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

VARIABLES BLANKED FOR CONFIDENTIALITY REASONS

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

- BENEFICIARY CLAIM ACCOUNT NUMBER
- BENEFICIARY CLAIM ACCOUNT NUMBER
- BENEFICIARY MAILING CONTACT ZIP CODE
- BENEFICIARY MAILING CONTACT ZIP CODE
- BENEFICIARY NCH STATE SEGMENT NEAR-LINE CODE
- BENEFICIARY RESIDENCE SSA STANDARD COUNTY CODE
- BENEFICIARY RESIDENCE SSA STANDARD COUNTY CODE
- CARRIER CLAIM REFERRING PHYSICIAN NPI NUMBER
- CARRIER CLAIM REFERRING PIN NUMBER
- CARRIER CLAIM REFERRING UPIN NUMBER
- CARRIER LINE PERFORMING NPI NUMBER
- CARRIER LINE PERFORMING PROVIDER ZIP CODE
- CLAIM ATTENDING PHYSICIAN GIVEN NAME
- CLAIM ATTENDING PHYSICIAN MIDDLE INITIAL NAME
- CLAIM ATTENDING PHYSICIAN NPI NUMBER
- CLAIM ATTENDING PHYSICIAN SURNAME
- CLAIM ATTENDING PHYSICIAN UPIN NUMBER
- CLAIM OPERATING PHYSICIAN GIVEN NAME
- CLAIM OPERATING PHYSICIAN MIDDLE INITIAL NAME
- CLAIM OPERATING PHYSICIAN NPI NUMBER
- CLAIM OPERATING PHYSICIAN SURNAME
- CLAIM OPERATING PHYSICIAN UPIN NUMBER
- CLAIM OTHER PHYSICIAN GIVEN NAME
- CLAIM OTHER PHYSICIAN IDENTIFICATION NUMBER
- CLAIM OTHER PHYSICIAN MIDDLE INITIAL NAME
- CLAIM OTHER PHYSICIAN NPI NUMBER
- CLAIM OTHER PHYSICIAN SURNAME
- CLAIM OTHER PHYSICIAN UPIN NUMBER
- CLAIM PATIENT 1ST INITIAL GIVEN NAME
- CLAIM PATIENT 1ST INITIAL GIVEN NAME
- CLAIM PATIENT 1ST INITIAL MIDDLE NAME
- CLAIM PATIENT 1ST INITIAL MIDDLE NAME
- CLAIM PATIENT 6 POSITION SURNAME
- CLAIM PRIMARY CARE PHYSICIAN IDENTIFICATION NUMBER
- CLAIM PRINCIPAL PROCEDURE PHYSICIAN IDENTIFICATION NUMBER
- CROSS REFERENCE CANBIC
- CWFB PERFORMING PROVIDER PROFILING NUMBER
- CWFB PERFORMING PROVIDER PROFILING NUMBER
DMERC 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>**** DMERC Claim Record</td>
<td>REC</td>
<td>VAR</td>
<td></td>
<td></td>
<td>Durable medical equipment (DME) regional carrier (DMERC) claim record for version I of the NCH.</td>
</tr>
<tr>
<td>SYSTEM ALIAS: UTLDMERI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: DMERC_CLM_REC</td>
</tr>
<tr>
<td>**** DMERC Claim Fixed Group</td>
<td>GROUP</td>
<td>341</td>
<td>1</td>
<td>341</td>
<td>Fixed portion of the durable medical equipment regional carrier (DMERC) claim record for version I of the NCH.</td>
</tr>
<tr>
<td>SYSTEM ALIAS: DMERC_CLM_FIX_GRP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: DMERC_CLM_FIX_GRP</td>
</tr>
<tr>
<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>SYSTEM ALIAS: CLM_REC_IDENT_GRP</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>Effective with Version H, the count (in bytes) of the length of the claim record.</td>
</tr>
<tr>
<td>NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 DIGITS SIGNED</td>
</tr>
</tbody>
</table>
2. NCH Near-Line Record
Version Code

CHAR 1 4 4

The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored.

DB2 ALIAS: NCH_REC_VRSN_CD
SAS ALIAS: REC_LVL
STANDARD ALIAS: NCH_NEAR_LINE_REC_VRSN_CD
TITLE ALIAS: NCH_VERSION

CODES:
A = Record format as of January 1991
B = Record format as of April 1991
C = Record format as of May 1991
D = Record format as of January 1992
E = Record format as of March 1992
F = Record format as of May 1992
G = Record format as of October 1993
H = Record format as of September 1998
I = Record format as of July 2000

1

DMERC 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>POSITION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

SOURCE:
NCH

3. NCH Near Line Record
Identification Code

CHAR 1 5 5

A code defining the type of claim record being processed.

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

SOURCE:
NCH
CODES:
   REFER TO: NCH_NEAR_LINE_RIC_TB
   IN THE CODES APPENDIX

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

SOURCE:
NCH

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

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

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

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

   NOTE: During the Version H conversion this field was populated with data through-out history (back to 1991).

DMERC Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001
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’ ENounter 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_EFECTV_DT
    MCO_PRD_TRMNTN_DT

INPATIENT ‘FULL’ ENcounter TYPE CODE DERIVED FROM:
  (HDC processing -- AVAILABLE IN NMUD)
    FI_NUM

INPATIENT ‘ABBREVIATED’ ENounter TYPE CODE DERIVED FROM:
  (HDC processing -- AVAILABLE IN NMUD)
    FI_NUM
    CLM_FAC_TYPE_CD
    CLM_SRVC_CLSFTN_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’ ENounter 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

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

POSITIONS

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

DERIVATION RULES:

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

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

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

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
4. FI_NUM = 80881

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

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)

DMERC 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>
</table>

WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 - 12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
   MCO_OPTN_CD = 'C'
   CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   FI_NUM = 80881 AND
2.   CLM_FAC_TYPE_CD = '1'; CLM_SRV_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)

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

WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2.   HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).
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

This number uniquely identifies the beneficiary in the NCH Nearline.

COMMON ALIAS: HIC
STANDARD ALIAS: CLM_LCTR_NUM_GRP
TITLE ALIAS: HICAN

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

COMMON ALIAS: CAN
DA3 ALIAS: CLAIM_ACCOUNT_NUMBER
DB2 ALIAS: BENE_CLM_ACNT_NUM
SAS ALIAS: CAN
STANDARD ALIAS: BENE_CLM_ACNT_NUM
TITLE ALIAS: CAN

SOURCE:
SSA, RRB

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

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

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

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
9. NCH State Segment Code

- **CHAR**
- **1 22 22**
- The code identifying the segment of the NCH Nearline file containing the beneficiary’s record for a specific service year. Effective 12/96, segmentation is by CLM_LCTR_NUM, then final action sequence within residence state. (Prior to 12/96, segmentation was by ranges of county codes within the residence state.)

- **DB2 ALIAS:** NCH_STATE_SGMT_CD
- **SAS ALIAS:** ST_SGMT
- **STANDARD ALIAS:** NCH_STATE_SGMT_CD

---


- **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:** 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
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

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

<table>
<thead>
<tr>
<th>13. NCH Weekly Claim Processing</th>
<th>NUM</th>
<th>8</th>
<th>41</th>
<th>48</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>14. CWF Claim Accretion Date</th>
<th>NUM</th>
<th>8</th>
<th>49</th>
<th>56</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The date the claim record is accreted (posted/
processed) to the beneficiary master record
at the CWF host site and authorization for
payment is returned to the fiscal interme-
diary or carrier.
<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>CWF Claim Accretion Number</td>
<td>PACK</td>
<td>2</td>
<td>57</td>
<td>58</td>
<td>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. <strong>(Exception: If the claim record is missing the accretion date HCFA’s CWFMQA system places a zero in the accretion number.</strong></td>
</tr>
<tr>
<td>Carrier Claim Control Number</td>
<td>CHAR</td>
<td>15</td>
<td>59</td>
<td>73</td>
<td>Unique control number assigned by a carrier to a non-institutional claim. <strong>COMMON ALIAS: CCN</strong> <strong>DB2 ALIAS: CARR_CLM_CNTL_NUM</strong> <strong>SAS ALIAS: CARRCNTL</strong> <strong>STANDARD ALIAS: CARR_CLM_CNTL_NUM</strong> <strong>TITLE ALIAS: CCN</strong></td>
</tr>
</tbody>
</table>
**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

<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>17. FILLER</td>
<td>CHAR</td>
<td>38</td>
<td>74</td>
<td>111</td>
<td></td>
</tr>
</tbody>
</table>

**DMERC Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001**

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).

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

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

SOURCE:
NCH

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

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

9 DIGITS SIGNED

DB2 ALIAS: NCH_SGMT_LINK_NUM
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).

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:
21. Claim Segment Number  NUM  2  127  128  Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim.

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

2 DIGITS UNSIGNED

DB2 ALIAS: CLM_SGMT_NUM
SAS ALIAS: SGMT_NUM
STANDARD ALIAS: CLM_SGMT_NUM
TITLE ALIAS: SEGMENT_NUMBER

SOURCE:
CWF

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

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

3 DIGITS UNSIGNED

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

DMERC 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>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: TOTAL_LINE_COUNT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
23. Claim Segment Line Count  NUM  2  132  133  Effective with Version I, the count used to identify the number of revenue center lines on a record/segment.

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

2 DIGITS UNSIGNED

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

****  Carrier/DMERC Claim Common  GROUP  194  134  327  Information common to both carrier and DMERC claims for version I of NCH.

STANDARD ALIAS: CARR_DMERC_CLM_CMN_2_GRP

24. FILLER  CHAR  5  134  138

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

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

CODES:
1 = Original debit; void of original debit
   (If CLM_DISP_CD = 3, code 1 means voided original debit)
3 = Full credit
5 = Replacement debit
9 = Accrete bill history only (internal; effective 2/22/91)
**COMMENT:**
Prior to Version H this field was named: CWFB_CLM_ENTRY_CD.

**SOURCE:**
CWF

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

28. NCH Edit Disposition Code      CHAR 2 143 144

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

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

**DB2 ALIAS:** NCH_EDIT_DISP_CD
**SAS ALIAS:** EDITDISP
**STANDARD ALIAS:** NCH_EDIT_DISP_CD
**TITLE ALIAS:** NCH_EDIT_DISP

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

SOURCE:
NCH QA Process

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

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

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

NAME          TYPE LENGTH BEG END CONTENTS
---------------------------  ----  ------ ---------  ------------------------------------------------------------
CODES:
H = BIC submitted by CWF = HA, HB or HC
blank = No HA, HB or HC BIC present

SOURCE:
NCH QA Process

30. Beneficiary Residence SSA Standard County Code

CHAR  3  146  148 The SSA standard county code of a beneficiary’s residence.

DA3 ALIAS: SSA_STANDARD_COUNTY_CODE
DB2 ALIAS: BENE_SSA_CNTY_CD
SAS ALIAS: CNTY_CD
STANDARD ALIAS: BENE_RSDNC_SSA_STD_CNTY_CD
TITLE ALIAS: BENE_COUNTY_CD

EDIT-RULES:
OPTIONAL: MAY BE BLANK

SOURCE:
SSA/EDB
### 31. Carrier Claim Receipt Date

**NUM** 8 149 156

The date the carrier receives the non-institutional claim.

**8 DIGITS UNSIGNED**

- **DB2 ALIAS**: CARR_CLM_RCPT_DT
- **SAS ALIAS**: RCPT_DT
- **STANDARD ALIAS**: CARR_CLM_RCPT_DT
- **TITLE ALIAS**: RECEIPT_DT

**EDIT-RULES:**

YYYYMMDD

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

**SOURCE:**
CWF

### 32. Carrier Claim Scheduled Payment Date

**NUM** 8 157 164

The scheduled date of payment to the physician or supplier, as appearing on the original non-institutional claim sent to the CWF host.

**Note:** This date is considered to be the date paid since no additional information as to the actual payment date is available.

**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

---

**DMERC Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001**

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
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<tbody>
<tr>
<td></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: FICARR_CLM_PMT_DT.
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
   SAS ALIAS: CARR_NUM
   STANDARD ALIAS: CARR_NUM
   SYSTEM ALIAS: LTCARR
   TITLE ALIAS: CARRIER

   CODES:
   REFER TO: CARR_NUM_TB
   IN THE CODES APPENDIX

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

   SOURCE:
   CWF

35. FILLER
   CHAR 8 178 185

36. CWF Transmission Batch
   CHAR 4 186 189 Effective with Version H, the number assigned
Number

to each batch of claims transactions sent from
CWF (used for internal editing purposes).

DMERC 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>Note: Beginning 11/98, this field will be populated with data. Claims processed prior to 11/98 will contain spaces in this field.</td>
<td></td>
<td></td>
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</table>

DB2 ALIAS: TRNSMSN_BATCH_NUM
SAS ALIAS: FIBATCH
STANDARD ALIAS: CWF_TRNSMSN BATCH_NUM
TITLE ALIAS: BATCH_NUM
SOURCE:
CWF

37. Beneficiary Mailing Contact ZIP 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>The ZIP code of the mailing address where the beneficiary may be contacted.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DB2 ALIAS: BENE_MLG_ZIP_CD
SAS ALIAS: BENE ZIP
STANDARD ALIAS: BENE_MLG_CNTCT ZIP_CD
TITLE ALIAS: BENE_ZIP
SOURCE:
EDB

38. Beneficiary Sex Identification Code

<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>The sex of a beneficiary.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

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
39. Beneficiary Race Code

CHAR 1 200 200

The race of a beneficiary.

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

CODES:

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

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
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<th>CONTENTS</th>
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<td>3</td>
<td>Other</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>3 = Other</td>
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<tr>
<td>4</td>
<td>Asian</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>4 = Asian</td>
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<tr>
<td>5</td>
<td>Hispanic</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>5 = Hispanic</td>
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<tr>
<td>6</td>
<td>North American Native</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>6 = North American Native</td>
</tr>
</tbody>
</table>

SOURCE:
SSA

40. Beneficiary Birth Date

NUM 8 201 208

The beneficiary’s date of birth.

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF
**41. CWF Beneficiary Medicare Status Code**

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

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

**DERIVATION:**
CWF derives MSC from the following:
1. Date of Birth
2. Claim Through Date
3. Original/Current Reasons for entitlement
4. ESRD Indicator
5. Beneficiary Claim Number

Items 1,3,4,5 come from the CWF Beneficiary Master Record; item 2 comes from the FI/Carrier claim record. MSC is assigned as follows:

<table>
<thead>
<tr>
<th>MSC</th>
<th>OASI</th>
<th>DIB</th>
<th>ESRD</th>
<th>AGE</th>
<th>BIC</th>
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<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>
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<tr>
<td>31</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>any age</td>
<td>T.</td>
</tr>
</tbody>
</table>

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**DMERC Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001**

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

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

**COMMENT:**
Prior to Version H this field was named: BENE_MDCR_STUS_CD. The name has been changed to distinguish this CWF-derived field from the
<table>
<thead>
<tr>
<th>Field Description</th>
<th>Data Type</th>
<th>Positions</th>
<th>Start Position</th>
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<tbody>
<tr>
<td>42. Claim Patient 6 Position Surname</td>
<td>CHAR</td>
<td>6</td>
<td>211 216</td>
</tr>
<tr>
<td>43. Claim Patient 1st Initial Given Name</td>
<td>CHAR</td>
<td>1</td>
<td>217 217</td>
</tr>
</tbody>
</table>

EDB-derived MSC (BENE_MDCR_STUS_CD).

SOURCE:
CWF

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

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.
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Patient First Initial Middle Name</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></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><em>NOTE1:</em> Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><em>NOTE2:</em> For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.</td>
</tr>
</tbody>
</table>
|                                           |      |        |     |     | **COMMON ALIAS:** PATIENT_MIDDLE_NAME  
|                                           |      |        |     |     | **DB2 ALIAS:** 1ST_INITL_MDL_NAME  
|                                           |      |        |     |     | **SAS ALIAS:** MDL_INIT  
|                                           |      |        |     |     | **STANDARD ALIAS:** CLM_PTNT_1ST_INITL_MDL_NAME  
|                                           |      |        |     |     | **TITLE ALIAS:** PATIENT_MIDDLE_INITIAL  
|                                           |      |        |     |     | **SOURCE:** CWF  
|                                           |      |        |     |     | **CODES:** |

| Beneficiary CWF Location Code             | CHAR | 1      | 219 | 219 | The code that identifies the Common Working File (CWF) location (the host site) where a beneficiary’s Medicare utilization records are maintained.                                                                 |
|                                           |      |        |     |     | **COMMON ALIAS:** CWF_HOST  
|                                           |      |        |     |     | **DB2 ALIAS:** BENE_CWF_LOC_CD  
|                                           |      |        |     |     | **SAS ALIAS:** CWFLOCCD  
|                                           |      |        |     |     | **STANDARD ALIAS:** BENE_CWF_LOC_CD  
|                                           |      |        |     |     | **SYSTEM ALIAS:** LTCWFLOC  
|                                           |      |        |     |     | **TITLE ALIAS:** CWF_HOST  
<p>|                                           |      |        |     |     | <strong>CODES:</strong> |</p>
<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>CWF</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. NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer. DB2 ALIAS: PRNCPAL_DGNS_CD SAS ALIAS: PDGNS_CD STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD TITLE ALIAS: PRINCIPAL_DIAGNOSIS</td>
</tr>
<tr>
<td>46. Claim Principal Diagnosis Code</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FILLER</td>
<td>CHAR</td>
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<td>225</td>
<td>225</td>
<td></td>
</tr>
<tr>
<td>47. FILLER</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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. DB2 ALIAS: CARR_PMT_DNL_CD SAS ALIAS: PMTDNLCD STANDARD ALIAS: CARR_CLM_PMT_DNL_CD TITLE ALIAS: PMT_DENIAL_CD</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.

**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).

1 DMERC 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>

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.)

DMERC 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>CWF</td>
</tr>
<tr>
<td>LIMITATIONS:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM_DISP_CD of ’02’, the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over or under the actual Medicare payment amount. Effective with Version H, the amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a non-institutional claim. NOTE: During the Version H conversion, this field was populated with data throughout history (back to service year 1991) by summing up the line item primary payer amounts.</td>
</tr>
</tbody>
</table>
| 51. Carrier Claim Primary Payer Paid Amount | PACK | 6     | 234 | 239 | 9.2 DIGITS SIGNED  
DB2 ALIAS: CARR_PRMRY_PYR_AMT  
SAS ALIAS: PRPAYAMT  
STANDARD ALIAS: CARR_CLM_PRMRY_PYR_PD_AMT  
TITLE ALIAS: PRIMARY_PAYER_AMOUNT  
EDIT-RULES:  
$$$$$$$$$CC
<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>52. FILLER</td>
<td>CHAR</td>
<td>1</td>
<td>240</td>
<td>240</td>
<td></td>
</tr>
<tr>
<td>53. DMERC Claim Ordering Physician UPIN Number</td>
<td>CHAR</td>
<td>6</td>
<td>241</td>
<td>246</td>
<td>Effective with Version G, the unique physician identification number (UPIN) of the physician ordering the Part B services/DMEPOS item.</td>
</tr>
</tbody>
</table>
|                                            |      |        |     |     | DB2 ALIAS: ORDRG_PHYSN_UPIN
|                                            |      |        |     |     | SAS ALIAS: ORD_UPIN
|                                            |      |        |     |     | STANDARD ALIAS: DMERC_CLM_ORDRG_PHYSN_UPIN_NUM
|                                            |      |        |     |     | TITLE ALIAS: ORDRG_UPIN
|                                            |      |        |     |     | COMMENT: Prior to Version H this field was named: CWFB_CLM_ORDRG_PHYSN_UPIN_NUM.                                                                                     |
| 55. Carrier Claim Provider Assignment Indicator Switch | CHAR | 1    | 257| 257| A switch indicating whether or not the provider accepts assignment for the noninstitutional claim.                                                                 |
|                                            |      |        |     |     | DB2 ALIAS: PRVDR_ASGNMT_SW
|                                            |      |        |     |     | SAS ALIAS: ASGMNTCD
|                                            |      |        |     |     | STANDARD ALIAS: CARR_CLM_PRVDR_ASGNMT_IND_SW
|                                            |      |        |     |     | TITLE ALIAS: ASSIGNMENT_SW

SOURCE: CWF
56. NCH Claim Provider Payment Amount  PACK  6  258  263  Effective with Version H, the total payments made to the provider for this claim (sum of line item provider payment amounts.)

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

9.2 DIGITS SIGNED

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

SOURCE:
NCH QA Process

57. NCH Claim Beneficiary Payment Amount  PACK  6  264  269  Effective with Version H, the total payments made to the beneficiary for this claim (sum of line item payment amounts to the beneficiary.)

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

9.2 DIGITS SIGNED

DB2 ALIAS: NCH_BENE_PMT_AMT

SOURCE:
NCH QA Process
58. Carrier Claim Beneficiary Paid Amount

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

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

9.2 DIGITS SIGNED

DB2 ALIAS: CARR_BENE_PD_AMT
SAS ALIAS: BENEPaid
STANDARD ALIAS: CARR_CLM_BENE_PD_AMT
TITLE ALIAS: BENE_PD_AMT

SOURCE:
NCH QA Process

59. NCH Carrier Claim Submitted Charge Amount

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

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

9.2 DIGITS SIGNED

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
### 60. NCH Carrier Claim Allowed

**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>Charge Amount</td>
<td>---</td>
<td>------</td>
<td>----</td>
<td>-----</td>
<td>----------</td>
</tr>
</tbody>
</table>

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

---

### 61. Carrier Claim Cash Deductible Applied Amount

<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 Cash</td>
<td>PACK</td>
<td>6</td>
<td>288</td>
<td>293</td>
<td></td>
</tr>
</tbody>
</table>

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

---

### 62. Carrier Claim HCPCS Year 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>Carrier Claim HCPCS Year</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.
<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>63. Carrier Claim MCO Override</td>
<td>CHAR</td>
<td>1</td>
<td>295</td>
<td>295</td>
<td>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.</td>
</tr>
<tr>
<td>64. Carrier Claim Hospice Override</td>
<td>CHAR</td>
<td>1</td>
<td>296</td>
<td>296</td>
<td>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). Codes: 0 = No Investigation, 1 = MCO Investigation does not apply to this claim.</td>
</tr>
</tbody>
</table>
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

66. DMERC NCH Edit Code Count
 NUM  2  328  329

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

2 DIGITS UNSIGNED

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

1

NAME | TYPE | LENGTH | BEG | END | CONTENTS
--------------------------- | ------ | --------- |  |  |  
DB2 ALIAS: DMERC_EDIT_CD_CNT
SAS ALIAS: DEDCNT
STANDARD ALIAS: DMERC_NCH_EDIT_CD_CNT

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

SOURCE:
NCH

67. DMERC NCH Patch Code Count
 NUM  2  330  331

Effective with Version H, the count of the number of HCFA patch codes annotated to the
DMERC 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: DMERC_PATCH_CD_CNT
SAS ALIAS: DPATCNT
STANDARD ALIAS: DMERC_NCH_PATCH_CD_I_CNT

SOURCE: NCH

68. DMERC MCO Period Count       NUM       1   332  332  Effective with Version H, the count of the number of Managed Care Organization (MCO) periods reported on a DMERC claim. The purpose of this count is to indicate how many MCO period trailers are present.

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

1 DIGIT UNSIGNED

DB2 ALIAS: DMERC_MCO_PRD_CNT
SAS ALIAS: DMCOCNT
STANDARD ALIAS: DMERC_MCO_PRD_CNT

EDIT-RULES:
RANGE: 0 TO 2

SOURCE: NCH

69. DMERC Claim Health PlanID Count       NUM       1   333  333  A placeholder field (effective with Version H) for storing the count of the number of Health PlanIDs reported on the DMERC claim. The

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

POSITIONS

NAME TYPE LENGTH BEG END CONTENTS
<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>70. DMERC Claim Demonstration ID Count</strong></td>
<td>NUM</td>
<td>1</td>
<td>334</td>
<td>334</td>
<td>Effective with Version H, the count of the number of claim demonstration IDs reported on a DMERC 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.</td>
</tr>
</tbody>
</table>

1 DIGIT UNSIGNED

DB2 ALIAS: DMERC_DEMO_ID_CNT
SAS ALIAS: DDEMCNT
STANDARD ALIAS: DMERC_CLM_DEMO_ID_CNT

EDIT-RULES:
RANGE: 0 TO 5

SOURCE:
NCH

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>71. DMERC Claim Diagnosis Code Count</strong></td>
<td>NUM</td>
<td>1</td>
<td>335</td>
<td>335</td>
<td>The count of the number of diagnosis codes (both principal and other) reported on a DMERC claim. The purpose of this count is to indicate how many claim diagnosis trailers are present.</td>
</tr>
</tbody>
</table>

1 DIGIT UNSIGNED
**DMERC Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001**

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>72. DMERC Claim Line Count</td>
<td>NUM</td>
<td>2</td>
<td>336</td>
<td>337</td>
<td>The count of the number of line items reported on the DMERC claim. The purpose of this count is to indicate how many line item trailers are present.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 DIGITS UNSIGNED</td>
</tr>
<tr>
<td>SOURCE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NCH</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DMERC_CLM_LINE_CNT</td>
</tr>
<tr>
<td>EDIT-RULES:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RANGE: 1 TO 13</td>
</tr>
<tr>
<td>COMMENT:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prior to Version H this field was named: CLM_DGNS_CD_CNT.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DMERC_CLM_LINE_CNT</td>
</tr>
</tbody>
</table>

| 73. FILLER                | CHAR | 4      | 338 | 341   | Variable portion of the durable medical equipment (DME) regional carrier (DMERC) claim record for version H of the NCH. |
|                          |      |        |     |       | DMERC_CLM_VAR_GRP                                                     |

**DMERC Claim Record**

- **NAME**: SOURCE
- **TYPE**: NCH
- **LENGTH**: 2
- **BEG**: 336
- **END**: 337
- **CONTENTS**: The count of the number of line items reported on the DMERC claim. The purpose of this count is to indicate how many line item trailers are present.

- **EDIT-RULES**: RANGE: 1 TO 13
- **COMMENT**: Prior to Version H this field was named: CLM_DGNS_CD_CNT.

- **NAME**: SOURCE
- **TYPE**: CWFB_CLM_NUM_LINE_ITM_CNT
- **LENGTH**: 4
- **BEG**: 338
- **END**: 341
- **CONTENTS**: Variable portion of the durable medical equipment (DME) regional carrier (DMERC) claim record for version H of the NCH.

- **EDIT-RULES**: RANGE: 1 TO 13
- **COMMENT**: Prior to Version H this field was named: CWFB_CLM_NUM_LINE_ITM_CNT.
The number of claim edit trailers is determined by the claim edit code count.

OCCURS: UP TO 13 TIMES DEPENDING ON DMERC_NCH_EDIT_CD_CNT

STANDARD ALIAS: NCH_EDIT_GRP

74. 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:
DMERC Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

75. NCH Edit 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
DB2 ALIAS: NCH_EDIT_CD
SAS ALIAS: EDIT_CD
STANDARD ALIAS: NCH_EDIT_CD
TITLE ALIAS: QA_ERROR_CD

CODES:
REFER TO: NCH_EDIT_TB
76. 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

77. 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

<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>STANDARD ALIAS: NCH_PATCH_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: NCH_PATCH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CODES:
REFER TO: NCH_PATCH_TB  
IN THE CODES APPENDIX

SOURCE:  
NCH

78. NCH Patch Applied Date  NUM  8  
Effective with Version H, the date the NCH patch was applied to the claim.  
8 DIGITS UNSIGNED  
DB2 ALIAS: NCH_PATCH_APPLY_DT  
SAS ALIAS: PATCHDT  
STANDARD ALIAS: NCH_PATCH_APPLY_DT  
TITLE ALIAS: NCH_PATCH_DT  
EDIT-RULES:  
YYYYMMDD  
SOURCE:  
NCH

**** MCO Period Group  GROUP  37  
The number of managed care organization (MCO) period data trailers present is determined by the claim MCO period trailer count. This field reflects the two most current MCO periods in the CWF beneficiary history record. It may have no connection to the services on the claim.  
OCCURS: UP TO 2 TIMES  
DEPENDING ON DMERC_MCO_PRD_CNT  
STANDARD ALIAS: MCO_PRD_GRP

79. NCH MCO Trailer Indicator  CHAR  1  
Effective with Version H, the code indicating the presence of a Managed Care Organization (MCO) trailer.  
NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.  
COBOL ALIAS: MCO_IND  
DB2 ALIAS: MCO_TRLR_IND_CD  
SAS ALIAS: MCOIND
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
</table>
| 80. MCO Contract Number     | CHAR | 5      |     |     | Effective with Version H, this field represents the plan contract number of the Managed Care Organization (MCO).  
NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.  
DB2 ALIAS: MCO_CNTRCT_NUM  
SAS ALIAS: MCONUM  
STANDARD ALIAS: MCO_CNTRCT_NUM  
TITLE ALIAS: MCO_NUM  
SOURCE: CWF                                                                 |
| 81. 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

82. 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.

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

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

83. 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.
84. 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.

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

** SOURCE:
CWF

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

1

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
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</thead>
<tbody>
<tr>
<td>Claim Health PlanID Group</td>
<td>GROUP</td>
<td>16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

** OCCURS: UP TO 3 TIMES DEPENDING ON DMERC_CLM_HLTH_PLANID_CNT

STANDARD ALIAS: CLM_HLTH_PLANID_GRP
85. NCH Health PlanID Trailer
Indicator Code

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:
1 = Health PlanID trailer present

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

SOURCE:
NCH

86. Claim Health PlanID Code

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

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

SOURCE:
CWF

87. Claim Health PlanID Number

A placeholder field (effective with Version H) for storing the Health PlanID number. Prior to Version ‘I’ this field was named:
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
<th>DB2 ALIAS: CLM_PLANID_NUM</th>
<th>SAS ALIAS: PLANID</th>
<th>STANDARD ALIAS: CLM_HLTH_PLANID_NUM</th>
<th>TITLE ALIAS: PLANID</th>
<th>COMMENT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLM_PAYERID_NUM.</td>
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<td></td>
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</tr>
<tr>
<td>Prior to Version I this field was named: CLM_PAYERID_NUM.</td>
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</tbody>
</table>

** 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 DMERC_CLM_DEMO_ID_CNT

STANDARD ALIAS: CLM_DEMO_ID_GRP

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
<th>DB2 ALIAS: DEMO_TRLR_IND_CD</th>
<th>SAS ALIAS: DEMOIND</th>
<th>STANDARD ALIAS: NCH_DEMO_TRLR_IND_CD</th>
<th>TITLE ALIAS: DEMO_INDICATOR</th>
<th>CODES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>88. NCH Demonstration Trailer Indicator Code</td>
<td>CHAR</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D = Demo trailer present</td>
</tr>
<tr>
<td>SOURCE:</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td>NCH</td>
</tr>
</tbody>
</table>
89. Claim Demonstration Identification Number

<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>states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a RUGS indicator and one or more revenue center codes in the 9,000 series.</td>
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</tr>
</tbody>
</table>

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

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

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

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

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

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

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

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

04 = United Mine Workers of America (UMWA) Managed Care Demo -- testing risk sharing for Part A services, paying special capitation rates for all UMWA beneficiaries residing in 13 designated counties in 3 states. Under the demo, UMWA will waive the 3-day qualifying hospital stay for a SNF admission. The claims contain TOB '18X', '21X', '28X' and '51X'; condition 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 cross-walked from MCO plan contract # in the Claim Edit Group, 4th occurrence, 2nd position, in Version 'G').

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

NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit Date no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID '06' on the claim. The FI adds the ID to the claim based on the presence of DRG '106' or '107' from specific providers for specified time periods; the carrier adds the ID to the claim based on receiving 'Daily Census List' from participating hospitals. Demo 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, 380897, 450897, 110082, 230156 or 360085 for specified service dates; noninstitutional - presence of HCPCS modifier (initial and/or second) = 'Q2' and a carrier number =00700/31143 00630, 01380, 00900, 01040/00511, 00710, 00623, or 13630 for specified service dates.

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

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

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

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

15 = ESRD Managed Care (MCO encounter data) -- testing open enrollment of ESRD beneficiaries and capitation rates adjusted for patient treatment needs at 3 MCOs in 3 States. The claims contain one of the specific MCO Plan Contract # assigned to the ESRD demo site.
NOTE: Effective 10/1/97 (but not actually implemented at a site until 1/1/98) for all claim types -- the FI and carrier add Demo ID ‘15’ to claim based on the presence of the MCO plan contract #.

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

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

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

37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries 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

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

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

<table>
<thead>
<tr>
<th>NAME</th>
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<th>BEG</th>
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<tr>
<td>90. Claim Demonstration Information Text</td>
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<td></td>
<td>Effective with Version H, the text field that contains related demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field.</td>
</tr>
</tbody>
</table>
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 reflect ‘INVALID CHOICES PLAN NUMBER’. When

<table>
<thead>
<tr>
<th>POSITIONS</th>
<th>NAME</th>
<th>TYPE</th>
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<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
</table>
|           | date; or non-PPS claim and the from date is within HMO effective/termination date and (2) CHOICES plan number matches the HMO plan number. If either condition is not met the text field will reflect ‘INVALID CHOICES PLAN NUMBER’. When
CHOICES plan number not present, text will reflect ‘INVALID’.

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

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

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

SOURCE:
CWF

<table>
<thead>
<tr>
<th>Field Description</th>
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<td>**** Carrier Claim Diagnosis Group</td>
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<tr>
<td>91. NCH Diagnosis Trailer Indicator Code</td>
<td>CHAR</td>
<td>1</td>
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<tr>
<td>92. Claim Diagnosis Code</td>
<td>CHAR</td>
<td>5</td>
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</table>

SOURCE:
CWF

**Carrier Claim Diagnosis Group**

**OCCURS:** UP TO 4 TIMES DEPENDING ON DMERC_CLM_DGNS_CD_CNT

**STANDARD ALIAS:** CARR_CLM_DGNS_GRP

**Effect** 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

**Claim Diagnosis Code**

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.

<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>codes. During the Version H conversion the CLM_PRNCPAL_DGNS_CD was added as the first occurrence.</td>
<td></td>
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<td>DB2 ALIAS: CLM_DGNS_CD</td>
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<td>SAS ALIAS: DGNS_CD</td>
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<td>STANDARD ALIAS: CLM_DGNS_CD</td>
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<td>TITLE ALIAS: DIAGNOSIS</td>
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<td>EDIT-RULES: ICD-9-CM</td>
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<td>COMMENT: Prior to Version H this field was named: CLM_OTHR_DGNS_CD.</td>
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<tr>
<td>93. FILLER</td>
<td>CHAR</td>
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<tr>
<td>**** DMERC Line Item Group</td>
<td>GROUP</td>
<td>260</td>
<td></td>
<td></td>
<td>The DMERC line item trailer group may occur multiple times in one DMERC claim.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>OCCURS: UP TO 13 TIMES DEPENDING ON DMERC_CLM_LINE_CNT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: DMERC_LINE_GRP</td>
</tr>
<tr>
<td>94. NCH Line Item Trailer</td>
<td>CHAR</td>
<td>1</td>
<td></td>
<td></td>
<td>Effective with Version H, the code indicating the presence of a line item trailer on the non-institutional claim.</td>
</tr>
<tr>
<td>Indicator Code</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>DB2 ALIAS: LINE_TRLR_IND_CD</td>
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<td>SAS ALIAS: LINEIND</td>
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<td></td>
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<td></td>
<td>STANDARD ALIAS: NCH_LINE_TRLR_IND_CD</td>
</tr>
</tbody>
</table>
95. DMERC Line Supplier Provider Number  CHAR  10

Effective with Version G, billing number assigned to the supplier of the Part B service/DMEPOS by the National Supplier Clearinghouse, as reported on the line item for the DMERC claim.

DB2 ALIAS: SUPLR_PRVDR_NUM
SAS ALIAS: SUPLRNUM
STANDARD ALIAS: DMERC_LINE_SUPLR_PRVDR_NUM
TITLE ALIAS: SUPLR_NUM

Prior to Version H this field was named: CWFB_SUPLR_PRVDR_NUM.

SOURCE:
NCH

96. DMERC Line Item Supplier NPI Number  CHAR  10

A placeholder field (effective with Version H) for storing the NPI assigned to the supplier of the Part B service/DMEPOS line item.

COMMON ALIAS: SUPPLIER_NPI
DB2 ALIAS: SUPLR_NPI_NUM
SAS ALIAS: SUP_NPI
STANDARD ALIAS: DMERC_LINE_SUPLR_NPI_NUM
TITLE ALIAS: SUPLR_NPI

SOURCE:
CWF

97. DMERC Line Pricing State Code  CHAR  2

Effective with Version G, the SSA standard state code (converted from the state postal abbreviation) representing the pricing location of the service reported on the DMERC line item. This is usually the beneficiary state of
residence.

Note: the BENE_RSDNC_SSA_STD_STATE_CD reported in the fixed portion of the DMERC claim record may differ from this field. This can happen when the beneficiary is in another state when the service is rendered (other than the primary residence state), or the beneficiary has moved to another state and the CWF master record has not yet been changed.

DB2 ALIAS: DMERC_PRCNG_STATE
SAS ALIAS: PRCNG_ST
STANDARD ALIAS: DMERC_LINE_PRCNG_STATE_CD
TITLE ALIAS: DMERC_PRCNG_STATE_CD

CODES:
   REFER TO: GEO_SSA_STATE_TB
           IN THE CODES APPENDIX

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

SOURCE:
CWF/NCH

<table>
<thead>
<tr>
<th>98. DMERC Line Provider State Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAR 2</td>
</tr>
</tbody>
</table>

Effective with Version G, the SSA standard state code (converted from the state postal abbreviation) representing the supplier’s location, as reported on the DMERC line item.

1 DMERC 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>POSITIONS</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>CONTENTS</td>
<td></td>
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</tr>
</tbody>
</table>

NOTE: Although created for Version ‘G’, this field was blank until 1/95 when the supplier state code was added to the DME claim record as a required field.

DB2 ALIAS: DMERC_PRVDR_STATE
SAS ALIAS: PRVSTATE
STANDARD ALIAS: DMERC_LINE_PRVDR_STATE_CD
TITLE ALIAS: DMERC_PRVDR_STATE_CD
<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Data Type</th>
<th>Length</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99</td>
<td>DMERC Line Supplier Type Code</td>
<td>CHAR</td>
<td>1</td>
<td>Code identifying the type of supplier furnishing the line item service on the DMERC claim.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: SUPLR_TYPE_CD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: SUP_TYPE</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: DMERC_LINE_SUPLR_TYPE_CD</td>
</tr>
<tr>
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<td></td>
<td>TITLE ALIAS: SUPLR_TYPE</td>
</tr>
<tr>
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<td>CODES: REFER TO: DMERC_LINE_SUPLR_TYPE_TB IN THE CODES APPENDIX</td>
</tr>
<tr>
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<td>COMMENT: Prior to Version H this field on the DMERC claim was named: CWFB_PRVDR_TYPE_CD.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>SOURCE: CWF</td>
</tr>
<tr>
<td>100</td>
<td>Line Provider Tax Number</td>
<td>CHAR</td>
<td>10</td>
<td>Social security number or employee identification number of physician/supplier used to identify to whom payment is made for the line item service on the noninstitutional claim.</td>
</tr>
<tr>
<td></td>
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<td>DB2 ALIAS: LINE_PRVDR_TAX_NUM</td>
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<td></td>
<td>SAS ALIAS: TAX_NUM</td>
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<td>STANDARD ALIAS: LINE_PRVDR_TAX_NUM</td>
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<td>COMMENT: Prior to Version H this field was named: CWFB_PRVDR_TAX_NUM.</td>
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<td>SOURCE: CWF</td>
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<td>----------------------------------</td>
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</tr>
<tr>
<td>101. Line HCFA Provider Specialty Code</td>
<td>CHAR</td>
<td>2</td>
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</tr>
<tr>
<td>102. Line Provider Participating Indicator Code</td>
<td>CHAR</td>
<td>1</td>
<td></td>
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</tbody>
</table>
103. Line Service Count        PACK     2

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

3 DIGITS SIGNED

DB2 ALIAS: SRVC_CNT
SAS ALIAS: SRVC_CNT
STANDARD ALIAS: LINE_SRVC_CNT

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

104. Line HCFA Type Service Code  CHAR    1

Code indicating the type of service, as defined in the HCFA Medicare Carrier Manual, for this line item on the non-institutional claim.

DB2 ALIAS: HCFA_TYPE_SRVC_CD
SAS ALIAS: TYPSRVCB
STANDARD ALIAS: LINE_HCFA_TYPE_SRVC_CD
SYSTEM ALIAS: LTTOS
TITLE ALIAS: HCFA_TYPE_SRVC

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

CODES:
 REFER TO: HCFA_TYPE_SRVC_TB
 IN THE CODES APPENDIX

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

SOURCE:
CWF
105. 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.

COMMON ALIAS: POS
DB2 ALIAS: LINE_PLC_SRVC_CD
SAS ALIAS: PLCSRVC
STANDARD ALIAS: LINE_PLC_SRVC_CD
TITLE ALIAS: PLC_SRVC

CODES:
REFER TO: LINE_PLC_SRVC_TB
IN THE CODES APPENDIX

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

SOURCE:
CWF

106. Line First Expense Date  NUM  8
Beginning date (1st expense) for this line item service on the noninstitutional claim.

8 DIGITS UNSIGNED

DMERC 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>POS</td>
<td>CHAR</td>
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<td></td>
</tr>
<tr>
<td>DB2 ALIAS: LINE_1ST_EXPNS_DT</td>
<td>NUM</td>
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<td>SAS ALIAS: EXPNSDT1</td>
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<tr>
<td>STANDARD ALIAS: LINE_1ST_EXPNS_DT</td>
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<td></td>
</tr>
<tr>
<td>TITLE ALIAS: 1ST_EXPNS_DT</td>
<td></td>
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</tr>
</tbody>
</table>

EDIT-RULES:
YYYYMMDD

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

SOURCE:
CWF
107. Line Last Expense Date  NUM  8

The ending date (last expense) for the line item service on the noninstitutional claim.

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: LINE_LAST_EXPNS_DT

EDIT-RULES:
YYYYMMDD

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

SOURCE:
CWF

108. Line HCPCS Code  CHAR  5

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

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

COMMENT:
Prior to Version H this line item field was named: HCPCS_CD. With Version H, a prefix was added to denote the location of this field.

DMERC Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001
on each claim type (institutional: REV_CNTR and noninstitutional: LINE).

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

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

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.

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

DB2 ALIAS: HCPCS_1ST_MDFR_CD
## DMERC Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001

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

**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

### 110. Line HCPCS Second Modifier 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

### 111. DMERC Line HCPCS Third Modifier Code

Effective with Version G, a third modifier to the HCPCS procedure code used to process the DMERC line

**DB2 ALIAS:** HCPCS_3RD_MDFR_CD
**SAS ALIAS:** MDFR_CD3
**STANDARD ALIAS:** LINE_HCPCS_3RD_MDFR_CD
**TITLE ALIAS:** THIRD_MODIFIER

**EDIT-RULES:**
CARRIER INFORMATION FILE

**COMMENT:**
Prior to Version H this field was named: HCPCS_3RD_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
**112. DMERC Line HCPCS Fourth Modifier Code**

```
12. DMERC Line HCPCS Fourth Modifier Code  CHAR  2
```

Effective with Version G, a fourth modifier to the HCPCS procedure code used to process the DMERC line item.

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

**SOURCE:**
CWF

**COMMENT:**
Prior to Version H this field was named: HCPCS_4TH_MDFR_CD.

**DB2 ALIAS:** HCPCS_4TH_MDFR_CD
**SAS ALIAS:** MDFR_CD4
**STANDARD ALIAS:** DMERC_LINE_HCPCS_4TH_MDFR_CD
**TITLE ALIAS:** HCPCS_4TH_MDFR

---

**113. Line NCH BETOS Code**

```
13. 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).

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

**SOURCE:**
CWF

**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

114. Line IDE Number      CHAR      7

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

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

DB2 ALIAS: LINE_IDE_NUM
SAS ALIAS: LINE_IDE
STANDARD ALIAS: LINE_IDE_NUM
TITLE ALIAS: IDE_NUMBER

SOURCE:
CWF

115. DMERC Line Not Otherwise Classified HCPCS Code Text
CHAR 14

Effective with Version G, the text describing the not otherwise classified HCPCS code relating to this DMERC line item.

DB2 ALIAS: NOC_HCPCS_CD_TXT
SAS ALIAS: NOC_TXT
STANDARD ALIAS: DMERC_LINE_NOC_HCPCS_CD_TXT
TITLE ALIAS: NOC_HCPCS_TXT

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

SOURCE:
CWF

116. 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

117. 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
<table>
<thead>
<tr>
<th>POSITION</th>
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<tbody>
<tr>
<td>COMMON ALIAS: REIMBURSEMENT</td>
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<tr>
<td>DB2 ALIAS: LINE_NCH_PMT_AMT</td>
</tr>
<tr>
<td>SAS ALIAS: LINEPMT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
</table>
| 118. Line Beneficiary Payment Amount | PACK | 6 | | | 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  

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
</table>
| 119. Line Provider Payment Amount | PACK | 6 | | | Effective with Version H, the payment made to the provider for the line item service on the noninstitutional claim.  

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

9.2 DIGITS SIGNED

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

SOURCE:
CWF

120. Line Beneficiary Part B Deductible Amount

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

9.2 DIGITS SIGNED

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

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

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

SOURCE:
CWF

121. Line Beneficiary Primary Payer Code

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

DB2 ALIAS: LINE_PRMRY_PYR_CD
SAS ALIAS: LPRPAYCD
STANDARD ALIAS: LINE_BENE_PRMRY_PYR_CD
TITLE ALIAS: PRIMARY_PAYER_CD

CODES:
  REFER TO: BENE_PRMRY_PYR_TB
    IN THE CODES APPENDIX

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

SOURCE:
CWF, VA, DOL, SSA

122. Line Beneficiary Primary Payer Paid Amount

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

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_PRMRY_PYR_PD
SAS ALIAS: LPRPDAMT
STANDARD ALIAS: LINE_BENE_PRMRY_PYR_PD_AMT
TITLE ALIAS: PRMRY_PYR_PD

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

NAME  TYPE  LENGTH  BEG  END  CONTENTS
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EDIT-RULES:
$$$$$$$$$$CC

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

SOURCE:
CWF
123. Line Coinsurance Amount  PACK  6

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

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

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_COINSRNC_AMT
SAS ALIAS: COINAMT
STANDARD ALIAS: LINE_COINSRNC_AMT
TITLE ALIAS: COINSRNC_AMT

SOURCE:
CWF

124. Line Interest Amount  PACK  6

Amount of interest to be paid for this line item service on the noninstitutional claim.

**NOTE: This is not included in the line item NCH payment (reimbursement) amount.

9.2 DIGITS SIGNED

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

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

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

SOURCE:
CWF

125. Line Primary Payer Allowed Charge Amount  PACK  6

Effective with Version H, the primary payer allowed charge amount for the line item service on the noninstitutional claim.
### 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>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>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>126. Line 10% Penalty Reduction</th>
<th>PACK</th>
<th>6</th>
<th></th>
<th></th>
<th>Effective with Version H, the 10% payment reduction amount (applicable to a late filing claim) for the line item service. on the noninstitutional claim.</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>127. Line Submitted Charge Amount</th>
<th>PACK</th>
<th>6</th>
<th></th>
<th></th>
<th>The amount of submitted charges for the line item service on the noninstitutional claim.</th>
</tr>
</thead>
</table>

9.2 DIGITS SIGNED

`DB2 ALIAS: LINE_SBMT_CHRG_AMT`

`SAS ALIAS: LSBMTCHG`

`STANDARD ALIAS: LINE_SBMT_CHRG_AMT`

`TITLE ALIAS: SBMT_CHRG`

**EDIT-RULES:**

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

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
TITLE ALIAS: ALOW_CHRG

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

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

Effective with Version G, the amount of savings attributable to the coverage screen for this DMERC line item.

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_SCRN_SVGS_AMT
SAS ALIAS: SCRNSVGS
STANDARD ALIAS: DMERC_LINE_SCRN_SVGS_AMT
130. Line DME Purchase Price

Amount

Effective 5/92, the amount representing the lower of fee schedule for purchase of new or used DME, or actual charge. In case of rental DME, this amount represents the purchase cap; rental payments can only be made until the cap is met. This line item field is applicable to non-institutional claims involving DME, prosthetic, orthotic and supply items, immunosuppressive drugs, pen, ESRD and oxygen items referred to as DMEPOS.

9.2 DIGITS SIGNED

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

1 DMERC Claim Record -- FROM HCFA DATA DICTIONARY -- 03/16/2001
132. 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.

SOURCE:
CWF

133. Line Service Deductible CHAR 1

Switch indicating whether or not the line item
Indicator Switch

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

134. 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:

REFER TO: LINE_PMT_IND_TB
IN THE CODES APPENDIX

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

SOURCE:
CWF

135. DMERC Line Miles/Time/Units/Services Count

PACK 4

Effective with Version G, the count of the total units associated with the DMERC line item service needing unit reporting, including number of services, volume of oxygen and drug dose.

7 DIGITS SIGNED

DB2 ALIAS: DMERC_MTUS_CNT
### 136. DMERC Line

**Name:** Miles/Time/Units/Services Indicator Code  
**Type:** CHAR  
**Length:** 1  
**Source:** CWF

Effective with Version G, the code indicating the type of units reported for the DMERC line item.

- **DB2 Alias:** DMERC_MTUS_IND_CD  
- **SAS Alias:** UNIT_IND  
- **Standard Alias:** DMERC_LINE_MTUS_IND_CD  
- **Title Alias:** MTUS_IND

**Codes:**
- 0 = Values reported as zero
- 3 = Number of services
- 4 = Oxygen volume units
- 6 = Drug dosage

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

**Source:** CWF

---

### 137. Line Diagnosis Code

**Name:**  
**Type:** CHAR  
**Length:** 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

138. FILLER

139. Line Additional Claim Documentation Indicator Code

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

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

140. DMERC Line Screen Suspension Indicator Code

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CHAR</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Effective with Version G, the code identifying the medical review (MR) screen that caused DMERC line item to suspend.

DB2 ALIAS: SCRN_SUSPNSN_CD
SAS ALIAS: SUSP_IND
STANDARD ALIAS: DMERC_LINE_SCRN_SUSPNSN_IND_CD
TITLE ALIAS: SCRN_SUSPNSN_IND

CODES:
MUXX = Mandated unbundling screens
UXXX = Local unbundling screens
CXXX = Statutorily noncovered screens
M1XX = Mandate CAT I screens
1XXX = Local CAT I screens
M2XX = Mandate CAT II screens
2XXX = Local CAT II screens
M3XX = Mandate CAT III screens
3XXX = Local CAT III screens

SOURCE:
CWF

141. DMERC Line Screen Result Indicator Code
CHAR  1

Effective with Version G, code indicating the outcome of the medical review (MR) unit’s evaluation of the DMERC line item.

DB2 ALIAS: SCRN_RSLT_IND_CD
SAS ALIAS: RSLT_IND
STANDARD ALIAS: DMERC_LINE_SCRN_RSLT_IND_CD
TITLE ALIAS: SCRN_RSLT_IND

CODES:
REFER TO: DMERC_LINE_SCRN_RSLT_IND_TB IN THE CODES APPENDIX

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

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

POSITIONS

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

142. DMERC Line Waiver Of Provider Liability Switch
CHAR  1

Effective with Version G, the switch indicating the beneficiary was notified that the item, reported as a DMERC line item, may not be considered medically necessary and has agreed in writing to pay for the item.

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

POSITIONS

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CWF</td>
<td>CHAR</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
143. DMERC Line Decision Indicator Switch  CHAR  1

Effective with Version G, the switch identifying whether the DMERC claim represents an original decision or a reversal of an earlier decision on the original claim.

SOURCE:
CWF

144. FILLER  CHAR  50

SOURCE:
CWF

145. 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.

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>CODES:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>EOR = End of Record/Segment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>EOC= End of Claim</td>
</tr>
<tr>
<td>COMMENT:</td>
<td></td>
<td></td>
<td></td>
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<td>Prior to Version I this field was named: END_REC_CNSTNT.</td>
</tr>
<tr>
<td>SOURCE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NCH</td>
</tr>
</tbody>
</table>

**BENE_IDENT_TB**

Beneficiary Identification Code (BIC) Table

Social Security Administration:

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

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

---

DP = Remarried widower (2nd claimant)
DQ = Remarried widower (3rd claimant)
DR = Remarried widower (4th claimant)
DS = Surviving divorced husband (3rd claimant)
DT = Remarried widow (5th claimant)
DV = Surviving divorced wife (3rd claimant)
DW = Surviving divorced wife (4th claimant)
DX = Surviving divorced husband (4th claimant)
DY = Surviving divorced wife (5th claimant)
DZ = Surviving divorced husband (5th claimant)
E = Mother (widow) (1st claimant)
E1 = Surviving divorced mother (1st claimant)
E2 = Mother (widow) (2nd claimant)
E3 = Surviving divorced mother (2nd claimant)
E4 = Father (widower) (1st claimant)
E5 = Surviving divorced father (widower) (1st claimant)
E6 = Father (widower) (2nd claimant)
E7 = Mother (widow) (3rd claimant)
E8 = Mother (widow) (4th claimant)
E9 = Surviving divorced father (widower) (2nd claimant)
EA = Mother (widow) (5th claimant)
EB = Surviving divorced mother (3rd claimant)
EC = Surviving divorced mother (4th claimant)
ED = Surviving divorced mother (5th claimant)
EF = Father (widower) (3rd claimant)
EG = Father (widower) (4th claimant)
EH = Father (widower) (5th claimant)
EJ = Surviving divorced father (3rd claimant)
EK = Surviving divorced father (4th claimant)
EM = Surviving divorced father (5th claimant)
F1 = Father
F2 = Mother
F3 = Stepfather
F4 = Stepmother
F5 = Adopting father
F6 = Adopting mother
F7 = Second alleged father
F8 = Second alleged mother
J1 = Primary prouty entitled to HIB (less than 3 Q.C.) (general fund)
J2 = Primary prouty entitled to HIB (over 2 Q.C.) (RSI trust fund)
J3 = Primary prouty not entitled to HIB (less than 3 Q.C.) (general fund)
J4 = Primary prouty not entitled to HIB
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>K1</td>
<td>Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)</td>
<td></td>
</tr>
<tr>
<td>K2</td>
<td>Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)</td>
<td></td>
</tr>
<tr>
<td>K3</td>
<td>Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)</td>
<td></td>
</tr>
<tr>
<td>K4</td>
<td>Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)</td>
<td></td>
</tr>
<tr>
<td>K5</td>
<td>Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)</td>
<td></td>
</tr>
<tr>
<td>K6</td>
<td>Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)</td>
<td></td>
</tr>
<tr>
<td>K7</td>
<td>Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)</td>
<td></td>
</tr>
<tr>
<td>K8</td>
<td>Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)</td>
<td></td>
</tr>
<tr>
<td>K9</td>
<td>Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)</td>
<td></td>
</tr>
<tr>
<td>KA</td>
<td>Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)</td>
<td></td>
</tr>
<tr>
<td>KB</td>
<td>Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)</td>
<td></td>
</tr>
<tr>
<td>KC</td>
<td>Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)</td>
<td></td>
</tr>
<tr>
<td>KD</td>
<td>Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (4th claimant)</td>
<td></td>
</tr>
<tr>
<td>KE</td>
<td>Prouty wife entitled to HIB (over 2 Q.C.) (4th claimant)</td>
<td></td>
</tr>
<tr>
<td>KF</td>
<td>Prouty wife not entitled to HIB (less than 3 Q.C.) (4th claimant)</td>
<td></td>
</tr>
<tr>
<td>KG</td>
<td>Prouty wife not entitled to HIB (over 2 Q.C.) (4th claimant)</td>
<td></td>
</tr>
<tr>
<td>KH</td>
<td>Prouty wife entitled to HIB (less than 3 Q.C.) (5th claimant)</td>
<td></td>
</tr>
<tr>
<td>KJ</td>
<td>Prouty wife entitled to HIB (over 2 Q.C.) (5th claimant)</td>
<td></td>
</tr>
<tr>
<td>KL</td>
<td>Prouty wife not entitled to HIB (less than 3 Q.C.) (5th claimant)</td>
<td></td>
</tr>
</tbody>
</table>
than 3 Q.C.) (5th claimant)
KM = Prouty wife not entitled to HIB (over
2 Q.C.) (5th claimant)
M = Uninsured—not qualified for deemed HIB
M1 = Uninsured-qualified but refused HIB
T = Uninsured—entitled to HIB under deemed
or renal provisions
TA = MQGE (primary claimant)
TB = MQGE aged spouse (first claimant)
TC = MQGE disabled adult child (first claimant)
TD = MQGE aged widow(er) (first claimant)
TE = MQGE young widow(er) (first claimant)
TF = MQGE parent (male)
TG = MQGE aged spouse (second claimant)

<table>
<thead>
<tr>
<th>BENE_IDENT_TB</th>
<th>Beneficiary Identification Code (BIC) Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-------------------------------------------</td>
</tr>
</tbody>
</table>

TH = MQGE aged spouse (third claimant)
TJ = MQGE aged spouse (fourth claimant)
TK = MQGE aged spouse (fifth claimant)
TL = MQGE aged widow(er) (second claimant)
TM = MQGE aged widow(er) (third claimant)
TN = MQGE aged widow(er) (fourth claimant)
TP = MQGE aged widow(er) (fifth claimant)
TQ = MQGE parent (female)
TR = MQGE young widow(er) (second claimant)
TS = MQGE young widow(er) (third claimant)
TT = MQGE young widow(er) (fourth claimant)
TU = MQGE young widow(er) (fifth claimant)
TV = MQGE disabled widow(er) fifth claimant
TW = MQGE disabled widow(er) first claimant
TX = MQGE disabled widow(er) second claimant
TY = MQGE disabled widow(er) third claimant
TZ = MQGE disabled widow(er) fourth claimant
T2-T9 = Disabled child (second to ninth
claimant)
W = Disabled widow, age 50 or over (1st
claimant)
W1 = Disabled widower, age 50 or over (1st
claimant)
W2 = Disabled widow (2nd claimant)
W3 = Disabled widower (2nd claimant)
W4 = Disabled widow (3rd claimant)
W5 = Disabled widower (3rd claimant)
W6 = Disabled surviving divorced wife (1st
claimant)
W7 = Disabled surviving divorced wife (2nd
claimant)
W8 = Disabled surviving divorced wife (3rd claimant)
W9 = Disabled widow (4th claimant)
WB = Disabled widower (4th claimant)
WC = Disabled surviving divorced wife (4th claimant)
WF = Disabled widow (5th claimant)
WG = Disabled widower (5th claimant)
WJ = Disabled surviving divorced wife (5th claimant)
WR = Disabled surviving divorced husband (1st claimant)
WT = Disabled surviving divorced husband (2nd claimant)

Railroad Retirement Board:

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

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

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

**Beneficiary Primary Payer Table**

- **A** = Working aged bene/spouse with employer group health plan (EGHP)
- **B** = End stage renal disease (ESRD) beneficiary in the 18 month coordination period with an employer group health plan
- **C** = Conditional payment by Medicare; future reimbursement expected
- **D** = Automobile no-fault (eff. 4/97; Prior to 3/94, also included any liability insurance)
- **E** = Workers’ compensation
- **F** = Public Health Service or other federal agency (other than Dept. of Veterans Affairs)
- **G** = Working disabled bene (under age 65 with LGHP)
- **H** = Black Lung
- **I** = Dept. of Veterans Affairs
- **J** = Any liability insurance (eff. 3/94 - 3/97)
- **L** = Any liability insurance (eff. 4/97) (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)
- **M** = Override code: EGHP services involved (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)
- **N** = Override code: non-EGHP services involved (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)
- **BLANK** = Medicare is primary payer (not sure of effective date: in use 1/91, if
not earlier)

\[ T = \text{MSP cost avoided - IEQ contractor} \]
\[ \text{(eff. 7/96 carrier claims only)} \]

\[ U = \text{MSP cost avoided - HMO rate cell adjustment contractor} \]
\[ \text{(eff. 7/96 carrier claims only)} \]

\[ V = \text{MSP cost avoided - litigation settlement contractor} \]
\[ \text{(eff. 7/96 carrier claims only)} \]

\[ X = \text{MSP cost avoided override code} \]
\[ \text{(eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)} \]

***Prior to 12/90***

\[ Y = \text{Other secondary payer investigation shows Medicare as primary payer} \]

\[ Z = \text{Medicare is primary payer} \]

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 supposed to be effective after 12/90, but may have been used prior to that date.)

1 BENE_PRMRY_PYR_TB
---------------------
Beneficiary Primary Payer Table
---------------------

1 BETOS_TB
---------
BETOS Table
---------

M1A = Office visits - new
M1B = Office visits - established
M2A = Hospital visit - initial
M2B = Hospital visit - subsequent
M2C = Hospital visit - critical care
M3 = Emergency room visit
M4A = Home visit
M4B = Nursing home visit
M5A = Specialist - pathology
M5B = Specialist - psychiatry
M5C = Specialist - opthamology
<table>
<thead>
<tr>
<th>Code</th>
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<tr>
<td>M5D</td>
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<td>M6</td>
<td>Consultations</td>
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<td>P1A</td>
<td>Major procedure - breast</td>
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<tr>
<td>P1B</td>
<td>Major procedure - colectomy</td>
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<tr>
<td>P1C</td>
<td>Major procedure - cholecystectomy</td>
</tr>
<tr>
<td>P1D</td>
<td>Major procedure - turp</td>
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<tr>
<td>P1E</td>
<td>Major procedure - hysterectomy</td>
</tr>
<tr>
<td>P1F</td>
<td>Major procedure - explor/decompr/excisdisc</td>
</tr>
<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>
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<tr>
<td>P2C</td>
<td>Major Procedure, cardiovascular-Thromboendarterectomy</td>
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<tr>
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<td>Major procedure, cardiovascular-Coronary angioplasty (PTCA)</td>
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<td>Major procedure, cardiovascular-Pacemaker insertion</td>
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<td>Eye procedure - cataract removal/lens insertion</td>
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<td>P4C</td>
<td>Eye procedure - retinal detachment</td>
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<td>P4D</td>
<td>Eye procedure - treatment</td>
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<td>P5B</td>
<td>Ambulatory procedures - musculoskeletal</td>
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<tr>
<td>P5C</td>
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<tr>
<td>P5D</td>
<td>Ambulatory procedures - lithotripsy</td>
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<td>P5E</td>
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<td>Minor procedures - musculoskeletal</td>
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<td>P6C</td>
<td>Minor procedures - other (Medicare fee schedule)</td>
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<td>Minor procedures - other (non-Medicare fee schedule)</td>
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<td>Endoscopy - colonoscopy</td>
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<td>P8E</td>
<td>Endoscopy - cystoscopy</td>
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<td>P8F</td>
<td>Endoscopy - bronchoscopy</td>
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<td>P8G</td>
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<td>Endoscopy - laryngoscopy</td>
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<tr>
<td>P9A</td>
<td>Dialysis services</td>
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</table>
I1A = Standard imaging - chest
I1B = Standard imaging - musculoskeletal
I1C = Standard imaging - breast
I1D = Standard imaging - contrast gastrointestinal
I1E = Standard imaging - nuclear medicine
I1F = Standard imaging - other
I2A = Advanced imaging - CAT: head
I2B = Advanced imaging - CAT: other
I2C = Advanced imaging - MRI: brain
I2D = Advanced imaging - MRI: other
I3A = Echography - eye
I3B = Echography - abdomen/pelvis
I3C = Echography - heart
I3D = Echography - carotid arteries
I3E = Echography - prostate, transrectal
I3F = Echography - other
I4A = Imaging/procedure - heart including cardiac catheter
I4B = Imaging/procedure - other
T1A = Lab tests - routine venipuncture (non Medicare fee schedule)
T1B = Lab tests - automated general profiles
T1C = Lab tests - urinalysis
T1D = Lab tests - blood counts
T1E = Lab tests - glucose
T1F = Lab tests - bacterial cultures
T1G = Lab tests - other (Medicare fee schedule)
T1H = Lab tests - other (non-Medicare fee schedule)
T2A = Other tests - electrocardiograms
T2B = Other tests - cardiovascular stress tests
T2C = Other tests - EKG monitoring
T2D = Other tests - other
D1A = Medical/surgical supplies
D1B = Hospital beds
D1C = Oxygen and supplies
D1D = Wheelchairs
D1E = Other DME
D1F = Orthotic devices
O1A = Ambulance
O1B = Chiropractic
O1C = Enteral and parenteral
O1D = Chemotherapy
O1E = Other drugs
O1F = Vision, hearing and speech services
O1G = Influenza immunization
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<td>Local codes</td>
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<td>Z2</td>
<td>Undefined codes</td>
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1 CARR_CLM_PMT_DNL_TB

---

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
-----------------------
Carrier Line Provider Type Table
-----------------------

For Physician/Supplier (RIC O) Claims:

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

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

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

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

00510 = Alabama BS (eff. 1983)
00511 = Georgia - Alabama BS (eff. 1998)
00512 = Mississippi - Alabama BS (eff. 2000)
00520 = Arkansas BS (eff. 1983)
00521 = New Mexico - Arkansas BS (eff. 1998)
00522 = Oklahoma - Arkansas BS (eff. 1998)
00523 = Missouri - Arkansas BS (eff. 1999)
00528 = Louisiana - Arkansas BS (eff. 1984)
00542 = California BS (eff. 1983; term. 1996)
00550 = Colorado BS (eff. 1983; term. 1994)
00570 = Delaware - Pennsylvania BS (eff. 1983; term. 1997)
00580 = District of Columbia - Pennsylvania BS (eff. 1983; term. 1997)
CARR_NUM_TB

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<td>00591</td>
<td>Connecticut - Florida BS (eff. 2000)</td>
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<tr>
<td>00621</td>
<td>Illinois BS - HCSC (eff. 1983; term. 1998)</td>
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<tr>
<td>00630</td>
<td>Indiana - Administar (eff. 1983)</td>
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<tr>
<td>00635</td>
<td>DMERC-B (Administar Federal, Inc.) (eff. 1993)</td>
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<td>00640</td>
<td>Iowa - Wellmark, Inc. (eff. 1983; term. 1998)</td>
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<td>00645</td>
<td>Nebraska - Iowa BS (eff. 1985; term. 1987)</td>
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<td>Massachusetts BS (eff. 1983; term. 1997)</td>
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<td>Michigan BS (eff. 1983; term. 1994)</td>
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<tr>
<td>00720</td>
<td>Minnesota BS (eff. 1983; term. 1995)</td>
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<td>00740</td>
<td>Missouri - BS Kansas City (eff. 1983)</td>
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<td>00751</td>
<td>Montana BS (eff. 1983)</td>
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<tr>
<td>00770</td>
<td>New Hampshire/Vermont Physician Services (eff. 1983; term. 1984)</td>
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<tr>
<td>00780</td>
<td>New Hampshire/Vermont - Massachusetts BS (eff. 1985; term. 1997)</td>
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<tr>
<td>00801</td>
<td>New York - Western BS (eff. 1983)</td>
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<tr>
<td>00803</td>
<td>New York - Empire BS (eff. 1983)</td>
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<tr>
<td>00805</td>
<td>New Jersey - Empire BS (eff. 3/99)</td>
</tr>
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<td>00811</td>
<td>DMERC (A) - Western New York BS (eff. 2000)</td>
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<td>00820</td>
<td>North Dakota - North Dakota BS (eff. 1983)</td>
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<td>Wyoming - North Dakota BS (eff. 1990)</td>
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<td>00831</td>
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<td>00832</td>
<td>Arizona - North Dakota BS (eff. 1998)</td>
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<td>Hawaii - North Dakota BS (eff. 1998)</td>
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<td>00834</td>
<td>Nevada - North Dakota BS (eff. 1998)</td>
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<td>00835</td>
<td>Oregon - North Dakota BS (eff. 1998)</td>
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<td>00836</td>
<td>Washington - North Dakota BS (eff. 1998)</td>
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<td>New Jersey - Pennsylvania BS (eff. 1988; term. 1999)</td>
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<td>00865</td>
<td>Pennsylvania BS (eff. 1983)</td>
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<td>00870</td>
<td>Rhode Island BS (eff. 1983)</td>
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<td>00880</td>
<td>South Carolina BS (eff. 1983)</td>
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<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>
</tbody>
</table>
00900 = Texas BS (eff. 1983)
00901 = Maryland - Texas BS (eff. 1995)
00902 = Delaware - Texas BS (eff. 1998)
00903 = District of Columbia - Texas BS (eff. 1998)
00904 = Virginia - Texas BS (eff. 2000)
00910 = Utah BS (eff. 1983)
00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)
00952 = Illinois - Wisconsin Phy Svc (eff. 1999)
00953 = Michigan - Wisconsin Phy Svc (eff. 1999)
00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
00973 = Triple-S, Inc. - Puerto Rico (eff. 1983)
00974 = Triple-S, Inc. - Virgin Islands
01020 = Alaska - AETNA (eff. 1983; term. 1997)
01030 = Arizona - AETNA (eff. 1983; term. 1997)
01040 = Georgia - AETNA (eff. 1988; term. 1997)
01120 = Hawaii - AETNA (eff. 1983; term. 1997)
01290 = Nevada - AETNA (eff. 1983; term. 1997)
01360 = New Mexico - AETNA (eff. 1986; term. 1997)
01370 = Oklahoma - AETNA (eff. 1983; term. 1997)
01380 = Oregon - AETNA (eff. 1983; term. 1997)
01390 = Washington - AETNA (eff. 1994; term. 1997)
02050 = California - TOLIC (eff. 1983)
          (term. 2000)
03070 = Connecticut General Life Insurance Co.
          (eff. 1983; term. 1985)
05130 = Idaho - Connecticut General (eff. 1983)
05320 = New Mexico - Equitable Insurance
          (eff. 1983; term. 1985)
05440 = Tennessee - Connecticut General (eff. 1983)
05530 = Wyoming - Equitable Insurance (eff. 1983)
          (term. 1989)
05535 = North Carolina - Connecticut General
          (eff. 1988)
05655 = DMERC-D - Connecticut General (eff. 1993)
10071 = Railroad Board Travelers (eff. 1983)
          (term. 2000)
10230 = Connecticut - Metra Health (eff. 1986)
          (term. 2000)
10240 = Minnesota - Metra Health (eff. 1983)
          (term. 2000)
10250 = Mississippi - Metra Health (eff. 1983)
          (term. 2000)
10490 = Virginia - Metra Health (eff. 1983)
          (term. 2000)
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

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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

-------------------------
    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)
<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
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<tr>
<td>F1-F8</td>
<td>Equatable only to itself (e.g., F3 is equatable to F3)</td>
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<tr>
<td>CA-CZ</td>
<td>Equatable only to itself. (e.g., CA is only equatable to CA)</td>
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</tbody>
</table>

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**RRB Categories**

- 10 = 10
- 11 = 11
- 13 = 13; 17
- 14 = 14; 16
- 15 = 15
- 43 = 43
- 45 = 45
- 46 = 46
- 80 = 80
- 83 = 83
- 84 = 84; 86
- 85 = 85
A = Denied for lack of medical necessity; highest level of review was automated level I review
B = Reduced (partially denied) for lack of medical necessity; highest level of review was automated level I review
C = Denied as statutorily noncovered; highest level of review was automated level I review
D = Reserved for future use
E = Paid after automated level I review
F = Denied for lack of medical necessity; highest level of review was manual level I review
G = Reduced (partially denied) for lack of medical necessity; highest level of review was manual level I review
H = Denied as statutorily noncovered; highest level of review was manual level I review
I = Denied for coding/unbundling reasons; highest level of review was manual level I review
J = Paid after manual level I review
K = Denied for lack of medical necessity; highest level of review was manual level II review
L = Reduced (partially denied) for lack of medical necessity; highest level of review was manual level II review
M = Denied as statutorily noncovered; highest level of review was manual level II review
N = Denied for coding/unbundling reasons; highest level of review was manual level II review
O = Paid after manual level II review
P = Denied for lack of medical necessity; highest level of review was manual level III review
Q = Reduced (partially denied) for lack of medical necessity; highest level of review was manual level III review
R = Denied as statutorily noncovered; highest level of review was manual level III review
S = Denied for coding/unbundling reasons; highest level of review was manual level III review
T = Paid after manual level III review

1 DMERC_LINE_SUPLR_TYPE_TB
DMERC Line Supplier Type Table

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.

1 GEO_SSA_STATE_TB
State Table

01 = Alabama
02 = Alaska
03 = Arizona
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<td>New York</td>
</tr>
<tr>
<td>34</td>
<td>North Carolina</td>
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<tr>
<td>35</td>
<td>North Dakota</td>
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<td>36</td>
<td>Ohio</td>
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<td>Oklahoma</td>
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<td>38</td>
<td>Oregon</td>
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<td>39</td>
<td>Pennsylvania</td>
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<tr>
<td>40</td>
<td>Puerto Rico</td>
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<tr>
<td>41</td>
<td>Rhode Island</td>
</tr>
<tr>
<td>42</td>
<td>South Carolina</td>
</tr>
<tr>
<td>43</td>
<td>South Dakota</td>
</tr>
<tr>
<td>44</td>
<td>Tennessee</td>
</tr>
<tr>
<td>45</td>
<td>Texas</td>
</tr>
<tr>
<td>46</td>
<td>Utah</td>
</tr>
<tr>
<td>47</td>
<td>Vermont</td>
</tr>
<tr>
<td>48</td>
<td>Virgin Islands</td>
</tr>
<tr>
<td>49</td>
<td>Virginia</td>
</tr>
<tr>
<td>50</td>
<td>Washington</td>
</tr>
<tr>
<td>51</td>
<td>West Virginia</td>
</tr>
<tr>
<td>GEO_SSA_STATE_TB</td>
<td>State Table</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>58 = Europe</td>
<td></td>
</tr>
<tr>
<td>59 = Mexico</td>
<td></td>
</tr>
<tr>
<td>60 = Oceania</td>
<td></td>
</tr>
<tr>
<td>61 = Philippines</td>
<td></td>
</tr>
<tr>
<td>62 = South America</td>
<td></td>
</tr>
<tr>
<td>63 = U.S. Possessions</td>
<td></td>
</tr>
<tr>
<td>64 = American Samoa</td>
<td></td>
</tr>
<tr>
<td>65 = Guam</td>
<td></td>
</tr>
<tr>
<td>66 = Saipan</td>
<td></td>
</tr>
<tr>
<td>97 = Northern Marianas</td>
<td></td>
</tr>
<tr>
<td>98 = Guam</td>
<td></td>
</tr>
<tr>
<td>99 = With 000 county code is American Samoa; otherwise unknown</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPA_PRVDR_SPCLTY_TB</th>
<th>HCFA Provider Specialty Table</th>
</tr>
</thead>
</table>

**Prior to 5/92**

<table>
<thead>
<tr>
<th>Code</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>General practice</td>
</tr>
<tr>
<td>02</td>
<td>General surgery</td>
</tr>
<tr>
<td>03</td>
<td>Allergy (revised 10/91 to mean allergy/immunology)</td>
</tr>
<tr>
<td>04</td>
<td>Otolaryngology, rhinology</td>
</tr>
<tr>
<td></td>
<td>revised 10/91 to mean oto-laryngology)</td>
</tr>
<tr>
<td>05</td>
<td>Anesthesiology</td>
</tr>
<tr>
<td>06</td>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td></td>
<td>(revised 10/91 to mean cardiology)</td>
</tr>
<tr>
<td>07</td>
<td>Dermatology</td>
</tr>
<tr>
<td>08</td>
<td>Family practice</td>
</tr>
<tr>
<td>09</td>
<td>Gynecology--osteopaths only</td>
</tr>
<tr>
<td></td>
<td>(deleted 10/91; changed to '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>Manipulative therapy</td>
</tr>
<tr>
<td></td>
<td>(osteopaths only)</td>
</tr>
<tr>
<td></td>
<td>(revised 10/91 to mean osteopathic manipulative therapy)</td>
</tr>
<tr>
<td>Number</td>
<td>Specialty</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>13</td>
<td>Neurology</td>
</tr>
<tr>
<td>14</td>
<td>Neurological surgery (revised 10/91 to mean neurosurgery)</td>
</tr>
<tr>
<td>15</td>
<td>Obstetrics--osteopaths only (deleted 10/91; changed to '16')</td>
</tr>
<tr>
<td>16</td>
<td>OB-gynecology</td>
</tr>
<tr>
<td>17</td>
<td>Ophthalmology, otology, laryngology rhinology--osteopaths only (deleted 10/91; changed to '18' if physicians practice is more than 50% ophthalmology or to '04' if physician’s practice is more than 50% otolaryngology. If practice is 50/50, choose specialty with greater allowed charges.)</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 (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</td>
</tr>
</tbody>
</table>
38 = Geriatrics (revised 10/91 to mean geriatric medicine)
39 = Nephrology
40 = Hand surgery
41 = Optometrist - services related to condition of aphakia (revised 10/91 to mean optometrist)
42 = Certified nurse midwife (added 7/88)
43 = Certified registered nurse anesthetist (revised 10/91 to mean CRNA, anesthesia assistant)
44 = Infectious disease
46 = Endocrinology (added 10/91)
48 = Podiatry - surgery chiropody (revised 10/91 to mean podiatry)
49 = Miscellaneous (include ASCS)
51 = Medical supply company with C.O. certification (certified orthotist - certified by American Board for Certification in Prosthetics and Orthotics).
52 = Medical supply company with C.P. certification (certified prosthetist - certified by American Board for Certification in Prosthetics and Orthotics).
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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>63</td>
<td>Portable X-ray supplier--billing independently (revised 10/91 to mean portable X-ray supplier)</td>
</tr>
<tr>
<td>64</td>
<td>Audiologist (billing independently)</td>
</tr>
<tr>
<td>65</td>
<td>Physical therapist (independent practice)</td>
</tr>
<tr>
<td>66</td>
<td>Rheumatology (added 10/91)</td>
</tr>
<tr>
<td>67</td>
<td>Occupational therapist--independent practice</td>
</tr>
<tr>
<td>68</td>
<td>Clinical psychologist</td>
</tr>
<tr>
<td>69</td>
<td>Independent laboratory--billing independently (revised 10/91 to mean independent clinical laboratory -- billing independently)</td>
</tr>
<tr>
<td>70</td>
<td>Clinic or other group practice, except Group Practice Prepayment Plan (GPPP)</td>
</tr>
<tr>
<td>71</td>
<td>Group Practice Prepayment Plan - diagnostic X-ray (do not use after 1/92)</td>
</tr>
<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>Code</td>
<td>Specialty</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------</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>
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<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—including 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>Specialty</th>
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<tbody>
<tr>
<td>00</td>
<td>Carrier wide</td>
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<tr>
<td>01</td>
<td>General practice</td>
</tr>
<tr>
<td>02</td>
<td>General surgery</td>
</tr>
<tr>
<td>03</td>
<td>Allergy/immunology</td>
</tr>
<tr>
<td>04</td>
<td>Otolaryngology</td>
</tr>
<tr>
<td>05</td>
<td>Anesthesiology</td>
</tr>
<tr>
<td>06</td>
<td>Cardiology</td>
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<tr>
<td>07</td>
<td>Dermatology</td>
</tr>
<tr>
<td>08</td>
<td>Family practice</td>
</tr>
<tr>
<td>09</td>
<td>Gynecology (osteopaths only)</td>
</tr>
<tr>
<td>10</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>11</td>
<td>Internal medicine</td>
</tr>
<tr>
<td>12</td>
<td>Osteopathic manipulative therapy</td>
</tr>
<tr>
<td>13</td>
<td>Neurology</td>
</tr>
<tr>
<td>14</td>
<td>Neurosurgery</td>
</tr>
<tr>
<td>15</td>
<td>Obstetrics (osteopaths only)</td>
</tr>
<tr>
<td>16</td>
<td>Obstetrics/gynecology</td>
</tr>
<tr>
<td>17</td>
<td>Ophthalmology, otology, laryngology, rhinology (osteopaths only)</td>
</tr>
<tr>
<td>18</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>19</td>
<td>Oral surgery (dentists only)</td>
</tr>
<tr>
<td>20</td>
<td>Orthopedic surgery</td>
</tr>
<tr>
<td>21</td>
<td>Pathologic anatomy, clinical pathology (osteopaths only)</td>
</tr>
<tr>
<td>22</td>
<td>Pathology</td>
</tr>
<tr>
<td>Code</td>
<td>Specialty</td>
</tr>
<tr>
<td>------</td>
<td>-----------</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>
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<tr>
<td>37</td>
<td>Pediatric medicine</td>
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<td>38</td>
<td>Geriatric medicine</td>
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<tr>
<td>39</td>
<td>Nephrology</td>
</tr>
<tr>
<td>40</td>
<td>Hand surgery</td>
</tr>
<tr>
<td>41</td>
<td>Optometry (revised 10/93 to mean optometrist)</td>
</tr>
<tr>
<td>42</td>
<td>Certified nurse midwife (eff 1/87)</td>
</tr>
<tr>
<td>43</td>
<td>Crna, anesthesia assistant (eff 1/87)</td>
</tr>
<tr>
<td>44</td>
<td>Infectious disease</td>
</tr>
<tr>
<td>45</td>
<td>Mammography screening center</td>
</tr>
<tr>
<td>46</td>
<td>Endocrinology (eff 5/92)</td>
</tr>
<tr>
<td>47</td>
<td>Independent Diagnostic Testing Facility (IDTF) (eff. 6/98)</td>
</tr>
<tr>
<td>48</td>
<td>Podiatry</td>
</tr>
<tr>
<td>49</td>
<td>Ambulatory surgical center (formerly miscellaneous)</td>
</tr>
<tr>
<td>50</td>
<td>Nurse practitioner</td>
</tr>
<tr>
<td>51</td>
<td>Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics)</td>
</tr>
<tr>
<td>52</td>
<td>Medical supply company with certified prosthetist</td>
</tr>
</tbody>
</table>
(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 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

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

  code 88 eff 10/93)

1  HCFA_TYPE_SRVC_TB  
  --------------  
  HCFA Type of Service 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)

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

**Effective 1/92**

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

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

1 LINE_PMT_IND_TB Line Payment Indicator Table
----------------

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

1 LINE_PRCGS_IND_TB Line Processing Indicator Table
----------------

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

1 LINE_PRVDR_PRTCPTG_IND_TB
-------------------------
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
---------------
10 = HHA claim
20 = Non swing bed SNF claim
30 = Swing bed SNF claim
40 = Outpatient claim
41 = Outpatient ‘Full-Encounter’ claim (available in NMUD)
42 = Outpatient ‘Abbreviated-Encounter’ claim
(available in NMUD)

50 = Hospice claim
60 = Inpatient claim
61 = Inpatient 'Full-Encounter’ claim
62 = Inpatient 'Abbreviated-Encounter' claim
(available in NMUD)
71 = RIC O local carrier non-DMEPOS claim
72 = RIC O local carrier DMEPOS claim
73 = Physician 'Full-Encounter’ claim
(available in NMUD)
81 = RIC M DMERC non-DMEPOS claim
82 = RIC M DMERC DMEPOS claim

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

A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
A000 = (C) REIMB > $100,000 OR UNITS > 150
A002 = (C) CLAIM IDENTIFIER (CAN)
A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
A004 = (C) PATIENT SURNAME BLANK
A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
A006 = (C) DATE OF BIRTH IS NOT NUMERIC
A007 = (C) INVALID GENDER (0, 1, 2)
A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
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 DESCRIP MISSING
D5X3 = (C) DME INVALID USE OF MS MODIFIER
D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED
D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS
D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>D6X1</td>
<td>DME SUPPLIER NUMBER MISSING</td>
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<tr>
<td>D7X1</td>
<td>DME PURCHASE ALLOWABLE INVALID</td>
</tr>
<tr>
<td>D919</td>
<td>CAPPED/PEN PUMPS, NUM OF SRVCS &gt; 1</td>
</tr>
<tr>
<td>D921</td>
<td>SHOE HCPC W/O MOD RT, LT REQ U=2/4/6</td>
</tr>
<tr>
<td>XXXX</td>
<td>SYS DUPL: HOST/BATCH/QUERY-CODE</td>
</tr>
<tr>
<td>Y001</td>
<td>HCPCS R0075/UNITS&gt;1/SERVICES=1</td>
</tr>
<tr>
<td>Y002</td>
<td>HCPCS R0075/UNITS=1/SERVICES&gt;1</td>
</tr>
<tr>
<td>Y003</td>
<td>HCPCS R0075/UNITS=SERVICES</td>
</tr>
<tr>
<td>Y010</td>
<td>TOB=13X/14X AND T.C.&gt;$7,500</td>
</tr>
<tr>
<td>Y011</td>
<td>INP CLAIM/REIM &gt; $75,000</td>
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<tr>
<td>Z001</td>
<td>RVNU 820-859 REQ COND CODE 71-76</td>
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<tr>
<td>Z002</td>
<td>CC M2 PRESENT/REIMB &gt; $150,000</td>
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<tr>
<td>Z003</td>
<td>CC M2 PRESENT/UNITS &gt; 150</td>
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<tr>
<td>Z004</td>
<td>CC M2 PRESENT/UNITS &amp; REIM &lt; MAX</td>
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<tr>
<td>Z005</td>
<td>REIMB&gt;99999 AND REIMB&lt;150000</td>
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<tr>
<td>Z006</td>
<td>UNITS&gt;99 AND UNITS&lt;150</td>
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<tr>
<td>Z237</td>
<td>HOSPICE OVERLAP - DATE ZERO</td>
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<tr>
<td>0011</td>
<td>ACTION CODE INVALID</td>
</tr>
<tr>
<td>0013</td>
<td>CABG/PCOE AND INVALID ADMIT DATE</td>
</tr>
<tr>
<td>0014</td>
<td>DEMO NUM NOT=01-06,08,15,31</td>
</tr>
<tr>
<td>0015</td>
<td>ESRD PLAN BUT DEMO ID NOT = 15</td>
</tr>
<tr>
<td>0016</td>
<td>INVALID VA CLAIM</td>
</tr>
<tr>
<td>0017</td>
<td>DEMO=31,TOB&lt;&gt;11 OR SPEC&lt;&gt;08</td>
</tr>
<tr>
<td>0018</td>
<td>DEMO=31,ACT CD&lt;&gt;1/5 OR ENT CD&lt;&gt;1/5</td>
</tr>
<tr>
<td>0020</td>
<td>CANCEL ONLY CODE INVALID</td>
</tr>
<tr>
<td>0021</td>
<td>DEMO COUNT &gt; 1</td>
</tr>
<tr>
<td>0301</td>
<td>INVALID HI CLAIM NUMBER</td>
</tr>
</tbody>
</table>

1 NCH_EDIT_TB
   -----------

NCH_EDIT_TABLE

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>0302</td>
<td>BENE IDEN CDE (BIC) INVAL OR BLK</td>
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<tr>
<td>04A1</td>
<td>PATIENT SURNAME BLANK (PHYS/SUP)</td>
</tr>
<tr>
<td>04B1</td>
<td>PATIENT 1ST INITIAL NOT-ALPHABETIC</td>
</tr>
<tr>
<td>0401</td>
<td>BILL TYPE/PROVIDER INVALID</td>
</tr>
<tr>
<td>0402</td>
<td>BILL TYPE/REV CODE/PROVR RANGE</td>
</tr>
<tr>
<td>0406</td>
<td>MAMMOGRAPHY WITH NO HCPCS 76092</td>
</tr>
<tr>
<td>0407</td>
<td>RESPITE CARE BILL TYPE 34X, NO REV 66</td>
</tr>
<tr>
<td>0408</td>
<td>REV CODE 403 /TYPE 71X/ PROV3800-974</td>
</tr>
<tr>
<td>0410</td>
<td>IMMUNO DRUG OCCR-36, NO REV-25 OR 636</td>
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<tr>
<td>0412</td>
<td>BILL TYPE XX5 HAS ACCOM. REV. CODES</td>
</tr>
<tr>
<td>0413</td>
<td>CABG/PCOE BUT TOB = HHA, OUT, HOS</td>
</tr>
<tr>
<td>0414</td>
<td>VALU CD 61, MSA AMOUNT MISSING</td>
</tr>
<tr>
<td>0415</td>
<td>HOME HEALTH INCORRECT ALPHA RIC</td>
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<tr>
<td>05X4</td>
<td>UPIN REQUIRED FOR TYPE-OF-SERVICE</td>
</tr>
<tr>
<td>05X5</td>
<td>UPIN REQUIRED FOR DME HCPCS</td>
</tr>
<tr>
<td>0501</td>
<td>UNIQUE PHY IDEN. (UPIN) BLANK</td>
</tr>
<tr>
<td>0502</td>
<td>UNIQUE PHY IDEN. (UPIN) INVALID</td>
</tr>
</tbody>
</table>
0601 = (C) GENDER INVALID
0701 = (C) CONTRACTOR INVALID CARRIER/ETC
0702 = (C) PROVIDER NUMBER INCONSISTANT
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
0704 = (C) INVALID CONT FOR CABG DEMO
0705 = (C) INVALID CONT FOR PCOE DEMO
0901 = (C) INVALID DISP CODE OF 02
0902 = (C) INVALID DISP CODE OF SPACES
0903 = (C) INVALID DISP CODE
1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE
13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
1301 = (C) LINE COUNT NOT NUMERIC OR > 13
1302 = (C) RECORD LENGTH INVALID
1401 = (C) INVALID MEDICARE STATUS CODE
1501 = (C) ADMIT DATE/ENTRY CODE INVALID
1502 = (C) ADMIT DATE > STAY FROM DATE
1503 = (C) ADMIT DATE INVALID WITH THRU DATE
1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
1505 = (C) HCPCS W SERVICE DATES > 09-30-94
1601 = (C) INVESTIGATION IND INVALID
1701 = (C) SPLIT IND INVALID
1801 = (C) PAY-DENY CODE INVALID
1802 = (C) HEADER AMT AND NOT DENIED CLAIM
1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME
1901 = (C) AB CROSSOVER IND INVALID
2001 = (C) HOSPICE OVERRIDE INVALID
2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
2102 = (C) FROM/THRU DATE OR KRON/PAT STAT
2201 = (C) FROM/THRU DATE OR HCPCS YR INVAL
2202 = (C) STAY-FROM DATE > THRU-DATE
2203 = (C) THRU DATE INVALID
2204 = (C) FROM DATE BEFORE EFFECTIVE DATE
2205 = (C) DATE YEARS DIFFERENT ON OUTPAT
2207 = (C) MAMMOGRAPHY BEFORE 1991
2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID
2302 = (C) COVERED DAYS INVALID OR INCONSIST
2303 = (C) COST REPORT DAYS > ACCOMODATION
2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL
2305 = (C) UTIL DAYS = INCONSISTENCIES
2306 = (C) UTIL DAYS/NOPAY/REIMB INCONSISTENT
2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09
2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
2401 = (C) NON-UTIL DAYS INVALID
2501 = (C) CLAIM RCV DT OR COINSURANCE 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
2509 = (C) LIFE RESERVE > RATE FOR CAL YEAR
2510 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
2511 = (C) UTIL DAYS > FROM TO BENEF EXH
2512 = (C) UTIL DAYS > FROM BENEF EXH
2513 = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
2514 = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
2515 = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
2516 = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
2517 = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
2518 = (C) INVALID OCC CODE
2519 = (C) BENE EXH DATE OUTSIDE SERVICE DATES
2520 = (C) OCCUR DATE INVALID
2521 = (C) OCCUR = 20 AND TRANS = 4
2522 = (C) OCCUR 20 DATE < ADMIT DATE
2523 = (C) OCCUR 20 DATE > ADMIT + 12
2524 = (C) OCCUR 20 AND ADMIT NOT = FROM
2525 = (C) OCCUR 20 DATE < BENE EXH DATE
2526 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
2527 = (C) OCCUR 22 DATE < FROM OR > THRU
2528 = (C) OCCUR DATE INVALID
2529 = (C) OCCUR = 20 AND TRANS = 4
2530 = (C) OCCUR 20 DATE < ADMIT DATE
2531 = (C) OCCUR 20 DATE > ADMIT + 12
2532 = (C) OCCUR 20 AND ADMIT NOT = FROM
2533 = (C) OCCUR 20 DATE < BENE EXH DATE
2534 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
2535 = (C) OCCUR 22 DATE < FROM OR > THRU
2536 = (C) OCCUR DATE INVALID
2537 = (C) OCCUR = 20 AND TRANS = 4
2538 = (C) OCCUR 20 DATE < ADMIT DATE
2539 = (C) OCCUR 20 DATE > ADMIT + 12
2540 = (C) OCCUR 20 AND ADMIT NOT = FROM
2541 = (C) OCCUR 20 DATE < BENE EXH DATE
2542 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
2543 = (C) OCCUR 22 DATE < FROM OR > THRU
2544 = (C) OCCUR DATE INVALID
2545 = (C) OCCUR = 20 AND TRANS = 4
2546 = (C) OCCUR 20 DATE < ADMIT DATE
2547 = (C) OCCUR 20 DATE > ADMIT + 12
2548 = (C) OCCUR 20 AND ADMIT NOT = FROM
2549 = (C) OCCUR 20 DATE < BENE EXH DATE
2550 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
2551 = (C) OCCUR 22 DATE < FROM OR > THRU
2552 = (C) OCCUR DATE INVALID
2553 = (C) OCCUR = 20 AND TRANS = 4
2554 = (C) OCCUR 20 DATE < ADMIT DATE
2555 = (C) OCCUR 20 DATE > ADMIT + 12
2556 = (C) OCCUR 20 AND ADMIT NOT = FROM
2557 = (C) OCCUR 20 DATE < BENE EXH DATE
2558 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
2559 = (C) OCCUR 22 DATE < FROM OR > THRU
2560 = (C) OCCUR DATE INVALID
2561 = (C) OCCUR = 20 AND TRANS = 4
2562 = (C) OCCUR 20 DATE < ADMIT DATE
2563 = (C) OCCUR 20 DATE > ADMIT + 12
2564 = (C) OCCUR 20 AND ADMIT NOT = FROM
2565 = (C) OCCUR 20 DATE < BENE EXH DATE
2566 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
2567 = (C) OCCUR 22 DATE < FROM OR > THRU
2568 = (C) OCCUR DATE INVALID
2569 = (C) OCCUR = 20 AND TRANS = 4
2570 = (C) OCCUR 20 DATE < ADMIT DATE
2571 = (C) OCCUR 20 DATE > ADMIT + 12
2572 = (C) OCCUR 20 AND ADMIT NOT = FROM
2573 = (C) OCCUR 20 DATE < BENE EXH DATE
2574 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
2575 = (C) OCCUR 22 DATE < FROM OR > THRU
2576 = (C) OCCUR DATE INVALID
2577 = (C) OCCUR = 20 AND TRANS = 4
2578 = (C) OCCUR 20 DATE < ADMIT DATE
2579 = (C) OCCUR 20 DATE > ADMIT + 12
2580 = (C) OCCUR 20 AND ADMIT NOT = FROM
2581 = (C) OCCUR 20 DATE < BENE EXH DATE
2582 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
2583 = (C) OCCUR 22 DATE < FROM OR > THRU
2584 = (C) OCCUR DATE INVALID
2585 = (C) OCCUR = 20 AND TRANS = 4
2586 = (C) OCCUR 20 DATE < ADMIT DATE
2587 = (C) OCCUR 20 DATE > ADMIT + 12
2588 = (C) OCCUR 20 AND ADMIT NOT = FROM
2589 = (C) OCCUR 20 DATE < BENE EXH DATE
2590 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
2591 = (C) OCCUR 22 DATE < FROM OR > THRU
2592 = (C) OCCUR DATE INVALID
2593 = (C) OCCUR = 20 AND TRANS = 4
2594 = (C) OCCUR 20 DATE < ADMIT DATE
2595 = (C) OCCUR 20 DATE > ADMIT + 12
2596 = (C) OCCUR 20 AND ADMIT NOT = FROM
2597 = (C) OCCUR 20 DATE < BENE EXH DATE
2598 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
2599 = (C) OCCUR 22 DATE < FROM OR > THRU
2600 = (C) OCCUR DATE INVALID
2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
2602 = (C) LR-DYS, NO VAL 08,10/PD/DEN>CUR+27
2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
2604 = (C) PPS BILL, NO DAY OUTLIER
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
28XA = (C) UTIL DAYS > FROM TO BENEF EXH
28XB = (C) BENEFITS EXH DATE > FROM DATE
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN = (C) INVALID OCC CODE
28XO = (C) BENE EXH DATE OUTSIDE SERVICE DATES
28X1 = (C) OCCUR DATE INVALID
28X2 = (C) OCCUR 20 AND TRANS = 4
28X3 = (C) OCCUR 20 DATE < ADMIT DATE
28X4 = (C) OCCUR 20 DATE > ADMIT + 12
28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM
28X6 = (C) OCCUR 20 DATE < BENE EXH DATE
28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
28X8 = (C) OCCUR 22 DATE < FROM OR > THRU
28X9 = (C) UTIL > FROM - THRU LESS NCOV
33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)
33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)
33X3 = (C) QS DAYS/ADMISSION ARE INVALID
33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)
33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE
33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091
33X7 = (C) TOB<>18/21/28/51,COND=WO
33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001
33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT
34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN
3401 = (C) DEMO ID = 04 AND RIC NOT = 1
35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS
35X2 = (C) COND = 60 OR 61 AND NO VALU 17
35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0
36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU
3701 = (C) ASSIGN CODE INVALID
3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA
3706 = (C) INVALID IDE NUMBER—NOT IN FILE
3710 = (C) NUM OF IDE# > REV 0624
3715 = (C) NUM OF IDE# < REV 0624
3720 = (C) IDE AND LINE ITEM NUMBER > 2
3801 = (C) AMT BENE PD INVALID
4001 = (C) BLOOD PINTS FURNISHED INVALID
4002 = (C) BLOOD FURNISHED/REPLACED INVALID
1         NCH_EDIT_TB                                       NCH EDIT TABLE
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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
46XN = (C) VALUE CODE 37,38,39 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
46XR = (C) BLD FIELDS VS REV CDE 380,381,382
46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT
46XT = (C) CABG/PCOE,VC<>Y1,Y2,Y3,Y4,VA NOT>0
46X1 = (C) VALUE AMOUNT INVALID
46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61
46X7 = (C) OUTLIER (VAL 17) > REIMB + VAL6-16
46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
4601 = (C) CABG/PCOE, MSP CODE PRESENT
4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
4901 = (C) PCOE/CABG,DEN CD NOT D
4902 = (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
5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
51XA = (C) HCPCS EYEWARE & REV CODE NOT 274
51XC = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51XD = (C) HCPCS REQUIRES UNITS > ZERO
51XE = (C) HCPCS REQUIRES REVENUE CODE 636
51XF = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51XG = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
51XH = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044
51XI = (C) TOB 21X/P82<>2/3/4:REV CD<9001,>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/<9045,RC<>4/234
51XN = (C) 21X,RC>9032/<9042,RC<>4/234
51XO = (C) REV CENTER CODE INVALID
51XP = (C) HHA RC DATE OF SRVC MISSING
51XR = (C) DEMO ID=01,RIC NOT=2
51XS = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21
51X1 = (C) REV CODE CHECK
51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
51X3 = (C) UNITS MUST BE > 0
51X4 = (C) INP:CHGS/YR-RATE,Etc; OUTP:PSYCH>YR
51X5 = (C) REVENUE NON-COVERED > TOTAL CHRG
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
51X9 = (C) HCPCS/REV CODE/BILL TYPE
5100 = (U) TRANSITION SPELL / SNF
5160 = (U) LATE CHG HSF BILL STAY DAYS > 0
5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT
5169 = (U) PROVIDER NE TO WORK PROVIDER
5177 = (U) PROVIDER NE TO WORK PROVIDER
5178 = (U) HOSPICE BILL THRU < DOLBA
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
5200 = (E) ENTITLEMENT EFFECTIVE DATE
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
5202 = (U) HOSPICE TRAILER ERROR
5203 = (E) ENTITLEMENT HOSPICE PERIODS
5203 = (U) HOSPICE START DATE ERROR
NCH_EDIT_TB
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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 2ND
5209 = (U) HOSPICE DATE DISCREPANCY
5210 = (E) ENTITLEMENT FRM/TRU/END DATES
5211 = (E) ENTITLEMENT DATE DEATH/THRU
5212 = (E) ENTITLEMENT DATE DEATH/THRU
5213 = (E) ENTITLEMENT DATE DEATH MBR
5214 = (E) ENTITLEMENT FROM/EFF DATES
5215 = (E) ENT INP PPS SPAN 70 DATES
5216 = (E) ENTL HMO NO HMO OVERRIDE CDE
5217 = (E) ENTITLEMENT HMO PERIODS
5218 = (E) ENTITLEMENT HMO NUMBER NEEDED
5219 = (E) ENTITLEMENT HMO HOSP+NO CC07
5220 = (E) ENTITLEMENT HMO HOSP + CC07
5221 = (E) ENTITLEMENT HOSP OVERLAP
5222 = (U) HOSPICE CLAIM OVERLAP > 90
5223 = (U) HOSPICE CLAIM OVERLAP > 60
5224 = (E) HOSP OVERLAP NO OVD NO DEMO
5225 = (U) HOSPICE DAYS STAY+USED > 90
5226 = (U) HOSPICE DAYS STAY+USED > 60
5227 = (C) INVALID CARRIER FOR RRB
5228 = (C) HMO=90091,INVALID SERVICE DTE
5229 = (E) DEMO CABG/PCOE MISSING ENTL
5230 = (C) INVALID CARRIER FOR NON RRB
5231 = (E) HMO/HOSP 6/7 NO OVD NO DEMO
5232 = (U) HOSPICE DOEBA/DOLBA
5233 = (U) HOSPICE DAYS USED
5234 = (U) HOSPICE DAYS USED > 999
5235 = (E) HMO/HOSP DEMO 5/15 REIMB > 0
5236 = (E) HMO/HOSP DEMO 5/15 REIMB = 0
5237 = (E) HMO/HOSP DEMO OVD=1 REIMB > 0
5238 = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
5239 = (U) HOSPICE PERIOD NUMBER ERROR

NCH Edit Table
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5320 = (U) BILL > DOEBA AND IND-1 = 2
5321 = (U) HOSPICE DOEBA/DOLBA SECONDARY
5322 = (U) HOSPICE DAYS USED SECONDARY
5323 = (C) SERVICE DATE < AGE 50
5324 = (U) HOSPICE PERIOD NUM MATCH
5325 = (U) INPAT DEDUCTABLE
5326 = (U) PART B DEDUCTABLE CHECK
5327 = (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, PAND A 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
59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE
59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS
59XG = (C) CAPPED/FREQ-MAINT/PROST HCPCS
59XH = (C) HCPCS E0620/TYPE/DATE
59XI = (C) HCPCS E0627-9/ DATE < 1991
59XL = (C) HCPCS 00104 - TOS/POS
59X1 = (C) INVALID HCPCS/TOS COMBINATION
59X2 = (C) ASC IND/TYPE OF SERVICE INVALID
59X3 = (C) TOS INVALID TO MODIFIER
59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB
59X5 = (C) MAMMOGRAPHY FOR MALE
59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS
59X7 = (C) CAPPED-HCPCS/FROM DATE
59X8 = (C) FREQUENTLY MAINTAINED HCPCS
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<thead>
<tr>
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<th>Description</th>
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<tbody>
<tr>
<td>59X9</td>
<td>(C) HCPCS E1220/FROM DATE/TYP IS R</td>
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<td>(U) ERROR CODE OF Q</td>
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<tr>
<td>60X1</td>
<td>(C) ASSIGN IND INVALID</td>
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<td>6000</td>
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<tr>
<td>6020</td>
<td>(U) CURRENT SPELL DOEBA &lt; 1990</td>
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<tr>
<td>6030</td>
<td>(U) ADJUSTMENT BILL SPELL DATA</td>
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<td>6035</td>
<td>(U) ADJUSTMENT BILL THRU DTE/DLOBA</td>
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<td>(C) PAY PROCESS IND INVALID</td>
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<tr>
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<td>(C) DENIED CLAIM/NO DENIED LINE</td>
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<tr>
<td>61X3</td>
<td>(C) PAY PROCESS IND/ALLOWED CHARGES</td>
</tr>
<tr>
<td>61X4</td>
<td>(C) RATE MISSING OR NON-NUMERIC</td>
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<tr>
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<td>(C) REV 0001 NOT PRESENT ON CLAIM</td>
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<td>(C) REV COMPUTED CHARGES NOT=TOTAL</td>
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<tr>
<td>6102</td>
<td>(C) REV COMPUTED NON-COVERED/NON-COV</td>
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<tr>
<td>6103</td>
<td>(C) REV TOTAL CHARGES &lt; PRIMARY PAYER</td>
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<td>62XA</td>
<td>(C) PSYC OT PT/REIM/TYP</td>
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<tr>
<td>62X1</td>
<td>(C) DME/DATE/100% OR INVAL REIMB IND</td>
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<td>62X6</td>
<td>(C) RAD PATH/PLACE/TYP/DATE/DED</td>
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<td>62X8</td>
<td>(C) KIDNEY DONO/TYP/100%</td>
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<td>62X9</td>
<td>(C) NEUM VACCINE/TYP/100%</td>
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<td>(C) TOTAL DEDUCT &gt; CHARGES/NON-COV</td>
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<tr>
<td>6203</td>
<td>(U) HOSPICE ADJUSTMENT PERIOD/DATE</td>
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<tr>
<td>6204</td>
<td>(U) HOSPICE ADJUSTMENT THRU&gt;DOLBA</td>
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<tr>
<td>6260</td>
<td>(U) HOSPICE ADJUSTMENT STAY DAYS</td>
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<td>(U) HOSPICE ADJUSTMENT DAYS USED</td>
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<td>6269</td>
<td>(U) HOSPICE ADJUSTMENT PERIOD# (MAIN)</td>
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<tr>
<td>63X1</td>
<td>(C) DEDUCT IND INVALID</td>
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<tr>
<td>63X2</td>
<td>(C) DED/HCFA COINS IN POCO/CABG</td>
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<tr>
<td>6365</td>
<td>(U) HOSPICE ADJUSTMENT SECONDARY DAYS</td>
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<td>6369</td>
<td>(U) HOSPICE ADJUSTMENT PERIOD# (SECOND)</td>
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<td>(C) PROVIDER IND INVALID</td>
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<td>(U) PART B DEDUCTABLE CHECK</td>
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<tr>
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<td>(C) PAYSCREEN IND INVALID</td>
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<tr>
<td>66XX</td>
<td>(D) POSS DUPE, CR/DB, DOC-ID</td>
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<td>66X2</td>
<td>(C) UNITS IND &gt; 0; AMT NOT VALID</td>
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<td>66X3</td>
<td>(C) UNITS IND = 0; AMT &gt; 0</td>
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<tr>
<td>66X4</td>
<td>(C) MT INDICATOR/AMOUNT</td>
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<tr>
<td>6600</td>
<td>(U) ADJUSTMENT BILL FULL DAYS</td>
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<tr>
<td>6610</td>
<td>(U) ADJUSTMENT BILL COIN DAYS</td>
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<tr>
<td>6620</td>
<td>(U) ADJUSTMENT BILL LIFE RESERVE</td>
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<tr>
<td>6630</td>
<td>(U) ADJUSTMENT BILL LIFE PSYCH DYS</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>-------</td>
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<tr>
<td>67X1</td>
<td>(C) UNITS INDICATOR INVALID</td>
</tr>
<tr>
<td>67X2</td>
<td>(C) CHG ALLOWED &gt; 0; UNITS IND = 0</td>
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<tr>
<td>67X3</td>
<td>(C) TOS/HCPCS=ANEST, MTU IND NOT = 2</td>
</tr>
<tr>
<td>67X4</td>
<td>(C) HCPCS = AMBULANCE, MTU IND NOT = 1</td>
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<tr>
<td>67X6</td>
<td>(C) INVALID PROC FOR MT IND 2, ANEST</td>
</tr>
<tr>
<td>67X7</td>
<td>(C) INVALID UNITS IND WITH TOS OF BLOOD</td>
</tr>
<tr>
<td>67X8</td>
<td>(C) INVALID PROC FOR MT IND 4, OXYGEN</td>
</tr>
<tr>
<td>6700</td>
<td>(U) ADJUSTMENT BILL FULL/SNF DAYS</td>
</tr>
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<td>6710</td>
<td>(U) ADJUSTMENT BILL COIN/SNF DAYS</td>
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<td>68X1</td>
<td>(C) INVALID HCPCS CODE</td>
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<tr>
<td>68X2</td>
<td>(C) MAMMOGRAPHY/DATE/PROC NOT 76092</td>
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<td>68X3</td>
<td>(C) TYPE OF SERVICE = G /PROC CODE</td>
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<tr>
<td>68X4</td>
<td>(C) HCPCS NOT VALID FOR SERVICE DATE</td>
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<tr>
<td>68X5</td>
<td>(C) MODIFIER NOT VALID FOR HCPCS, ETC</td>
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<tr>
<td>68X6</td>
<td>(C) TYPE SERVICE INVALID FOR HCPCS, ETC</td>
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<tr>
<td>68X7</td>
<td>(C) ZX MOD REQ FOR THER SHOES/INS/MOD.</td>
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<tr>
<td>68X8</td>
<td>(C) LINE ITEM INCORRECT OR DATE INVAL.</td>
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NCH_EDIT_TB

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
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<td>69X1</td>
<td>(C) MODIFIER NOT VALID FOR HCPCS/GLOBAL</td>
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<td>69X3</td>
<td>(C) PROC CODE MOD = LL / TYPE = R</td>
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<td>69X6</td>
<td>(C) PROC CODE MOD/NOT CAPPED</td>
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<td>69X8</td>
<td>(C) SPEC CODE NURSE PRACT, MOD INVAL</td>
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<td>6901</td>
<td>(C) KRON IND AND UTIL DYS EQUALS ZERO</td>
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<td>6902</td>
<td>(C) KRON IND AND NO-PAY CODE B OR N</td>
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<td>6903</td>
<td>(C) KRON IND AND INPATIENT DEDUCT = 0</td>
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<td>(C) KRON IND AND TRANS CODE IS 4</td>
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<td>6910</td>
<td>(C) REV CODES ON HOME HEALTH</td>
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<td>6911</td>
<td>(C) REV CODE 274 ON OUTPAT AND HH ONLY</td>
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<td>(C) REV CODE INVAL FOR PROSTH AND ORTHO</td>
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<td>(C) REV CODE INVAL FOR OXYGEN</td>
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<td>6914</td>
<td>(C) REV CODE INVAL FOR DME</td>
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<tr>
<td>6915</td>
<td>(C) PURCHASE OF RENT DME INVAL ON DATES</td>
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<td>6916</td>
<td>(C) PURCHASE OF RENT DME INVAL ON DATES</td>
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<td>6917</td>
<td>(C) PURCHASE OF LIFT CHAIR INVAL &gt; 91000</td>
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<td>6918</td>
<td>(C) HCPCS INVALID ON DATE RANGES</td>
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<td>(C) DME OXYGEN ON HH INVAL BEFORE 7/1/89</td>
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<td>(C) HCPCS INVAL ON REV 270/BILL 32-33</td>
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<td>(C) HCPCS ON REV CODE 272 BILL TYPE 83X</td>
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<td>(C) HCPCS ON BILL TYPE 83X -NOT REV 274</td>
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<td>6923</td>
<td>(C) RENTAL OF DME CUSTOMIZE AND REV 291</td>
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<td>6924</td>
<td>(C) INVAL MODIFIER FOR CAPPED RENTAL</td>
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<td>6925</td>
<td>(C) HCPCS ALLOWED ON BILL TYPES 32X-34X</td>
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<td>6929</td>
<td>(U) ADJUSTMENT BILL LIFE RESERVE</td>
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<tr>
<td>6930</td>
<td>(U) ADJUSTMENT BILL LIFE PSYCH DYS</td>
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<tr>
<td>7000</td>
<td>(U) INVALID DOEBA/DOLBA</td>
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</table>
8304 = (C) BILL TYPE INVALID FOR G0123/4
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
84X2 = (C) INVALID DME START DATE
84X3 = (C) INVALID DME START DATE W/HCPCS
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
84X5 = (C) HCPCS CODE WITH INV DIAG CODE
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
88XX = (D) POSS DUPE, DOC-ID, UNITS, ENT, ALWD
9000 = (U) DOEBA/DOLBA CALC
9005 = (U) FULL/COINS HOSP DAYS CALC
9010 = (U) FULL/COINS SNF DAYS CALC
9015 = (U) LIFE RESERVE DAYS CALC
9020 = (U) LIFE PSYCH DAYS CALC
9030 = (U) INPAT DEDUCTABLE CALC
9040 = (U) DATA INDICATOR 1 SET
9050 = (U) DATA INDICATOR 2 SET
91X1 = (C) PATIENT REIMB/PAY-DENY CODE
92X1 = (C) PATIENT REIMB INVALID
92X2 = (C) PROVIDER REIMB INVALID
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
92X7 = (C) REIMB/PAY-DENY INCONSISTANT
9201 = (C) UPIN REF NAME OR INITIAL MISSING
9202 = (C) UPIN REF FIRST 3 CHAR INVALID
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
93X1 = (C) CASH DEDUCTIBLE INVALID
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
93X4 = (C) FROM DATE/CASH DEDUCTIBLE
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
9301 = (C) UPIN OTHER, NOT PRESENT
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
94A1 = (C) NON-COVERED FROM DATE INVALID
94A2 = (C) NON-COVERED FROM > THRU DATE
94A3 = (C) NON-COVERED THRU DATE INVALID
94A4 = (C) NON-COVERED THRU DATE > ADMIT
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
94C1 = (C) PR-PSYCH DAYS INVALID
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
94F1 = (C) REIMBURSEMENT AMOUNT INVALID
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
94G1 = (C) NO-PAY CODE INVALID

1
NCH_EDIT_TB
-----------
NCH EDIT TABLE
--------------
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/TYP/E 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) HCPA 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/COIN AMT/ALLOW/CSH
98X4 = (C) DATE/MSP/TYP/CASH DED/ALLOW/COI
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
99X = (D) POSS DUPE, PART B DOC-ID
9901 = (C) REV CODE INVALID OR TRAILER CNT=0
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
9903 = (C) NO CLINIC VISITS FOR RHC
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE
991X = (C) NO DATE OF SERVICE
9910 = (C) EDIT 9910 (NEW)
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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9945</td>
<td>(C) SERVICE DATE &lt; 98001</td>
</tr>
<tr>
<td>9946</td>
<td>(C) INVALID DIAGNOSIS CODE</td>
</tr>
<tr>
<td>9947</td>
<td>(C) INVALID DIAGNOSIS CODE</td>
</tr>
<tr>
<td>9948</td>
<td>(C) STAY FROM &gt;96365, DIAG = V725</td>
</tr>
<tr>
<td>9960</td>
<td>(C) MED CHOICE BUT HMO DATA MISSING</td>
</tr>
<tr>
<td>9965</td>
<td>(C) HMO PRESENT BUT MED CHOICE MISSING</td>
</tr>
<tr>
<td>9968</td>
<td>(C) MED CHOICE NOT= HMO PLAN NUMBER</td>
</tr>
</tbody>
</table>

### NCH_NEAR_LINE_RIC_TB

NCH Near-Line Record Identification Code Table

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>Part B physician/supplier claim record (processed by local carriers; can include DMEPOS services)</td>
</tr>
<tr>
<td>V</td>
<td>Part A institutional claim record (inpatient (IP), skilled nursing facility (SNF), christian science (CS), home health agency (HHA), or hospice)</td>
</tr>
<tr>
<td>W</td>
<td>Part B institutional claim record (outpatient (OP), HHA)</td>
</tr>
<tr>
<td>U</td>
<td>Both Part A and B institutional home health agency (HHA) claim records -- due to HHPPS and HHA A/B split. (effective 10/00)</td>
</tr>
<tr>
<td>M</td>
<td>Part B DMEPOS claim record (processed by DME Regional Carrier) (effective 10/93)</td>
</tr>
</tbody>
</table>

### NCH_PATCH_TB

NCH Patch Table

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>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.</td>
</tr>
<tr>
<td>02</td>
<td>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.</td>
</tr>
</tbody>
</table>
03 = Garbage/nonnumeric Claim Total Charge Amount set to zeroes (Instnl) -- during the Version 'G' conversion, error occurred in the derivation of this field where the claim was missing revenue center code = '0001'. In 1994, patch was applied to the OP and HHA SAFs only. (This SAF patch indicator was stored in the redefined Claim Edit Group, 4th occurrence, position 2). During the 'H' conversion, patch applied to Nearline claims where garbage or nonnumeric values.

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

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

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

07 = Missing CWF bene 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' conversion to claims with NCH weekly process date 10/1/93-10/30/95, where MSP values = invalid '0', '1', '2', '3' or '4' (caused
by erroneous logic in HCFA program code, which was corrected on 11/1/95).

09 = Zero CWF claim accretion date replaced with NCH weekly process date (all claim types) -- applied during Version 'H' conversion to Instnl and D Mercer claims; applied during Version 'G' conversion to non-institutional (non-D Mercer) claims. Prior to Version 'H', patch indicator stored in redefined claim edit group, 3rd occurrence, position 1.

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

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

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

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

1 NCH_STATE_SGMT_TB ------------------------- NCH State Segment Table
---
01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennesee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
1 | NCH_STATE_SGMT_TB | NCH State Segment Table |
---|-------------------|-------------------------|
58 | Europe            |                         |
59 | Mexico            |                         |
60 | Oceania           |                         |
61 | Philippines       |                         |
62 | South America     |                         |
63 | US Possessions    |                         |
97 | Saipan - MP       |                         |
98 | Guam              |                         |
99 | American Samoa    |                         |