
<td>M1</td>
<td>Uninsured-qualified but refused HIB</td>
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<tr>
<td>T</td>
<td>Uninsured-entitled to HIB under deemed or renal provisions</td>
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<tr>
<td>TA</td>
<td>MQGE (primary claimant)</td>
</tr>
<tr>
<td>TB</td>
<td>MQGE aged spouse (first claimant)</td>
</tr>
<tr>
<td>TC</td>
<td>MQGE disabled adult child (first claimant)</td>
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<tr>
<td>TD</td>
<td>MQGE aged widow(er) (first claimant)</td>
</tr>
<tr>
<td>TE</td>
<td>MQGE young widow(er) (first claimant)</td>
</tr>
<tr>
<td>TF</td>
<td>MQGE parent (male)</td>
</tr>
<tr>
<td>TG</td>
<td>MQGE aged spouse (second claimant)</td>
</tr>
<tr>
<td>TH</td>
<td>MQGE aged spouse (third claimant)</td>
</tr>
<tr>
<td>TJ</td>
<td>MQGE aged spouse (fourth claimant)</td>
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<tr>
<td>TK</td>
<td>MQGE aged spouse (fifth claimant)</td>
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<tr>
<td>TL</td>
<td>MQGE aged widow(er) (second claimant)</td>
</tr>
<tr>
<td>TM</td>
<td>MQGE aged widow(er) (third claimant)</td>
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<tr>
<td>TN</td>
<td>MQGE aged widow(er) (fourth claimant)</td>
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<tr>
<td>TP</td>
<td>MQGE aged widow(er) (fifth claimant)</td>
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<td>TQ</td>
<td>MQGE parent (female)</td>
</tr>
<tr>
<td>TR</td>
<td>MQGE young widow(er) (second claimant)</td>
</tr>
<tr>
<td>TS</td>
<td>MQGE young widow(er) (third claimant)</td>
</tr>
<tr>
<td>TT</td>
<td>MQGE young widow(er) (fourth claimant)</td>
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<tr>
<td>TU</td>
<td>MQGE young widow(er) (fifth claimant)</td>
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<td>TV</td>
<td>MQGE disabled widow(er) fifth claimant</td>
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<tr>
<td>TW</td>
<td>MQGE disabled widow(er) first claimant</td>
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<tr>
<td>TX</td>
<td>MQGE disabled widow(er) second claimant</td>
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<td>TY</td>
<td>MQGE disabled widow(er) third claimant</td>
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<td>T2</td>
<td>MQGE disabled widow(er) fourth claimant</td>
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<tr>
<td>T2-T9</td>
<td>Disabled child (second to ninth claimant)</td>
</tr>
<tr>
<td>W</td>
<td>Disabled widow, age 50 or over (1st claimant)</td>
</tr>
<tr>
<td>W1</td>
<td>Disabled widower, age 50 or over (1st claimant)</td>
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<td>Disabled widow (2nd claimant)</td>
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<td>W3</td>
<td>Disabled widower (2nd claimant)</td>
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<td>W5</td>
<td>Disabled widower (3rd claimant)</td>
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<td>W6</td>
<td>Disabled surviving divorced wife (1st claimant)</td>
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<td>Disabled widow (4th claimant)</td>
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<td>WB</td>
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<td>WC</td>
<td>Disabled surviving divorced wife (4th claimant)</td>
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<tr>
<td>WF</td>
<td>Disabled widow (5th claimant)</td>
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</tbody>
</table>
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>1</th>
<th>BENE_IDENT_TB</th>
<th>Beneficiary Identification Code (BIC) Table</th>
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<tbody>
<tr>
<td>10</td>
<td>Retirement - employee or annuitant</td>
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<tr>
<td>80</td>
<td>RR pensioner (age or disability)</td>
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<tr>
<td>14</td>
<td>Spouse of RR employee or annuitant (husband or wife)</td>
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<tr>
<td>84</td>
<td>Spouse of RR pensioner</td>
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<tr>
<td>43</td>
<td>Child of RR employee</td>
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</tr>
<tr>
<td>13</td>
<td>Child of RR annuitant</td>
<td></td>
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<tr>
<td>17</td>
<td>Disabled adult child of RR annuitant</td>
<td></td>
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<tr>
<td>46</td>
<td>Widow/widower of RR employee</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Widow/widower of RR annuitant</td>
<td></td>
</tr>
<tr>
<td>86</td>
<td>Widow/widower of RR pensioner</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Widow of employee with a child in her care</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Widow of annuitant with a child in her care</td>
<td></td>
</tr>
<tr>
<td>83</td>
<td>Widow of pensioner with a child in her care</td>
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<tr>
<td>45</td>
<td>Parent of employee</td>
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<tr>
<td>15</td>
<td>Parent of annuitant</td>
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<tr>
<td>85</td>
<td>Parent of pensioner</td>
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<tr>
<td>11</td>
<td>Survivor joint annuitant (reduced benefits taken to insure benefits for surviving spouse)</td>
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<table>
<thead>
<tr>
<th>1</th>
<th>BENE_PRMRY_PYR_TB</th>
<th>Beneficiary Primary Payer Table</th>
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<tr>
<td>A</td>
<td>Working aged bene/spouse with employer group health plan (EGHP)</td>
<td></td>
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</tbody>
</table>
B = End stage renal disease (ESRD) beneficiary in the 18 month coordination period with an employer group health plan
C = Conditional payment by Medicare; future reimbursement expected
D = Automobile no-fault (eff. 4/97; Prior to 3/94, also included any liability insurance)
E = Workers’ compensation
F = Public Health Service or other federal agency (other than Dept. of Veterans Affairs)
G = Working disabled bene (under age 65 with LGHP)
H = Black Lung
I = Dept. of Veterans Affairs
J = Any liability insurance (eff. 3/94 - 3/97)
L = Any liability insurance (eff. 4/97) (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)
M = Override code: EGHP services involved (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)
N = Override code: non-EGHP services involved (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)
BLANK = Medicare is primary payer (not sure of effective date: in use 1/91, if not earlier)
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)
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.)

**BETOS Table**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>M1A</td>
<td>Office visits - new</td>
</tr>
<tr>
<td>M1B</td>
<td>Office visits - established</td>
</tr>
<tr>
<td>M2A</td>
<td>Hospital visit - initial</td>
</tr>
<tr>
<td>M2B</td>
<td>Hospital visit - subsequent</td>
</tr>
<tr>
<td>M2C</td>
<td>Hospital visit - critical care</td>
</tr>
<tr>
<td>M3</td>
<td>Emergency room visit</td>
</tr>
<tr>
<td>M4A</td>
<td>Home visit</td>
</tr>
<tr>
<td>M4B</td>
<td>Nursing home visit</td>
</tr>
<tr>
<td>M5A</td>
<td>Specialist - pathology</td>
</tr>
<tr>
<td>M5B</td>
<td>Specialist - psychiatry</td>
</tr>
<tr>
<td>M5C</td>
<td>Specialist - ophthalmology</td>
</tr>
<tr>
<td>M5D</td>
<td>Specialist - other</td>
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<tr>
<td>M6</td>
<td>Consultations</td>
</tr>
<tr>
<td>P0</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>P1A</td>
<td>Major procedure - breast</td>
</tr>
<tr>
<td>P1B</td>
<td>Major procedure - colectomy</td>
</tr>
<tr>
<td>P1C</td>
<td>Major procedure - cholecystectomy</td>
</tr>
<tr>
<td>P1D</td>
<td>Major procedure - turp</td>
</tr>
<tr>
<td>P1E</td>
<td>Major procedure - hysterctomy</td>
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<tr>
<td>P1F</td>
<td>Major procedure - explor/decompr/excisdisc</td>
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<tr>
<td>P1G</td>
<td>Major procedure - Other</td>
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<tr>
<td>P2A</td>
<td>Major procedure, cardiovascular-CABG</td>
</tr>
<tr>
<td>P2B</td>
<td>Major procedure, cardiovascular-Aneurysm repair</td>
</tr>
<tr>
<td>P2C</td>
<td>Major Procedure, cardiovascular-Thromboendarterectomy</td>
</tr>
<tr>
<td>P2D</td>
<td>Major procedure, cardiovascular-Coronary angioplasty (PTCA)</td>
</tr>
<tr>
<td>P2E</td>
<td>Major procedure, cardiovascular-Pacemaker insertion</td>
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<tr>
<td>P2F</td>
<td>Major procedure, cardiovascular-Other</td>
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<td>P3A</td>
<td>Major procedure, orthopedic - Hip fracture repair</td>
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<tr>
<td>P3B</td>
<td>Major procedure, orthopedic - Hip replacement</td>
</tr>
<tr>
<td>P3C</td>
<td>Major procedure, orthopedic - Knee replacement</td>
</tr>
<tr>
<td>P3D</td>
<td>Major procedure, orthopedic - other</td>
</tr>
</tbody>
</table>
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

1                BETOS_TB
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
| 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/HCFA 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
   Carriers 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.

1CARR_LINE_RDCD_PHYSN_ASTNT_TB

<table>
<thead>
<tr>
<th>Carrier Line Part B Reduced Physician Assistant Table</th>
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<tbody>
<tr>
<td>BLANK = Adjustment situation (where CLM_DISP_CD equal 3)</td>
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<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_NUM_TB

<table>
<thead>
<tr>
<th>Carrier Number Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>00510 = Alabama BS (eff. 1983)</td>
</tr>
<tr>
<td>00511 = Georgia - Alabama BS (eff. 1998)</td>
</tr>
<tr>
<td>00512 = Mississippi - Alabama BS (eff. 2000)</td>
</tr>
</tbody>
</table>
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 - Massachusetts BS (eff. 1983; term. 1997)
00801 = New York - Western BS (eff. 1983)
00803 = New York - Empire BS (eff. 1983)
00805 = New Jersey - Empire BS (eff. 3/99)
00811 = DMERC (A) - Western New York BS (eff. 2000)
00820 = North Dakota - North Dakota BS (eff. 1983)
00824 = Colorado - North Dakota BS (eff. 1995)
00825 = Wyoming - North Dakota BS (eff. 1990)
00826 = Iowa - North Dakota BS (eff. 1999)
00831 = Alaska - North Dakota BS (eff. 1998)
00832 = Arizona - North Dakota BS (eff. 1998)
00833 = Hawaii - North Dakota BS (eff. 1998)
00834 = Nevada - North Dakota BS (eff. 1998)
00835 = Oregon - North Dakota BS (eff. 1998)
00836 = Washington - North Dakota BS (eff. 1998)
00860 = New Jersey - Pennsylvania BS (eff. 1988; term. 1999)
00865 = Pennsylvania BS (eff. 1983)
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<th>CARR_NUM_TB</th>
<th>Carrier Number Table</th>
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<tbody>
<tr>
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<td>Rhode Island BS (eff. 1983)</td>
</tr>
<tr>
<td>00880</td>
<td>South Carolina BS (eff. 1983)</td>
</tr>
<tr>
<td>00882</td>
<td>RRB - South Carolina PGBA (eff. 2000)</td>
</tr>
<tr>
<td>00885</td>
<td>DMERC C - Palmetto (eff. 1993)</td>
</tr>
<tr>
<td>00900</td>
<td>Texas BS (eff. 1983)</td>
</tr>
<tr>
<td>00901</td>
<td>Maryland - Texas BS (eff. 1995)</td>
</tr>
<tr>
<td>00902</td>
<td>Delaware - Texas BS (eff. 1998)</td>
</tr>
<tr>
<td>00903</td>
<td>District of Columbia - Texas BS (eff. 1998)</td>
</tr>
<tr>
<td>00904</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>Hawaii - 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>01390</td>
<td>Washington - AETNA (eff. 1994; term. 1997)</td>
</tr>
<tr>
<td>02050</td>
<td>California - TOLIC (eff. 1983) (term. 2000)</td>
</tr>
<tr>
<td>05130</td>
<td>Idaho - Connecticut General (eff. 1983)</td>
</tr>
<tr>
<td>05320</td>
<td>New Mexico - Equitable Insurance (eff. 1983; term. 1985)</td>
</tr>
<tr>
<td>05440</td>
<td>Tennessee - Connecticut General (eff. 1983)</td>
</tr>
<tr>
<td>05535</td>
<td>North Carolina - Connecticut General (eff. 1988)</td>
</tr>
<tr>
<td>05655</td>
<td>DMERC-D - Connecticut General (eff. 1993)</td>
</tr>
<tr>
<td>10071</td>
<td>Railroad Board Travelers (eff. 1983) (term. 2000)</td>
</tr>
</tbody>
</table>
10555 = Travelers Insurance Co. (eff. 1993)
       (term. 2000)
11260 = Missouri - General American Life
       (eff. 1983; term. 1998)
14330 = New York - GHI (eff. 1983)
16360 = Ohio - Nationwide Insurance Co.
16510 = West Virginia - Nationwide Insurance Co.
21200 = Maine - BS of Massachusetts
31140 = California - National Heritage Ins.
31142 = Maine - National Heritage Ins.
31143 = Massachusetts - National Heritage Ins.
31144 = New Hampshire - National Heritage Ins.
31145 = Vermont - National Heritage Ins.

1 CARR_NUM_TB
-----------
Carrier Number Table

31146 = So. California - NHIC (eff. 2000)

1 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

1 CTGRY_EQTBL_BENE_IDENT_TB
-------------------------
Category Equatable Beneficiary Identification Code (BIC) Table

NCH BIC                  SSA Categories
-------                  --------------
A = A;J1;J2;J3;J4;M;M1;T;TA
B = B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6;
   TB(F);TD(F);TE(F);TW(F)
B1 = B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M)
   TD(M);TE(M);TW(M)
B3 = B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2
   W7;TG(F);TL(F);TR(F);TX(F)
B4 = B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG(M)
   TL(M);TR(M);TX(M)
B8 = B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4
<table>
<thead>
<tr>
<th>RRB Categories</th>
<th>GEO_SSA_STATE_TB</th>
<th>State Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 = 10</td>
<td>01 = Alabama</td>
<td>------------------------------</td>
</tr>
<tr>
<td>11 = 11</td>
<td>02 = Alaska</td>
<td>------------------------------</td>
</tr>
<tr>
<td>13 = 13;17</td>
<td>03 = Arizona</td>
<td>------------------------------</td>
</tr>
<tr>
<td>14 = 14;16</td>
<td>04 = Arkansas</td>
<td>------------------------------</td>
</tr>
<tr>
<td>15 = 15</td>
<td></td>
<td>------------------------------</td>
</tr>
<tr>
<td>43 = 43</td>
<td></td>
<td>------------------------------</td>
</tr>
<tr>
<td>45 = 45</td>
<td></td>
<td>------------------------------</td>
</tr>
<tr>
<td>46 = 46</td>
<td></td>
<td>------------------------------</td>
</tr>
<tr>
<td>80 = 80</td>
<td></td>
<td>------------------------------</td>
</tr>
<tr>
<td>83 = 83</td>
<td></td>
<td>------------------------------</td>
</tr>
<tr>
<td>84 = 84;86</td>
<td></td>
<td>------------------------------</td>
</tr>
<tr>
<td>85 = 85</td>
<td></td>
<td>------------------------------</td>
</tr>
</tbody>
</table>
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = Asia
56 = Canada & Islands
57 = Central America and West Indies

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

58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = U.S. Possessions
64 = American Samoa
65 = Guam
66 = Saipan
97 = Northern Marianas
98 = Guam
99 = With 000 county code is American Samoa; otherwise unknown

1 HCFA_PRVDR_SPCLTY_TB
--------------------
HCFA Provider Specialty Table

**Prior to 5/92**

01 = General practice
02 = General surgery
03 = Allergy (revised 10/91 to mean allergy/immunology)
04 = Otology, laryngology, rhinology revised 10/91 to mean otolaryngology
05 = Anesthesiology
06 = Cardiovascular disease (revised 10/91 to mean cardiology)
07 = Dermatology
08 = Family practice
09 = Gynecology—osteopaths only (deleted 10/91; changed to '16')
10 = Gastroenterology
11 = Internal medicine
12 = Manipulative therapy (osteopaths only) (revised 10/91 to mean osteopathic manipulative therapy)
13 = Neurology
14 = Neurological surgery (revised 10/91 to mean neurosurgery)
15 = Obstetrics—osteopaths only (deleted 10/91; changed to '16')
16 = OB-gynecology
17 = Ophthalmology, otology, laryngology rhinology—osteopaths only (deleted
<table>
<thead>
<tr>
<th>Code</th>
<th>Specialty Description</th>
</tr>
</thead>
<tbody>
<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 (deleted 10/91; changed to '22')</td>
</tr>
<tr>
<td>22</td>
<td>Pathology</td>
</tr>
<tr>
<td>23</td>
<td>Peripheral vascular disease or surgery (deleted 10/91; changed to '76')</td>
</tr>
<tr>
<td>24</td>
<td>Plastic surgery (revised to mean 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) (deleted 10/91; changed to '86')</td>
</tr>
<tr>
<td>28</td>
<td>Proctology (revised 10/91 to mean colorectal surgery).</td>
</tr>
<tr>
<td>29</td>
<td>Pulmonary disease</td>
</tr>
<tr>
<td>30</td>
<td>Radiology (revised 10/91 to mean diagnostic radiology)</td>
</tr>
<tr>
<td>31</td>
<td>Roentgenology, radiology (osteopaths) (deleted 10/91; changed to '30')</td>
</tr>
<tr>
<td>32</td>
<td>Radiation therapy—osteopaths (deleted 10/91; changed to '92')</td>
</tr>
<tr>
<td>33</td>
<td>Thoracic surgery</td>
</tr>
<tr>
<td>34</td>
<td>Urology</td>
</tr>
<tr>
<td>35</td>
<td>Chiropractor, licensed (revised 10/91 to mean chiropractic)</td>
</tr>
<tr>
<td>36</td>
<td>Nuclear medicine</td>
</tr>
<tr>
<td>37</td>
<td>Pediatrics (revised 10/91 to mean pediatric medicine)</td>
</tr>
<tr>
<td>38</td>
<td>Geriatrics (revised 10/91 to mean geriatric medicine)</td>
</tr>
<tr>
<td>39</td>
<td>Nephrology</td>
</tr>
<tr>
<td>40</td>
<td>Hand surgery</td>
</tr>
<tr>
<td>41</td>
<td>Optometrist — services related to condition of aphakia (revised 10/91 to mean optometrist)</td>
</tr>
<tr>
<td>42</td>
<td>Certified nurse midwife (added 7/88)</td>
</tr>
<tr>
<td>43</td>
<td>Certified registered nurse anesthetist (revised 10/91 to mean CRNA, anesthesia assistant)</td>
</tr>
</tbody>
</table>
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).
53 = Medical supply company with C.P.O. certification (certified prosthetist - orthotist - certified by American Board for Certification in Prosthetics and Orthotics).
54 = Medical supply company not included in 51, 52, or 53.
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist - orthotist
58 = Individuals not included in 55, 56 or 57
59 = Ambulance service supplier (e.g. private ambulance companies, funeral homes, etc.)
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities)
62 = Psychologist--billing independently
63 = Portable X-ray supplier--billing independently (revised 10/91 to mean portable X-ray supplier)
64 = Audiologist (billing independently)
65 = Physical therapist (independent practice)
66 = Rheumatology (added 10/91)
67 = Occupational therapist--independent practice
68 = Clinical psychologist
69 = Independent laboratory--billing independently (revised 10/91 to mean independent clinical laboratory -- billing independently)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<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>
<tr>
<td>72</td>
<td>Group Practice Prepayment Plan - diagnostic laboratory (do not use after 1/92)</td>
</tr>
<tr>
<td>73</td>
<td>Group Practice Prepayment Plan - physiotherapy (do not use after 1/92)</td>
</tr>
<tr>
<td>74</td>
<td>Group Practice Prepayment Plan - occupational therapy (do not use after 1/92)</td>
</tr>
<tr>
<td>75</td>
<td>Group Practice Prepayment Plan - other medical care (do not use after 1/92)</td>
</tr>
<tr>
<td>76</td>
<td>Peripheral vascular disease (added 10/91)</td>
</tr>
<tr>
<td>77</td>
<td>Vascular surgery (added 10/91)</td>
</tr>
<tr>
<td>78</td>
<td>Cardiac surgery (added 10/91)</td>
</tr>
<tr>
<td>79</td>
<td>Addiction medicine (added 10/91)</td>
</tr>
<tr>
<td>80</td>
<td>Clinical social worker (1991)</td>
</tr>
<tr>
<td>81</td>
<td>Critical care-intensivists (added 10/91)</td>
</tr>
<tr>
<td>82</td>
<td>Ophthalmology, cataracts specialty (added 10/91; used only until 5/92)</td>
</tr>
<tr>
<td>83</td>
<td>Hematology/oncology (added 10/91)</td>
</tr>
<tr>
<td>84</td>
<td>Preventive medicine (added 10/91)</td>
</tr>
<tr>
<td>85</td>
<td>Maxillofacial surgery (added 10/91)</td>
</tr>
<tr>
<td>86</td>
<td>Neuropsychiatry (added 10/91)</td>
</tr>
<tr>
<td>87</td>
<td>All other (e.g. drug and department stores) (revised 10/91 to mean all other suppliers)</td>
</tr>
<tr>
<td>88</td>
<td>Unknown (revised 10/91 to mean physician assistant)</td>
</tr>
<tr>
<td>90</td>
<td>Medical oncology (added 10/91)</td>
</tr>
<tr>
<td>91</td>
<td>Surgical oncology (added 10/91)</td>
</tr>
<tr>
<td>92</td>
<td>Radiation oncology (added 10/91)</td>
</tr>
<tr>
<td>93</td>
<td>Emergency medicine (added 10/91)</td>
</tr>
<tr>
<td>94</td>
<td>Interventional radiology (added 10/91)</td>
</tr>
<tr>
<td>95</td>
<td>Independent physiological laboratory (added 10/91)</td>
</tr>
<tr>
<td>96</td>
<td>Unknown physician specialty (added 10/91)</td>
</tr>
<tr>
<td>99</td>
<td>Unknown--incl. social worker’s psychiatric services (revised 10/91 to mean unknown supplier/provider)</td>
</tr>
</tbody>
</table>

**Effective 5/92**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Carrier wide</td>
</tr>
<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>
</tbody>
</table>

**HCFA Provider Specialty Table**
<table>
<thead>
<tr>
<th>Code</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<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) (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) (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) (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) (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) (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 proctology)</td>
</tr>
<tr>
<td>29</td>
<td>Pulmonary disease</td>
</tr>
<tr>
<td>30</td>
<td>Diagnostic radiology</td>
</tr>
<tr>
<td>31</td>
<td>Roentgenology, radiology (osteopaths only) (discontinued 5/92 use code 30)</td>
</tr>
<tr>
<td>32</td>
<td>Radiation therapy (osteopaths only) (discontinued 5/92 use code 92)</td>
</tr>
<tr>
<td>33</td>
<td>Thoracic surgery</td>
</tr>
<tr>
<td>34</td>
<td>Urology</td>
</tr>
<tr>
<td>35</td>
<td>Chiropractic</td>
</tr>
<tr>
<td>36</td>
<td>Nuclear medicine</td>
</tr>
<tr>
<td>37</td>
<td>Pediatric medicine</td>
</tr>
<tr>
<td>38</td>
<td>Geriatric medicine</td>
</tr>
<tr>
<td>39</td>
<td>Nephrology</td>
</tr>
<tr>
<td>40</td>
<td>Hand surgery</td>
</tr>
</tbody>
</table>
1 HCFA_PRVDR_SPCLTY_TB

HCFA Provider Specialty Table

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)
96 = Optician (eff 10/93)
97 = Physician assistant (eff 5/92)
98 = Gynecologist/oncologist (eff 10/94)
99 = Unknown physician specialty
A0 = Hospital (eff 10/93) (DMERCs only)
A1 = SNF (eff 10/93) (DMERCs only)
A2 = Intermediate care nursing facility (eff 10/93) (DMERCs only)
A3 = Nursing facility, other (eff 10/93) (DMERCs only)
A4 = HHA (eff 10/93) (DMERCs only)
A5 = Pharmacy (eff 10/93) (DMERCs only)
A6 = Medical supply company with respiratory therapist (eff 10/93) (DMERCs only)
A7 = Department store (for DMERC use: eff 10/94, but cross-walked from code 87 eff 10/93)
A8 = Grocery store (for DMERC use: eff 10/94, but cross-walked from code 88 eff 10/93)

HCFA_PRVDR_SPCLTY_TB
------------------------
HCFA Provider Specialty Table
------------------------

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

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
**Prior To 1/92**

1 = Office  
2 = Home  
3 = Inpatient hospital  
4 = SNF  
5 = Outpatient hospital  
6 = Independent lab  
7 = Other  
8 = Independent kidney disease treatment center  
9 = Ambulatory  
A = Ambulance service  
H = Hospice  
M = Mental health, rural mental health  
N = Nursing home  
R = Rural codes

**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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>56</td>
<td>Psychiatric residential treatment center</td>
</tr>
<tr>
<td>60</td>
<td>Mass immunizations center (eff. 9/1/97)</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive inpatient rehabilitation facility</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive outpatient rehabilitation facility</td>
</tr>
<tr>
<td>65</td>
<td>End stage renal disease treatment facility</td>
</tr>
<tr>
<td>71</td>
<td>State or local public health clinic</td>
</tr>
<tr>
<td>72</td>
<td>Rural health clinic</td>
</tr>
<tr>
<td>81</td>
<td>Independent laboratory</td>
</tr>
</tbody>
</table>

99 = Other unlisted facility

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Actual charge</td>
</tr>
<tr>
<td>2</td>
<td>Customary charge</td>
</tr>
<tr>
<td>3</td>
<td>Prevailing charge (adjusted, unadjusted gap fill, etc)</td>
</tr>
<tr>
<td>4</td>
<td>Other (ASC fees, radiology and outpatient limits, and non-payment because of denial.</td>
</tr>
<tr>
<td>5</td>
<td>Lab fee schedule</td>
</tr>
<tr>
<td>6</td>
<td>Physician fee schedule - full fee schedule amount</td>
</tr>
<tr>
<td>7</td>
<td>Physician fee schedule - transition</td>
</tr>
<tr>
<td>8</td>
<td>Clinical psychologist fee schedule</td>
</tr>
<tr>
<td>9</td>
<td>DME and prosthetics/orthotics fee schedules (eff. 4/97)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>Allowed</td>
</tr>
<tr>
<td>B</td>
<td>Benefits exhausted</td>
</tr>
<tr>
<td>C</td>
<td>Noncovered care</td>
</tr>
<tr>
<td>D</td>
<td>Denied (existed prior to 1991; from BMAD)</td>
</tr>
<tr>
<td>I</td>
<td>Invalid data</td>
</tr>
<tr>
<td>L</td>
<td>CLIA (eff 9/92)</td>
</tr>
<tr>
<td>M</td>
<td>Multiple submittal--duplicate line item</td>
</tr>
<tr>
<td>N</td>
<td>Medically unnecessary</td>
</tr>
<tr>
<td>O</td>
<td>Other</td>
</tr>
<tr>
<td>P</td>
<td>Physician ownership denial (eff 3/92)</td>
</tr>
</tbody>
</table>
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)

1 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.

1 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
NCH_EDIT_TB

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,DG1=7611,DG<>103,163,1589
A1X3 = (C) DT>96365,DIAG=V725
A1X4 = (C) INVALID DIAGNOSTIC CODES
C050 = (U) HOSPICE - SPELL VALUE INVALID
D102 = (C) DME DATE OF BIRTH INVALID
D2X2 = (C) DME SCREEN SAVINGS INVALID
D2X3 = (C) DME SCREEN RESULT INVALID
D2X4 = (C) DME DECISION IND INVALID
D2X5 = (C) DME WAIVER OF PROV LIAB INVALID
D3X1 = (C) DME NATIONAL DRUG CODE INVALID
D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID
D4X2 = (C) DME OUT OF DMERC SERVICE AREA
D4X3 = (C) DME STATE CODE INVALID
D5X1 = (C) TOS INVALID FOR DME HCPCS
D5X2 = (C) DME HCPCS NOC & NOC DESCRIPT 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
XXX = (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
<table>
<thead>
<tr>
<th>CODE</th>
<th>MESSAGE</th>
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</thead>
<tbody>
<tr>
<td>Y011</td>
<td>(C) INF CLAIM/REIM &gt; $75,000</td>
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<tr>
<td>2001</td>
<td>(C) RVNU 820-859 REQ COND CODE 71-76</td>
</tr>
<tr>
<td>2002</td>
<td>(C) CC M2 PRESENT/REIMB &gt; $150,000</td>
</tr>
<tr>
<td>2003</td>
<td>(C) CC M2 PRESENT/UNITS &gt; 150</td>
</tr>
<tr>
<td>2004</td>
<td>(C) CC M2 PRESENT/UNITS &amp; REIM &lt; MAX</td>
</tr>
<tr>
<td>2005</td>
<td>(C) REIMB&gt;99999 AND REIMB&lt;150000</td>
</tr>
<tr>
<td>2006</td>
<td>(C) UNITS&gt;99 AND UNITS&lt;150</td>
</tr>
<tr>
<td>2237</td>
<td>(E) HOSPICE OVERLAP - DATE ZERO</td>
</tr>
<tr>
<td>0011</td>
<td>(C) ACTION CODE INVALID</td>
</tr>
<tr>
<td>0013</td>
<td>(C) CABG/PCOE AND INVALID ADMIT DATE</td>
</tr>
<tr>
<td>0014</td>
<td>(C) DEMO NUM NOT=01-06,08,15,31</td>
</tr>
<tr>
<td>0015</td>
<td>(C) ESRD PLAN BUT DEMO ID NOT = 15</td>
</tr>
<tr>
<td>0016</td>
<td>(C) INVALID VA CLAIM</td>
</tr>
<tr>
<td>0017</td>
<td>(C) DEMO=31,TOB&lt;&gt;11 OR SPEC&lt;&gt;08</td>
</tr>
<tr>
<td>0018</td>
<td>(C) DEMO=31,ACT CD&lt;&gt;1/5 OR ENT CD&lt;&gt;1/5</td>
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<tr>
<td>0020</td>
<td>(C) CANCEL ONLY CODE INVALID</td>
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<tr>
<td>0021</td>
<td>(C) DEMO COUNT &gt; 1</td>
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<tr>
<td>0301</td>
<td>(C) INVALID HI CLAIM NUMBER</td>
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<tr>
<td>0302</td>
<td>(C) BENE IDEN CDE (BIC) INVAL OR BLK</td>
</tr>
<tr>
<td>04A1</td>
<td>(C) PATIENT SURNAME BLANK (PHYS/SUP)</td>
</tr>
<tr>
<td>04B1</td>
<td>(C) PATIENT 1ST INITIAL NOT-ALPHABETIC</td>
</tr>
<tr>
<td>0401</td>
<td>(C) BILL TYPE/PROVIDER INVALID</td>
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<tr>
<td>0402</td>
<td>(C) BILL TYPE/REV CODE/PROVR RANGE</td>
</tr>
<tr>
<td>0406</td>
<td>(C) MAMMOGRAPHY WITH NO HCPCS 76092</td>
</tr>
<tr>
<td>0407</td>
<td>(C) RESPITE CARE BILL TYPE 34X,NO REV 66</td>
</tr>
<tr>
<td>0408</td>
<td>(C) REV CODE 403 /TYPE 71X/ PROV3800-974</td>
</tr>
<tr>
<td>0410</td>
<td>(C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636</td>
</tr>
<tr>
<td>0412</td>
<td>(C) BILL TYPE XX5 HAS ACCOM. REV. CODES</td>
</tr>
<tr>
<td>0413</td>
<td>(C) CABG/PCOE BUT TOB = HHA,OUT,HOS</td>
</tr>
<tr>
<td>0414</td>
<td>(C) VALU CD 61,MSA AMOUNT MISSING</td>
</tr>
<tr>
<td>0415</td>
<td>(C) HOME HEALTH INCORRECT ALPHA RIC</td>
</tr>
<tr>
<td>05X4</td>
<td>(C) UPIN REQUIRED FOR TYPE-OF-SERVICE</td>
</tr>
<tr>
<td>05X5</td>
<td>(C) UPIN REQUIRED FOR DME HCPCS</td>
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<tr>
<td>0501</td>
<td>(C) UNIQUE PHY IDEN. (UPIN) BLANK</td>
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<tr>
<td>0502</td>
<td>(C) UNIQUE PHY IDEN. (UPIN) INVALID</td>
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<tr>
<td>0601</td>
<td>(C) GENDER INVALID</td>
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<td>0701</td>
<td>(C) CONTRACTOR INVALID CARRIER/ETC</td>
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<td>0702</td>
<td>(C) PROVIDER NUMBER INCONSISTANT</td>
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<td>0703</td>
<td>(C) MAMMOGRAPHY FOR NOT FEMALE</td>
</tr>
<tr>
<td>0704</td>
<td>(C) INVALID CONT FOR CABG DEMO</td>
</tr>
<tr>
<td>0705</td>
<td>(C) INVALID CONT FOR PCOE DEMO</td>
</tr>
<tr>
<td>0901</td>
<td>(C) INVALID DISP CODE OF 02</td>
</tr>
<tr>
<td>0902</td>
<td>(C) INVALID DISP CODE OF SPACES</td>
</tr>
<tr>
<td>0903</td>
<td>(C) INVALID DISP CODE</td>
</tr>
<tr>
<td>1001</td>
<td>(C) PROF REVIEW/ACT CODE/BILL TYPE</td>
</tr>
<tr>
<td>13X2</td>
<td>(C) MULTIPLE ITEMS FOR SAME SERVICE</td>
</tr>
<tr>
<td>1301</td>
<td>(C) LINE COUNT NOT NUMERIC OR &gt; 13</td>
</tr>
<tr>
<td>1302</td>
<td>(C) RECORD LENGTH INVALID</td>
</tr>
</tbody>
</table>
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 > ACCOMODATION
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 TABLE

2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
2401 = (C) NON-UTIL DAYS INVALID
2501 = (C) CLAIM RCV DT OR COINSURANCE INVALID
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)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>28XF</td>
<td>ACE DATE ON SNF (NOPAY = B, C, N, W)</td>
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<tr>
<td>28XG</td>
<td>SPAN CD 70+4+6+9 NOT = NONUTIL DAYS</td>
</tr>
<tr>
<td>28XM</td>
<td>OCC CD 42 DATE NOT = SRVCE THRU DTE</td>
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<tr>
<td>28XN</td>
<td>INVALID OCC CODE</td>
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<tr>
<td>28X0</td>
<td>BENE EXH DATE OUTSIDE SERVICE DATES</td>
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<td>OCCUR DATE INVALID</td>
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<tr>
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<td>OCCUR = 20 AND TRANS = 4</td>
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<tr>
<td>28X3</td>
<td>OCCUR 20 DATE &lt; ADMIT DATE</td>
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<tr>
<td>28X4</td>
<td>OCCUR 20 DATE &gt; ADMIT + 12</td>
</tr>
<tr>
<td>28X5</td>
<td>OCCUR 20 AND ADMIT NOT = FROM</td>
</tr>
<tr>
<td>28X6</td>
<td>OCCUR 20 DATE &lt; BENE EXH DATE</td>
</tr>
<tr>
<td>28X7</td>
<td>OCCUR 20 DATE+UTIL-COIN&gt;COVERAGE</td>
</tr>
<tr>
<td>28X8</td>
<td>OCCUR 22 DATE &lt; FROM OR &gt; THRU</td>
</tr>
<tr>
<td>28X9</td>
<td>UTIL &gt; FROM - THRU LESS NCOV</td>
</tr>
<tr>
<td>33X1</td>
<td>QUAL STAY DATES INVALID (SPAN=70)</td>
</tr>
<tr>
<td>33X2</td>
<td>QS FROM DATE NOT &lt; THRU (SPAN=70)</td>
</tr>
<tr>
<td>33X3</td>
<td>QS DAYS/ADMISSION ARE INVALID</td>
</tr>
<tr>
<td>33X4</td>
<td>QS THRU DATE &gt; ADMIT DATE (SPAN=70)</td>
</tr>
<tr>
<td>33X5</td>
<td>SPAN 70 INVALID FOR DATE OF SERVICE</td>
</tr>
<tr>
<td>33X6</td>
<td>TOB=18/21/28/51,COND=WO,HMO&lt;&gt;90091</td>
</tr>
<tr>
<td>33X7</td>
<td>TOB&lt;&gt;18/21/28/51,COND=WO,ADM DT&lt;97001</td>
</tr>
<tr>
<td>33X8</td>
<td>TOB=32X SPAN 70 OR OCCR BO PRESENT</td>
</tr>
<tr>
<td>34X1</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>
</tbody>
</table>

1 NCH_EDIT_TB

NCH EDIT TABLE

4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
4201 = (C) BLOOD PINTS UNREPLACED INVALID
4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED
4203 = (C) INVALID CPO PROVIDER NUMBER
4301 = (C) BLOOD DEDUCTABLE INVALID
4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
4304 = (C) BLOOD DEDUCT > 3 - REPLACED
4501 = (C) PRIMARY DIAGNOSIS INVALID
46XA = (C) MSP VET AND VET AT MEDICARE
46XB = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
46XC = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
46XG = (C) VALU CODE 20 INVALID
46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSNG
46XP = (C) BLD UNREP VS REV CDS AND/OR UNITS
46XQ = (C) VALUE CDE 37=39 AND 38 IS PRESENT
46XN = (C) VALUE CODE 37,38,39 INVALID
46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSNG
46XR = (C) BLD FIELDS VS REV CDE 380,381,382
46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT
46XT = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
4601 = (C) CABG/PCOE, MSP CODE PRESENT
4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
4601 = (C) PCOE/CABG,DEN CD NOT D
4602 = (C) PCOE/CABG BUT DME
50X1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
50X2 = (C) REV CD=054X,MOD NOT = QM,QN
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 HEMOPHILL1A
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) TOB 21X/P82=2/3/4,REV CD = NNX
51XL = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83
51XM = (C) 21X,RC>9041/<9042,RC<>4/234
51XN = (C) 21X,RC>9032/<9042,RC<>4/234
51XP = (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
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          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 CHRGE
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
51X7 = (C) REV CDE 403 WITH 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 OCCUR 27 DISCREPANCY
5200 = (E) ENTITLEMENT EFFECTIVE DATE
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
5202 = (U) HOSPICE TRAILER ERROR
5203 = (E) ENTITLEMENT HOSPICE PERIODS
5203 = (U) HOSPICE START DATE ERROR
5204 = (U) HOSPICE DATE DIFFERENCE NE 90
5205 = (U) HOSPICE DATE DISCREPANCY
5206 = (U) HOSPICE DATE DISCREPANCY
5207 = (U) HOSPICE THRU > TERM DATE 2ND
5208 = (U) HOSPICE PERIOD NUMBER BLANK
5209 = (U) HOSPICE DATE DISCREPANCY
5210 = (E) ENTITLEMENT FROM/TRU/END DATES
5211 = (E) ENTITLEMENT DEATH/THRU
5212 = (E) ENTITLEMENT DEATH/THRU
5213 = (E) ENTITLEMENT DEATH MBR
5220 = (E) ENTITLEMENT FROM/EFF DATES
5225 = (E) ENT 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
5252 = (E) HMO/HOSP 6/7 NO OVD NO DEMO
5250 = (U) HOSPICE DOEBA/DOLBA
5255 = (U) HOSPICE DAYS USED
5256 = (U) HOSPICE DAYS USED > 999
526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0
526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0
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
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NCH EDIT TABLE
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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) INFAT 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
5623 = (U) NON-PAY CODE IS P
57X1 = (C) PROVIDER SPECIALITY CODE INVALID
57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL
57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND
57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID
5700 = (U) LINKED TO THREE SPELLS
5701 = (C) DEMO ID=02,RIC NOT = 5
5702 = (C) DEMO ID=02,INVALID PROVIDER NUM
58X1 = (C) PROVIDER TYPE INVALID
58X9 = (C) TYPE OF SERVICE INVALID
5802 = (C) REIMB > $150,000
5803 = (C) UNITS/VISITS > 150
5804 = (C) UNITS/VISITS > 99
59XA = (C) PROST ORTH HCPCS/FROM DATE
59XB = (C) HCPCS/FROM DATE/TYPE P OR I
59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE
66?? = (D) POSS DUPE, CR/DB, DOC-ID
66XX = (D) POSS DUPE, CR/DB, DOC-ID
66X1 = (C) UNITS AMOUNT INVALID
66X2 = (C) UNITS IND > 0; AMT NOT VALID
66X3 = (C) UNITS IND = 0; AMT > 0
66X4 = (C) MT INDICATOR/AMOUNT
6600 = (U) ADJUSTMENT BILL FULL DAYS
6610 = (U) ADJUSTMENT BILL COIN DAYS
6620 = (U) ADJUSTMENT BILL LIFE RESERVE
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
67X1 = (C) UNITS INDICATOR INVALID
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0
67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS
68X1 = (C) INVALID HCPCS CODE
68X2 = (C) MAMMOGRAPY/DAT/PROC NOT 76092
68X3 = (C) TYPE OF SERVICE = G /PROC CODE
68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE
68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC
68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC
68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.
68X8 = (C) LINE ITEM INCORRECT OR DATE INVAL.

1 NCH_EDIT_TB
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69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
69X3 = (C) PROC CODE MOD = LL / TYPE = R
69X6 = (C) PROC CODE MOD/NOT CAPPED
69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL
6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO
6902 = (C) KRON IND AND NO-PAY CODE B OR N
6903 = (C) KRON IND AND INPATIENT DEDUCT = 0
6904 = (C) KRON IND AND TRANS CODE IS 4
6910 = (C) REV CODES ON HOME HEALTH
6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY
6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO
6913 = (C) REV CODE INVAL FOR OXYGEN
6914 = (C) REV CODE INVAL FOR DME
6915 = (C) PURCHASE OF RENT DME INVAL ON DATES
6916 = (C) PURCHASE OF RENT DME INVAL ON DATES
6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000
6918 = (C) HCPCS INVALID ON DATE RANGES
6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89
6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33
6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X
6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274
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 = (C) POSS DUPE, DOC-ID,UNITS,ENT,ALWD
9000 = (U) DOEBA/DOLBA CALC
9005 = (U) FULL/COINS HOSP DAYS CALC
9010 = (U) FULL/COINS SNF DAYS CALC
9015 = (U) LIFE RESERVE DAYS CALC
9020 = (U) LIFE PSYCH DAYS CALC
9030 = (U) INPAT DEDUCTABLE CALC
9040 = (U) DATA INDICATOR 1 SET
9050 = (U) DATA INDICATOR 2 SET
91X1 = (C) PATIENT REIMB/PAY-DENY CODE
92X1 = (C) PATIENT REIMB INVALID
92X2 = (C) PROVIDER REIMB INVALID
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB
92X4 = (C) MSF CODE/AMT/DATE/ALLOWED CHARGES
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
92X7 = (C) REIMB/PAY-DENY INCONSISTANT
9201 = (C) UPIN REF NAME OR INITIAL MISSING
9202 = (C) UPIN REF FIRST 3 CHAR INVALID
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
93X1 = (C) CASH DEDUCTABLE INVALID
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
93X4 = (C) FROM DATE/CASH DEDUCTIBLE
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
9300 = (C) UPIN OTHER, NOT PRESENT
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
94A1 = (C) NON-COVERED FROM DATE INVALID
94A2 = (C) NON-COVERED FROM > THRU DATE
94A3 = (C) NON-COVERED THRU DATE INVALID
94A4 = (C) NON-COVERED THRU DATE > ADMIT
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
94C1 = (C) PR-PSYCH DAYS INVALID
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
94F1 = (C) REIMBURSEMENT AMOUNT INVALID
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
94G1 = (C) NO-PAY CODE INVALID
94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
94G4 = (C) NO PAY CODE = R & REIMB PRESENT
94X1 = (C) BLOOD LIMIT INVALID
94X2 = (C) TYPE/BLOOD DEDUCTIBLE
94X3 = (C) TYPE/DATE/LIMIT AMOUNT
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
9401 = (C) BLOOD DEDUCTIBLE AMT > 3
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
9404 = (C) INVALID GENDER CODE ON PRO-PAY
9407 = (C) INVALID 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/TYP/CASH DED/ALLOW/CASH
98X4 = (C) DATE/MSP/TYP/CASH DED/ALLOW/CASH
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
99X1 = (C) POSS DUPE, PART B DOC-ID
99X2 = (C) REV CODE INVALID OR TRAILER CNT=0
99X3 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
99X4 = (C) INCOMPATIBLE DATES/CLAIM TYPE
9910 = (C) NO DATE OF SERVICE
9911 = (C) BLOOD VERIFIED INVALID
9920 = (C) EDIT 9920 (NEW)
9930 = (C) EDIT 9930 (NEW)
9931 = (C) OUTPAT COINSURANCE VALUES
9933 = (C) RATE EXCEEDS MAMMOGRAPHY LIMIT
9940 = (C) EDIT 9940 (NEW)
9942 = (C) EDIT 9942 (NEW)
9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
9945 = (C) SERVICE DATE < 98001
9946 = (C) INVALID DIAGNOSIS CODE
9947 = (C) INVALID DIAGNOSIS CODE
9948 = (C) STAY FROM>96365,DIAG=V725
9960 = (C) MED CHOICE BUT HMO DATA MISSING
9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
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)

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 SAF's 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
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 mediare 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' con-
version to claims with NCH weekly process
date 10/1/93-10/30/95, where MSP values =

NCH_PATCH_TABLE

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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.

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1   NCH_STATE_SGMT_TB
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    NCH State Segment 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
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