	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	Carrier Claim Record	REC	VAR			Carrier claim record (other than DMERC) for version I of the NCH. STANDARD ALIAS: CARR_CLM_REC SYSTEM ALIAS: UTLCARRI
****	DESY Header Group	GROUP	50	1	50	DESY header for whole record output.
1.	DESY System User	CHAR	30	1	30	A user-defined field that holds the description of the request. For example, "Cross-referenced HICs". STANDARD ALIAS: DSY_SYSTEM_USER
2.	Filler	CHAR	11	31	41	Filler STANDARD ALIAS: DSY_TBD
3.	DESY Sort Key	CHAR	9	42	50	This field contains the key to tie claims together for one beneficiary regardless of HICAN. STANDARD ALIAS: DSY_SORT_KEY
****	Carrier Claim Fixed Group	GROUP	375	51	425	Fixed portion of the carrier claim record for version I of the NCH. STANDARD ALIAS: CARR_CLM_FIX_GRP
****	Claim Record Identification Group	GROUP	8	51	58	Effective with Version 'I' the record length, version code, record identification, code and NCH derived claim type code were moved to this group for internal NCH processing. STANDARD ALIAS: CLM_REC_IDENT_GRP

NAME	TYPE	LENGTH	BEG	END	CONTENTS
4. Record Length Count	PACK	3	51	53	Effective with Version H, the count (in bytes) of the length of the claim record. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). 5 DIGITS SIGNED DB2 ALIAS: REC_LNGTH_CNT SAS ALIAS: REC_LEN STANDARD ALIAS: REC_LNGTH_CNT SOURCE: NCH
5. NCH Near-Line Record Version Code	CHAR	1	54	54	The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored.

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
					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

Field	Type	Len	Start	End	Description
					H = Record format as of September 1998 I = Record format as of July 2000 COMMENT: Prior to Version H this field was named: CLM_NEAR_LINE_REC_VRSN_CD. SOURCE: NCH
6. NCH Near Line Record Identification Code	CHAR	1	55	55	A code defining the type of claim record being processed. COMMON ALIAS: RIC DB2 ALIAS: NEAR_LINE_RIC_CD SAS ALIAS: RIC_CD STANDARD ALIAS: NCH_NEAR_LINE_RIC_CD TITLE ALIAS: RIC CODES: REFER TO: NCH_NEAR_LINE_RIC_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: RIC_CD. SOURCE: NCH
7. NCH MQA RIC Code	CHAR	1	56	56	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

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
					CODES: 1 = Inpatient 2 = SNF 3 = Hospice 4 = Outpatient 5 = Home Health Agency 6 = Physician/Supplier 7 = Durable Medical Equipment SOURCE: NCH QA PROCESS
8. NCH Claim Type Code	CHAR	2	57	58	The code used to identify the type of claim record being processed in NCH. NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991). NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added. DB2 ALIAS: NCH_CLM_TYPE_CD SAS ALIAS: CLM_TYPE STANDARD ALIAS: NCH_CLM_TYPE_CD SYSTEM ALIAS: LTTYPE TITLE ALIAS: CLAIM_TYPE DERIVATION: FFS CLAIM TYPE CODES DERIVED FROM:

NCH CLM_NEAR_LINE_RIC_CD
NCH PMT_EDIT_RIC_CD
NCH CLM_TRANS_CD
NCH PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(Pre-HDC processing -- AVAILABLE IN NCH)
CLM_MCO_PD_SW
CLM_RLT_COND_CD
MCO_CNTRCT_NUM
MCO_OPTN_CD
MCO_PRD_EFCTV_DT
MCO_PRD_TRMNTN_DT

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

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS

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

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

OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(AVAILABLE IN NMUD)
FI_NUM

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

DERIVATION RULES:

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

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

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

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

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED' ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)

1. FI_NUM = 80881
2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_CLSFCTN_TYPE_CD = '2', '3' OR '4' & CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:

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

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                                                          MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
                                                          ENROLLMENT PERIODS

                                                     SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                                                     CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
                                                     FOLLOWING CONDITIONS ARE MET:
                                                     1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                     2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                     3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'
                                                     4.   FI_NUM = 80881

                                                     SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
                                                     ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                                                     THE FOLLOWING CONDITIONS ARE MET:
                                                     1.   FI_NUM = 80881 AND
                                                     2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
                                                          TYPE_CD = '1'; CLM_FREQ_CD = 'Z'
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                                              POSITIONS
            NAME              TYPE  LENGTH BEG  END                                CONTENTS
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                                                     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
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                                                      2.   CLM_DEMO_ID_NUM = 38

                                                      SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
                                                         CLAIM)
                                                      WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                      1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                                      2.   HCPCS_CD not on DMEPOS table

                                                      SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                                                      WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                      1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                                      2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                                            more line item(s) match the HCPCS on the
                                                            DMEPOS table).

                                                    CODES:
                                                      REFER TO: NCH_CLM_TYPE_TB
                                                                IN THE CODES APPENDIX

                                                    SOURCE:
                                                    NCH

 ****  Carrier/DMERC Claim Link     GROUP   125    59  183  Effective with Version 'I', this group
       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

 ****  Claim Locator Number Group   GROUP    11    59   69  This number uniquely identifies the beneficiary in
                                                            the NCH Nearline.

                                                            COMMON ALIAS: HIC
                                                            STANDARD ALIAS: CLM_LCTR_NUM_GRP
                                                            TITLE ALIAS: HICAN
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NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
9. Beneficiary Claim Account Number	CHAR	9	59	67	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.
10. NCH Category Equatable Beneficiary Identification Code	CHAR	2	68	69	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

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
11.	Beneficiary Identification Code	CHAR	2	70	71	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.

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS

COMMON ALIAS: BIC
DA3 ALIAS: BENE_IDENT_CODE
DB2 ALIAS: BENE_IDENT_CD
SAS ALIAS: BIC
STANDARD ALIAS: BENE_IDENT_CD
TITLE ALIAS: BIC

EDIT-RULES:
EDB REQUIRED FIELD

CODES:
REFER TO: BENE_IDENT_TB
IN THE CODES APPENDIX

SOURCE:

					SSA/RRB
12. NCH State Segment Code	CHAR	1	72	72	The code identifying the segment of the NCH Nearline file containing the beneficiary's record for a specific service year. Effective 12/96, segmentation is by CLM_LCTR_NUM, then final action sequence within residence state. (Prior to 12/96, segmentation was by ranges of county codes within the residence state.) DB2 ALIAS: NCH_STATE_SGMT_CD SAS ALIAS: ST_SGMT STANDARD ALIAS: NCH_STATE_SGMT_CD TITLE ALIAS: NEAR_LINE_SEGMENT 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
13. Beneficiary Residence SSA Standard State Code	CHAR	2	73	74	The SSA standard state code of a beneficiary's residence. DA3 ALIAS: SSA_STANDARD_STATE_CODE DB2 ALIAS: BENE_SSA_STATE_CD SAS ALIAS: STATE_CD STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD TITLE ALIAS: BENE_STATE_CD EDIT-RULES: OPTIONAL: MAY BE BLANK CODES: REFER TO: GEO_SSA_STATE_TB IN THE CODES APPENDIX

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
					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
14. Claim From Date	NUM	8	75	82	The first day on the billing statement covering services rendered to the bene- ficiary (a.k.a. 'Statement Covers From Date'). NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match. 8 DIGITS UNSIGNED DB2 ALIAS: CLM_FROM_DT SAS ALIAS: FROM_DT STANDARD ALIAS: CLM_FROM_DT TITLE ALIAS: FROM_DATE EDIT-RULES: YYYYMMDD SOURCE: CWF
15. Claim Through Date	NUM	8	83	90	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

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
16. NCH Weekly Claim Processing Date	NUM	8	91	98	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

17. CWF Claim Accretion Date	NUM	8	99	106	The date the claim record is accreted (posted/processed) to the beneficiary master record at the CWF host site and authorization for payment is returned to the fiscal intermediary or carrier.

8 DIGITS UNSIGNED

DB2 ALIAS: CWF_CLM_ACRTN_DT
SAS ALIAS: ACRTN_DT
STANDARD ALIAS: CWF_CLM_ACRTN_DT
TITLE ALIAS: ACCRETION_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

18. CWF Claim Accretion Number	PACK	2	107	108	The sequence number assigned to the claim record when accreted (posted/processed) to the beneficiary master record at the CWF host site on a given date. This element indicates the position of the claim within that day's processing at the CWF host. **(Exception: If the claim record is missing the accretion date HCFA's CWFMQA system places a zero in the accretion number.

3 DIGITS SIGNED

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
					DB2 ALIAS: CWF_CLM_ACRTN_NUM SAS ALIAS: ACRTN_NM STANDARD ALIAS: CWF_CLM_ACRTN_NUM TITLE ALIAS: ACCRETION_NUMBER SOURCE: CWF
19. Carrier Claim Control Number	CHAR	15	109	123	Unique control number assigned by a carrier to a non-institutional claim. COMMON ALIAS: CCN DB2 ALIAS: CARR_CLM_CNTL_NUM SAS ALIAS: CARRCNTL STANDARD ALIAS: CARR_CLM_CNTL_NUM TITLE ALIAS: CCN EDIT-RULES: LEFT JUSTIFY COMMENT: For the physician/supplier or DMERC claim, this field allows HCFA to associate each line item with its respective claim. SOURCE: CWF
20. FILLER	CHAR	38	124	161	
21. NCH Daily Process Date	NUM	8	162	169	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 pop- ulated 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

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
22. NCH Segment Link Number	PACK	5	170	174	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

NAME	TYPE	LENGTH	BEG	END	CONTENTS
23. Claim Total Segment Count	NUM	2	175	176	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:
CWF

NAME	TYPE	LENGTH	BEG	END	CONTENTS
24. Claim Segment Number	NUM	2	177	178	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
25. Claim Total Line Count	NUM	3	179 181	Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim. NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). Prior to Version 'I', the maximum line count will be no more than 58. Effective with Version 'I', the maximum line count could be 450. 3 DIGITS UNSIGNED DB2 ALIAS: TOT_LINE_CNT SAS ALIAS: LINECNT STANDARD ALIAS: CLM_TOT_LINE_CNT TITLE ALIAS: TOTAL_LINE_COUNT SOURCE: CWF

No.	NAME	TYPE	LENGTH	BEG	END	CONTENTS
26.	Claim Segment Line Count	NUM	2	182	183	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

No.	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						DB2 ALIAS: SGMT_LINE_CNT SAS ALIAS: SGMTLINE STANDARD ALIAS: CLM_SGMT_LINE_CNT TITLE ALIAS: SEGMENT_LINE_COUNT SOURCE: CWF
****	Carrier/DMERC Claim Common 1 Group	GROUP	194	184	377	Information common to both carrier and DMERC claims for version I of NCH. STANDARD ALIAS: CARR_DMERC_CLM_CMN_1_GRP
27.	FILLER	CHAR	5	184	188	
28.	Carrier Claim Entry Code	CHAR	1	189	189	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

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
29. FILLER	CHAR	1	190	190	
30. Claim Disposition Code	CHAR	2	191	192	Code indicating the disposition or outcome of the processing of the claim record.

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

CODES:
REFER TO: CLM_DISP_TB
IN THE CODES APPENDIX

SOURCE:
CWF

#	Name	Type	Len	Start	End	Description
31.	NCH Edit Disposition Code	CHAR	2	193	194	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
32.	NCH Claim BIC Modify H Code	CHAR	1	195	195	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 CODES:

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

SOURCE:
NCH QA Process

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
33.	Beneficiary Residence SSA Standard County Code	CHAR	3	196	198	The SSA standard county code of a beneficiary's residence.

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
						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
34.	Carrier Claim Receipt Date	NUM	8	199	206	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

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
35.	Carrier Claim Scheduled Payment Date	NUM	8	207	214	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 EDIT-RULES: YYYYMMDD COMMENT: Prior to Version H this field was named: FICARR_CLM_PMT_DT.

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
						SOURCE: CWF
36.	CWF Forwarded Date	NUM	8	215	222	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

37. Carrier Number	CHAR	5	223	227	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
38. FILLER	CHAR	8	228	235	
39. CWF Transmission Batch	CHAR	4	236	239	Effective with Version H, the number assigned

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

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

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
						DB2 ALIAS: TRNSMSN_BATCH_NUM SAS ALIAS: FIBATCH STANDARD ALIAS: CWF_TRNSMSN_BATCH_NUM TITLE ALIAS: BATCH_NUM SOURCE: CWF
40.	Beneficiary Mailing Contact ZIP Code	CHAR	9	240	248	The ZIP code of the mailing address where the beneficiary may be contacted. DB2 ALIAS: BENE_MLG_ZIP_CD SAS ALIAS: BENE_ZIP STANDARD ALIAS: BENE_MLG_CNTCT_ZIP_CD TITLE ALIAS: BENE_ZIP SOURCE: EDB
41.	Beneficiary Sex Identification Code	CHAR	1	249	249	The sex of a beneficiary. COMMON ALIAS: SEX_CD DA3 ALIAS: SEX_CODE DB2 ALIAS: BENE_SEX_IDENT_CD SAS ALIAS: SEX STANDARD ALIAS: BENE_SEX_IDENT_CD SYSTEM ALIAS: LTSEX

TITLE ALIAS: SEX_CD

EDIT-RULES:
REQUIRED FIELD

CODES:
1 = Male
2 = Female
0 = Unknown

SOURCE:
SSA,RRB,EDB

NAME	TYPE	LENGTH	BEG	END	CONTENTS
42. Beneficiary Race Code	CHAR	1	250	250	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

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS

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

SOURCE:
SSA

No.	Field	Type	Length	Start	End	Description
43.	Beneficiary Birth Date	NUM	8	251	258	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
44.	CWF Beneficiary Medicare Status Code	CHAR	2	259	260	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:

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				(continued)

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

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

COMMENT:
Prior to Version H this field was named: BENE_MDCR_STUS_CD. The name has been changed to distinguish this CWF-derived field from the EDB-derived MSC (BENE_MDCR_STUS_CD).

SOURCE:
CWF

NAME	TYPE	LENGTH	BEG	END	CONTENTS
45. Claim Patient 6 Position Surname	CHAR	6	261	266	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

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                                                              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

 46. Claim Patient 1st Initial    CHAR      1   267  267  The first initial of the Medicare patient's
     Given Name                                         given name (first name) as reported by the
                                                        provider on the claim.
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                                                        NOTE1: Prior to Version H, this field was only
                                                              present on the IP/SNF claim record.
                                                              Effective with Version H, this field
                                                              is present on all claim types.

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

                                                        COMMON ALIAS: PATIENT_GIVEN_NAME
                                                        DB2 ALIAS: 1ST_INITL_GVN_NAME
                                                        SAS ALIAS: FRSTINIT
                                                        STANDARD ALIAS: CLM_PTNT_1ST_INITL_GVN_NAME
                                                        TITLE ALIAS: PATIENT_FIRST_INITIAL

                                                        SOURCE:
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CWF

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
47.	Claim Patient First Initial Middle Name	CHAR	1	268	268	The first initial of the Medicare patient's middle name as reported by the provider on the claim. NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types. NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field. COMMON ALIAS: PATIENT_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
48.	Beneficiary CWF Location Code	CHAR	1	269	269	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

					CODES: B = Mid-Atlantic C = Southwest D = Northeast E = Great Lakes F = Great Western G = Keystone H = Southeast I = South J = Pacific SOURCE: CWF
49. Claim Principal Diagnosis Code	CHAR	5	270	274	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 EDIT-RULES: ICD-9-CM SOURCE: CWF
50. FILLER	CHAR	1	275	275	
51. Carrier Claim Payment Denial Code	CHAR	1	276	276	The code on a noninstitutional claim indicating to whom payment was made or if the claim was denied.

DB2 ALIAS: CARR_PMT_DNL_CD
SAS ALIAS: PMTDNLCD
STANDARD ALIAS: CARR_CLM_PMT_DNL_CD
TITLE ALIAS: PMT_DENIAL_CD

CODES:
REFER TO: CARR_CLM_PMT_DNL_TB
IN THE CODES APPENDIX

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

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
52.	Claim Excepted/Nonexcepted Medical Treatment Code	CHAR	1	277	277	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

CODES:
0 = No Entry
1 = Excepted
2 = Nonexcepted

SOURCE:
CWF

53. Claim Payment Amount	PACK	6	278	283	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.

NAME	TYPE	LENGTH	BEG END	CONTENTS

Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total payment. The Medicare payment amount takes into account the wage index adjustment and the beneficiary deductible and coinsurance amounts. NOTE: There is no CWF edit check to validate that the revenue center Medicare payment amount equals the claim level Medicare payment amount.

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

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

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

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

> For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.
>
> For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

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

9.2 DIGITS SIGNED

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS

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. Als the noninstitutional claim records carried this field as a l item. Effective with Version H, this element is a claim lev field across all claim types (and the line item field has be renamed.)

SOURCE:

CWF

LIMITATIONS:
Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM_DISP_CD of '02', the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over or under the actual Medicare payment amount.

NAME	TYPE	LENGTH	BEG	END	CONTENTS
54. Carrier Claim Primary Payer Paid Amount	PACK	6	284	289	Effective with Version H, the amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a non-institutional claim.

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

9.2 DIGITS SIGNED

DB2 ALIAS: CARR_PRMRY_PYR_AMT
SAS ALIAS: PRPAYAMT
STANDARD ALIAS: CARR_CLM_PRMRY_PYR_PD_AMT
TITLE ALIAS: PRIMARY_PAYER_AMOUNT

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

SOURCE:
CWF

55.	FILLER	CHAR	1	290	290	
56.	Carrier Claim Referring UPIN Number	CHAR	6	291	296	The unique physician identification number (UPIN) of the physician who referred the beneficiary to the physician who performed the Part B services. COMMON ALIAS: REFERRING_PHYSICIAN_UPIN DB2 ALIAS: CARR_RFRG_UPIN_NUM SAS ALIAS: RFR_UPIN STANDARD ALIAS: CARR_CLM_RFRG_UPIN_NUM TITLE ALIAS: REFERRING_PHYSICIAN_UPIN COMMENT: Prior to Version H this field was named: CWFB_CLM_RFRG_UPIN_NUM. SOURCE: CWF
57.	Carrier Claim Referring Physician NPI Number	CHAR	10	297	306	A placeholder field (effective with Version H) for storing the NPI assigned to the referring physician. COMMON ALIAS: REFERRING_PHYSICIAN_NPI DB2 ALIAS: RFRG_PHYSN_NPI_NUM SAS ALIAS: RFR_NPI STANDARD ALIAS: CARR_CLM_RFRG_PHYSN_NPI_NUM TITLE ALIAS: RFRG_PHYSN_NPI SOURCE: CWF
58.	Carrier Claim Provider Assignment Indicator Switch	CHAR	1	307	307	A switch indicating whether or not the provider accepts assignment for the noninstitutional claim. DB2 ALIAS: PRVDR_ASGNMT_SW SAS ALIAS: ASGMNTCD

STANDARD ALIAS: CARR_CLM_PRVDR_ASGNMT_IND_SW
TITLE ALIAS: ASSIGNMENT_SW

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

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

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
59.	NCH Claim Provider Payment Amount	PACK	6	308	313	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
60.	NCH Claim Beneficiary	PACK	6	314	319	Effective with Version H, the total payments

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

                                                              9.2 DIGITS SIGNED

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

                                                              SOURCE:
                                                              NCH QA Process

 61. Carrier Claim Beneficiary    PACK      6   320  325  Effective with Version H, the amount paid by
     Paid Amount                                          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:
                                                          CWF
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No.	Name	Type	Length	Start	End	Description
62.	NCH Carrier Claim Submitted Charge Amount	PACK	6	326	331	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: $$$$$$$$$CC SOURCE: NCH QA Process
63.	NCH Carrier Claim Allowed Charge Amount	PACK	6	332	337	Effective with Version H, the total allowed charges on the claim (the sum of line item allowed charges). NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). 9.2 DIGITS SIGNED DB2 ALIAS: CARR_ALOW_CHRG_AMT SAS ALIAS: ALOWCHRG STANDARD ALIAS: NCH_CARR_ALOW_CHRG_AMT TITLE ALIAS: ALOW_CHRG EDIT-RULES: $$$$$$$CC

SOURCE:
NCH QA Process

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
64.	Carrier Claim Cash Deductible Applied Amount	PACK	6	338	343	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

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
						DB2 ALIAS: CASH_DDCTBL_AMT SAS ALIAS: DEDAPPLY STANDARD ALIAS: CARR_CLM_CASH_DDCTBL_APPLY_AMT TITLE ALIAS: CASH_DDCTBL SOURCE: CWF
65.	Carrier Claim HCPCS Year Code	NUM	1	344	344	Effective with Version H, the terminal digit of HCPCS version used to code the claim. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 1 DIGIT UNSIGNED DB2 ALIAS: CARR_HCPCS_YR_CD SAS ALIAS: HCPCS_YR STANDARD ALIAS: CARR_CLM_HCPCS_YR_CD

TITLE ALIAS: HCPCS_YR

SOURCE:
CWF

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
66.	Carrier Claim MCO Override Indicator Code	CHAR	1	345	345	Effective with Version H, the code used to indicate whether or not an MCO investigation applies to the claim (used for internal CWFMQA editing purposes). NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: MCO_OVRRD_IND_CD SAS ALIAS: MCOOVRRD STANDARD ALIAS: CARR_CLM_MCO_OVRRD_IND_CD TITLE ALIAS: MCO_OVERRIDE CODES: 0 = No Investigation 1 = MCO Investigation does not apply to this claim. SOURCE: CWF
67.	Carrier Claim Hospice Override Indicator Code	CHAR	1	346	346	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).

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
					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
68.	FILLER	CHAR	31	347	377	
****	Carrier Specific Group	GROUP	34	378	411	This group identifies those fields specific to the carrier claim record. STANDARD ALIAS: CARR_SPECFC_GRP
69.	Carrier Claim Referring PIN Number	CHAR	14	378	391	Carrier-assigned identification (profiling) number of the physician who referred the beneficiary to the physician that performed the Part B services. COMMON ALIAS: REFERRING_PHYSICIAN_PIN DB2 ALIAS: CARR_RFRG_PIN_NUM SAS ALIAS: RFR_PRFL STANDARD ALIAS: CARR_CLM_RFRG_PIN_NUM TITLE ALIAS: RFRG_PIN COMMENT: Prior to Version H this field was named: CWFB_CLM_RFRG_PHYSN_PRFLG_NUM. SOURCE:

CWF

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
70.	Care Plan Oversight (CPO) Provider Number	CHAR	6	392	397	Effective with NCH weekly process date 3/7/97, the Medicare provider number of the HHA or Hospice rendering Medicare covered services during period the physician is providing care plan oversight. The purpose of this field is to ensure compliance with the CPO requirement that the beneficiary must be receiving covered HHA or Hospice services during the billing period. There can be only one CPO provider number per claim, and no other services but CPO physician services are to be reported on the claim. This field is only present on the non-DMERC processed carrier claim.

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

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

SOURCE:
CWF

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
71.	CPO Organization NPI Number	CHAR	10	398	407	A placeholder field (effective with Version H) for storing the NPI assigned to the CPO organizational provider.

DB2 ALIAS: CPO_ORG_NPI_NUM

SAS ALIAS: CPO_NPI
STANDARD ALIAS: CPO_ORG_NPI_NUM
TITLE ALIAS: CPO_ORG_NPI

SOURCE:
CWF

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
72.	Claim Blood Pints Furnished Quantity	PACK	2	408	409	Number of whole pints of blood furnished to the beneficiary, as reported on the carrier claim (non-DMERC). 3 DIGITS SIGNED DB2 ALIAS: BLOOD_PT_FRNSH_QTY SAS ALIAS: BLDFRNSH STANDARD ALIAS: CLM_BLOOD_PT_FRNSH_QTY TITLE ALIAS: BLOOD_PINTS_FURNISHED EDIT-RULES: NUMERIC COMMENT: Prior to Version H this field was stored in a blood trailer. Version H eliminated the blood trailer. SOURCE: CWF
73.	Claim Blood Deductible Pints Quantity	PACK	2	410	411	The quantity of blood pints applied (blood deductible) as reported on the carrier claim (non-DMERC).

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS

3 DIGITS SIGNED

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

EDIT-RULES:
NUMERIC

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

SOURCE:
CWF

74.	Carrier NCH Edit Code Count	NUM	2	412	413	The count of the number of edit codes annotated to the carrier claim during HCFA's CWFMQA process. The purpose of this count is to indicate how many claim edit trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: CARR_EDIT_CD_CNT SAS ALIAS: CEDCNT STANDARD ALIAS: CARR_NCH_EDIT_CD_CNT COMMENT: Prior to Version H this field was named: CLM_EDIT_CD_CNT. SOURCE: NCH
75.	Carrier NCH Patch Code Count	NUM	2	414	415	Effective with Version H, the count of the number of HCFA patch codes annotated to the carrier claim during the Nearline maintenance

process. The purpose of this count is to indicate how many NCH patch trailers are present.
NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

2 DIGITS UNSIGNED

DB2 ALIAS: CARR_PATCH_CD_CNT
SAS ALIAS: CPATCNT
STANDARD ALIAS: CARR_NCH_PATCH_CD_I_CNT

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
					SOURCE: NCH
76. Carrier MCO Period Count	NUM	1	416	416	Effective with Version H, the count of the number of Managed Care Organization (MCO) periods reported on a carrier claim. The purpose of this count is to indicate how many MCO period trailers are present. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 1 DIGIT UNSIGNED DB2 ALIAS: CARR_MCO_PRD_CNT SAS ALIAS: CMCOCNT STANDARD ALIAS: CARR_MCO_PRD_CNT EDIT-RULES:

RANGE: 0 TO 2

SOURCE:
NCH

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
77.	Carrier Claim Health PlanID Count	NUM	1	417	417	A placeholder field (effective with Version H) for storing the count of the number of Health PlanIDs reported on the carrier claim. The purpose of this count is to indicate how many Health PlanID trailers are present. NOTE: Prior to Version 'I' this field was named: CARR_CLM_PAYERID_CNT. 1 DIGIT UNSIGNED DB2 ALIAS: CARR_PLANID_CNT SAS ALIAS: CPLNCNT STANDARD ALIAS: CARR_CLM_HLTH_PLANID_CNT EDIT-RULES: RANGE: 0 TO 3 SOURCE: NCH
78.	Carrier Claim Demonstration ID Count	NUM	1	418	418	Effective with Version H, the count of the number of claim demonstration IDs reported on an carrier claim. The purpose of this count is to indicate how many claim demonstration trailers are present. NOTE: During the Version H conversion this field was populated with data where a demo was identifiable.

					1 DIGIT UNSIGNED DB2 ALIAS: CARR_DEMO_ID_CNT SAS ALIAS: CDEMCNT STANDARD ALIAS: CARR_CLM_DEMO_ID_CNT EDIT-RULES: RANGE: 0 TO 5 SOURCE: NCH
79. Carrier Claim Diagnosis Code Count	NUM	1	419	419	The count of the number of diagnosis codes (both principal and other) reported on an carrier claim. The purpose of this count is to indicate how many claim diagnosis trailers are present. 1 DIGIT UNSIGNED DB2 ALIAS: CARR_DGNS_CD_CNT SAS ALIAS: CDGNCNT STANDARD ALIAS: CARR_CLM_DGNS_CD_CNT EDIT-RULES: RANGE: 0 TO 4 COMMENT: Prior to Version H this field was named: CLM_DGNS_CD_CNT. SOURCE: NCH
80. Carrier Claim Line Count	NUM	2	420	421	The count of the number of line items reported on the carrier claim. The purpose of this count is to indicate how many line item trailers are present. 2 DIGITS UNSIGNED

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

EDIT-RULES:
RANGE: 1 TO 13

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

SOURCE:
CWFB CLAIMS

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
81.	FILLER	CHAR	4	422	425	
****	Carrier Claim Variable Group	GROUP	VAR			Variable portion of the carrier claim record for version H of the NCH. STANDARD ALIAS: CARR_CLM_VAR_GRP
****	NCH Edit Group	GROUP	5			The number of claim edit trailers is determined by the claim edit code count. OCCURS: UP TO 13 TIMES DEPENDING ON CARR_NCH_EDIT_CD_CNT STANDARD ALIAS: NCH_EDIT_GRP
82.	NCH Edit Trailer Indicator Code	CHAR	1			Effective with Version H, the code indicating the presence of an NCH edit trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service

year 1991).

DB2 ALIAS: EDIT_TRLR_IND_CD
SAS ALIAS: EDITIND
STANDARD ALIAS: NCH_EDIT_TRLR_IND_CD

CODES:
E = Edit code trailer present

SOURCE:
NCH QA Process

NAME	TYPE	LENGTH	BEG	END	CONTENTS
83. NCH Edit Code	CHAR	4			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 IN THE CODES APPENDIX SOURCE: NCH QA EDIT PROCESS

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
**** NCH Patch Group	GROUP	11			OCCURS: UP TO 30 TIMES DEPENDING ON CARR_NCH_PATCH_CD_I_CNT

#	Name	Type	Length	Description
				STANDARD ALIAS: NCH_PATCH_GRP
84.	NCH Patch Trailer Indicator Code	CHAR	1	Effective with Version H, the code indicating the presence of an NCH patch trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). DB2 ALIAS: PATCH_TRLR_IND_CD SAS ALIAS: PATCHIND STANDARD ALIAS: NCH_PATCH_TRLR_IND_CD CODES: P = Patch code trailer present SOURCE: NCH
85.	NCH Patch Code	CHAR	2	Effective with Version H, the code annotated to the claim indicating a patch was applied to the record during an NCH Nearline record conversion and/or during current processing. NOTE: Prior to Version H this field was located in the third and fourth occurrence of the CLM_EDIT_CD. DB2 ALIAS: NCH_PATCH_CD SAS ALIAS: PATCHCD STANDARD ALIAS: NCH_PATCH_CD TITLE ALIAS: NCH_PATCH CODES: REFER TO: NCH_PATCH_TB IN THE CODES APPENDIX SOURCE: NCH

86. 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

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS

SOURCE:
NCH

**** MCO Period Group   GROUP   37

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

OCCURS: UP TO 2 TIMES
DEPENDING ON CARR_MCO_PRD_CNT

STANDARD ALIAS: MCO_PRD_GRP

87. NCH MCO Trailer Indicator Code   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.

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				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 STANDARD ALIAS: NCH_MCO_TRLR_IND_CD TITLE ALIAS: MCO_INDICATOR CODES: M = MCO trailer present SOURCE: NCH QA Process
88. 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

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
89. 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

90. MCO Period Effective Date NUM 8

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

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

8 DIGITS UNSIGNED

DB2 ALIAS: MCO_PRD_EFCTV_DT
SAS ALIAS: MCOEFFDT
STANDARD ALIAS: MCO_PRD_EFCTV_DT

TITLE ALIAS: MCO_PERIOD_EFF_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
91. MCO Period Termination Date	NUM	8		Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) was terminated.

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
92. MCO Health PLANID Number	CHAR	14		A placeholder field (effective with Version H) for storing the Health PlanID associated with the Managed Care Organization (MCO). Prior to Version 'I' this field was named:

MCO_PAYERID_NUM.

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

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

SOURCE:
CWF

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
****	Claim Health PlanID Group	GROUP	16			The number of Health PlanID data trailers is determined by the claim Health PlanID trailer count. Prior to Version 'I' this field was named: CLM_PAYERID_GRP.

OCCURS: UP TO 3 TIMES
DEPENDING ON CARR_CLM_HLTH_PLANID_CNT

STANDARD ALIAS: CLM_HLTH_PLANID_GRP

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
93.	NCH Health PlanID Trailer Indicator Code	CHAR	1			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

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS

CODES:

I = Health PlanID trailer present

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

SOURCE:
NCH

94. Claim Health PlanID Code	CHAR	1	A placeholder field (effective with Version H) for storing the code identifying the type of Health PlanID. Prior to Version 'I' this field was named: CLM_PAYERID-CD DB2 ALIAS: CLM_PLANID_CD SAS ALIAS: PLANIDCD STANDARD ALIAS: CLM_HLTH_PLANID_CD TITLE ALIAS: PLANID_TYPE CODES: 1 = Medicare Secondary Payer 2 = Medicaid 3 = Medigap 4 = Supplemental Insurer 5 = Managed Care Organization COMMENT: Prior to Version I this field was named: CLM_PAYERID_CD. SOURCE: CWF
95. Claim Health PlanID Number	CHAR	14	A placeholder field (effective with Version H) for storing the Health PlanID number. Prior to Version 'I' this field was named: CLM_PAYERID_NUM. DB2 ALIAS: CLM_PLANID_NUM SAS ALIAS: PLANID

STANDARD ALIAS: CLM_HLTH_PLANID_NUM
TITLE ALIAS: PLANID

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

SOURCE:
CWF

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
****	Claim Demonstration Identification Group	GROUP	18			The number of demonstration identification trailers present is determined by the claim demonstration identification trailer count.

OCCURS: UP TO 5 TIMES
DEPENDING ON CARR_CLM_DEMO_ID_CNT

STANDARD ALIAS: CLM_DEMO_ID_GRP

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
96.	NCH Demonstration Trailer Indicator Code	CHAR	1			Effective with Version H, the code indicating the presence of a demo trailer.

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

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

CODES:
D = Demo trailer present

SOURCE:
NCH

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
97. Claim Demonstration Identification Number	CHAR	2		Effective with Version H, the number assigned to identify a demo. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).

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

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

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

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS

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.

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				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.

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				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 facili-

ties 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 effective-

ness 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.

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS

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

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

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

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

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

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

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

NOTE: Effective October, 2000 for carrier claims.

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				DB2 ALIAS: CLM_DEMO_ID_NUM SAS ALIAS: DEMONUM STANDARD ALIAS: CLM_DEMO_ID_NUM TITLE ALIAS: DEMO_ID SOURCE: CWF
98. Claim Demonstration Information Text	CHAR	15		Effective with Version H, the text field that contains related demo information. For example,

a claim involving a CHOICES demo id '05' would
contain the MCO plan contract number in the first
five positions of this text field.

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

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 con-
tain the CHOICES plan number, if both of the follow-
ing 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

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				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 re- flect 'INVALID'. NOTE: In Version 'G', a valid CHOICES plan ID is stored as alpha character in redefined Claim Edit Group, 4th occurrence, 2nd position. If invalid, CHOICES indicator 'ZZ' displayed. Demo ID = 15 (ESRD Managed Care) -- text field will contain the ESRD/MCO plan number. If ESRD/ MCO plan number not present the field will reflect 'INVALID'. Demo ID = 38 (Physician Encounter Claims) -- text field will contain the MCO plan number. When MCO plan number not present the field will reflect 'INVALID'. SOURCE: CWF
**** Carrier Claim Diagnosis Group	GROUP	7		OCCURS: UP TO 4 TIMES DEPENDING ON CARR_CLM_DGNS_CD_CNT STANDARD ALIAS: CARR_CLM_DGNS_GRP

	NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
99.	NCH Diagnosis Trailer Indicator Code	CHAR	1		Effective with Version H, the code indicating the presence of a diagnosis trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). DB2 ALIAS: DGNS_TRLR_IND_CD SAS ALIAS: DGNSIND STANDARD ALIAS: NCH_DGNS_TRLR_IND_CD CODES: Y = Diagnosis code trailer present SOURCE: NCH
100.	Claim Diagnosis Code	CHAR	5		The ICD-9-CM based code identifying the beneficiary's principal or other diagnosis (including E code).

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				NOTE: Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM_PRNCPAL_DGNS_CD was added as the first occurrence. DB2 ALIAS: CLM_DGNS_CD SAS ALIAS: DGNS_CD STANDARD ALIAS: CLM_DGNS_CD TITLE ALIAS: DIAGNOSIS

				EDIT-RULES: ICD-9-CM COMMENT: Prior to Version H this field was named: CLM_OTHR_DGNS_CD.
101.	FILLER	CHAR	1	
****	Carrier Line Item Group	GROUP	294	The line item trailer group may occur multiple times in one carrier claim. Up to 13 occurrences may be present. OCCURS: UP TO 13 TIMES DEPENDING ON CARR_CLM_LINE_CNT STANDARD ALIAS: CARR_LINE_GRP
102.	NCH Line Item Trailer Indicator Code	CHAR	1	Effective with Version H, the code indicating the presence of a line item trailer on the non-institutional claim. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). DB2 ALIAS: LINE_TRLR_IND_CD SAS ALIAS: LINEIND STANDARD ALIAS: NCH_LINE_TRLR_IND_CD CODES: L = Line Item trailer present Blank = No trailer present SOURCE: NCH
103.	Carrier Line Performing PIN Number	CHAR	10	The profiling identification number (PIN) of the physician\supplier who performed the service for this line item on the carrier claim

(non-DMERC).

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
					COMMON ALIAS: PHYSICIAN/SUPPLIER_PROVIDER_NUM DB2 ALIAS: LINE_PRFRMG_PIN SAS ALIAS: PRF_PRFL STANDARD ALIAS: CARR_LINE_PRFRMG_PIN_NUM TITLE ALIAS: PRFRMG_PIN COMMENT: Prior to Version H this field was named: CWFB_PRFRMG_PRVDR_PRFLG_NUM. SOURCE: CWF
104. Carrier Line Performing UPIN Number	CHAR	6			The unique physician identification number (UPIN) of the physician who performed the service for this line item on the carrier claim (non-DMERC). DB2 ALIAS: LINE_PRFRMG_UPIN SAS ALIAS: PRF_UPIN STANDARD ALIAS: CARR_LINE_PRFRMG_UPIN_NUM TITLE ALIAS: PRFRMG_UPIN COMMENT: Prior to Version H this field was named: CWFB_PRFRMG_PRVDR_UPIN_NUM. SOURCE: CWF
105. Carrier Line Performing NPI Number	CHAR	10			A placeholder field (effective with Version H) for storing the NPI assigned to the performing

provider.

COMMON ALIAS: PERFORMING_PROVIDER_NPI
DB2 ALIAS: LINE_PRFRMG_NPI
SAS ALIAS: PRFNPI
STANDARD ALIAS: CARR_LINE_PRFRMG_NPI_NUM
TITLE ALIAS: PRFRMG_NPI

SOURCE:
CWF

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
106. Carrier Line Performing Group NPI Number	CHAR	10		A placeholder field (effective with Version H) for storing the NPI assigned to a group practice, where the performing physician is part of that group. If the physician is not part of a group, this field will be blank. DB2 ALIAS: PRFRMG_GRP_NPI SAS ALIAS: PRGRPNPI STANDARD ALIAS: CARR_LINE_PRFRMG_GRP_NPI_NUM TITLE ALIAS: PRFRMG_GROUP_NPI

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				SOURCE: CWF
107. Carrier Line Provider Type Code	CHAR	1		Code identifying the type of provider furnishing the service for this line item on the carrier claim (non-DMERC). DB2 ALIAS: LINE_PRVDR_TYPE_CD SAS ALIAS: PRV_TYPE STANDARD ALIAS: CARR_LINE_PRVDR_TYPE_CD TITLE ALIAS: PRVDR_TYPE CODES:

			REFER TO: CARR_LINE_PRVDR_TYPE_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_PRVDR_TYPE_CD. SOURCE: CWF
108. Line Provider Tax Number	CHAR	10	Social security number or employee identification number of physician/supplier used to identify to whom payment is made for the line item service on the noninstitutional claim. DB2 ALIAS: LINE_PRVDR_TAX_NUM SAS ALIAS: TAX_NUM STANDARD ALIAS: LINE_PRVDR_TAX_NUM TITLE ALIAS: PRVDR_TAX_NUM COMMENT: Prior to Version H this field was named: CWFB_PRVDR_TAX_NUM. SOURCE: CWF
109. Line NCH Provider State Code	CHAR	2	Effective with Version H, the two position SSA state code where provider facility is located. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). DB2 ALIAS: LINE_PRVDR_STATE SAS ALIAS: PRVSTATE STANDARD ALIAS: LINE_NCH_PRVDR_STATE_CD TITLE ALIAS: PRVDR_STATE

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
					DERIVATION: DERIVED FROM: CARR_LINE_PRFRMG_PRVDR_ZIP_CD DERIVATION RULES: Use the first three positions of the provider zip code to derive the LINE_NCH_PRVDR_STATE_CD from a crosswalk file. Where a match is not achieved this field will be blank. CODES: REFER TO: GEO_SSA_STATE_TB SOURCE: NCH
110. Carrier Line Performing Provider ZIP Code	CHAR	9			The ZIP code of the physician/supplier who performed the Part B service for this line item on the carrier claim (non-DMERC). DB2 ALIAS: LINE_PRVDR_ZIP_CD SAS ALIAS: PROVZIP STANDARD ALIAS: CARR_LINE_PRFRMG_PRVDR_ZIP_CD TITLE ALIAS: PRVDR_ZIP_CD COMMENT: Prior to Version H this field was named: CWFB_PRFRMG_PRVDR_ZIP_CD and the field size was S9(9). SOURCE: CWF

	NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
111.	Line HCFA Provider Specialty Code	CHAR	2		HCFA specialty code used for pricing the line item service on the noninstitutional claim. DB2 ALIAS: HCFA_SPCLTY_CD SAS ALIAS: HCFASPCL STANDARD ALIAS: LINE_HCFA_PRVDR_SPCLTY_CD TITLE ALIAS: HCFA_PRVDR_SPCLTY CODES: REFER TO: HCFA_PRVDR_SPCLTY_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_HCFA_PRVDR_SPCLTY_CD. SOURCE: CWF

	NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
112.	Carrier Line Provider Specialty Code	CHAR	2		The carrier's specialty code for the provider (usually different from HCFA's) used for pricing the service for this line item on the carrier claim (non-DMERC). DB2 ALIAS: PRVDR_SPCLTY_CD SAS ALIAS: CARRSPCL STANDARD ALIAS: CARR_LINE_PRVDR_SPCLTY_CD TITLE ALIAS: CARR_PRVDR_SPCLTY EDIT-RULES: CARRIER INFORMATION FILE COMMENT:

```
                                                     Prior to Version H this field was named:
                                                     CWFB_CARR_PRVDR_SPCLTY_CD.

                                                     SOURCE:
                                                     CWF

  113. Line Provider Participating  CHAR      1      Code indicating whether or not a provider is
       Indicator Code                                participating or accepting assignment for this
                                                     line item service on the noninstitutional claim.

                                                     DB2 ALIAS: PRVDR_PRTCPTG_CD
                                                     SAS ALIAS: PRTCPTG
                                                     STANDARD ALIAS: LINE_PRVDR_PRTCPTG_IND_CD
                                                     TITLE ALIAS: PRVDR_PRTCPTG_IND

                                                     CODES:
                                                       REFER TO: LINE_PRVDR_PRTCPTG_IND_TB
                                                                 IN THE CODES APPENDIX

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

                                                     SOURCE:
                                                     CWF

  114. Carrier Line Reduced         CHAR      1      Effective 1/92, the code on the carrier (non-DMERC)
       Payment Physician Assistant                   line item that identifies claims that have been
       Code                                          paid a reduced fee schedule amount (65%, 75% or 85%)
                                                     because a physician's assistant performed the
                                                     services.
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                                            POSITIONS
                NAME              TYPE  LENGTH BEG  END                            CONTENTS
       ---------------------------  ----  ------ ---------  ------------------------------------------------------------

                                                     COMMON ALIAS: PA_65/75/85%_FEE
                                                     DB2 ALIAS: PHYSN_ASTNT_CD
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SAS ALIAS: ASTNT_CD
STANDARD ALIAS: CARR_LINE_RDCD_PHYSN_ASTNT_CD
TITLE ALIAS: PHYSN_ASTNT_CD

CODES:
REFER TO: CARR_LINE_RDCD_PHYSN_ASTNT_TB
IN THE CODES APPENDIX

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

SOURCE:
CWF

115. 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.

SOURCE:
CWF

116. 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

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
						COMMENT: Prior to Version H this field was named: CWFB_HCFA_TYPE_SRVC_CD. SOURCE: CWF
117.	Carrier Line Type Service Code	CHAR	2			Carrier's type of service code (usually different from HCFA's) used for pricing the service reported on the line item on the carrier claim (non-DMERC). DB2 ALIAS: LINE_TYPE_SRVC_CD SAS ALIAS: PTYPESRV STANDARD ALIAS: CARR_LINE_TYPE_SRVC_CD TITLE ALIAS: CARR_TYPE_SRVC COMMENT: Prior to Version H this field was named: CWFB_CARR_TYPE_SRVC_CD. SOURCE: CWF

	NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
118.	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
119.	Carrier Line Pricing Locality Code	CHAR	2		Code denoting the carrier-specific locality used for pricing the service for this line item on the carrier claim (non-DMERC). DB2 ALIAS: PRCNG_LCLTY_CD SAS ALIAS: LCLTY_CD STANDARD ALIAS: CARR_LINE_PRCNG_LCLTY_CD TITLE ALIAS: PRICING_LOCALITY

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				EDIT-RULES: CARRIER INFORMATION FILE

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

SOURCE:
CWF

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

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

SOURCE:
CWF

121. 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: LAST_EXPNS_DT

EDIT-RULES:

YYYYMMDD

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

SOURCE:
CWF

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
122. 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 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.

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				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.

#	Name	Type	Length	Description
123.	Line HCPCS Initial Modifier Code	CHAR	2	A first modifier to the HCPCS procedure code to enable a more specific procedure identification for the line item service on the noninstitutional claim. DB2 ALIAS: HCPCS_1ST_MDFR_CD SAS ALIAS: MDFR_CD1 STANDARD ALIAS: LINE_HCPCS_INITL_MDFR_CD TITLE ALIAS: INITIAL_MODIFIER EDIT-RULES: CARRIER INFORMATION FILE COMMENT: Prior to Version H this field was named: HCPCS_INITL_MDFR_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV_CNTR and noninstitutional: LINE). SOURCE: CWF
124.	Line HCPCS Second Modifier Code	CHAR	2	A second modifier to the HCPCS procedure code to make it more specific than the first modifier code to identify the line item procedures for this claim. 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).

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				SOURCE: CWF
125. Line NCH BETOS Code	CHAR	3		Effective with Version H, the Berenson-Eggers type of service (BETOS) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services. This field is included as a line item on the noninstitutional claim. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). DB2 ALIAS: LINE_NCH_BETOS_CD SAS ALIAS: BETOS STANDARD ALIAS: LINE_NCH_BETOS_CD SYSTEM ALIAS: LTBETOS TITLE ALIAS: BETOS DERIVATION: DERIVED FROM: LINE_HCPCS_CD LINE_HCPCS_INITL_MDFR_CD LINE_HCPCS_2ND_MDFR_CD HCPCS MASTER FILE DERIVATION RULES: Match the HCPCS on the claim to the HCPCS on

the HCPCS Master File to obtain the BETOS code.

CODES:
REFER TO: BETOS_TB
IN THE CODES APPENDIX

SOURCE:
NCH

	NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
126.	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.

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				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

127. 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
128. Line NCH Payment Amount	PACK	6	Amount of payment made from the trust funds (after deductible and coinsurance amounts have been paid) for the line item service on the non-institutional claim. 9.2 DIGITS SIGNED COMMON ALIAS: REIMBURSEMENT DB2 ALIAS: LINE_NCH_PMT_AMT SAS ALIAS: LINEPMT STANDARD ALIAS: LINE_NCH_PMT_AMT TITLE ALIAS: REIMBURSEMENT EDIT-RULES: $$$$$$$$$CC COMMENT: Prior to Version H this line item field was named: CLM_PMT_AMT and the size of this field was S9(7)V99.

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				SOURCE: NCH
129. Line Beneficiary Payment Amount	PACK	6		Effective with Version H, the payment (reim-bursement) made to the beneficiary related to the line item service on the noninstitu-tional claim. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: LINE_BENE_PMT_AMT SAS ALIAS: LBENPMT STANDARD ALIAS: LINE_BENE_PMT_AMT TITLE ALIAS: BENE_PMT_AMT SOURCE: CWF
130. 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

	NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
131.	Line Beneficiary Part B Deductible Amount	PACK	6		The amount of money for which the carrier has determined that the beneficiary is liable for the Part B cash deductible for the line item service on the noninstitutional claim.

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

	NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
132.	Line Beneficiary Primary Payer Code	CHAR	1		The code specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's medical bills relating to the line item service

on the noninstitutional claim.

DB2 ALIAS: LINE_PRMRY_PYR_CD
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

133. Line Beneficiary Primary Payer Paid Amount PACK 6

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

9.2 DIGITS SIGNED

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

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

COMMENT:
Prior to Version H this field was named:
BENE_PRMRY_PYR_PMT_AMT and the field size

NAME	TYPE	LENGTH	BEG	END	CONTENTS
					was S9(5)V99. SOURCE: CWF
134. 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
135. Carrier Line Psychiatric, Occupational Therapy, Physical Therapy Limit Amount	PACK	6			For type of service psychiatric, occupational therapy or physical therapy, the amount of allowed charges applied toward the limit cap for this line item service on the noninstitutional claim. 9.2 DIGITS SIGNED DB2 ALIAS: PSYCH_OT_PT_LMT SAS ALIAS: LLMTAMT STANDARD ALIAS: CARR_LINE_PSYCH_OT_PT_LMT_AMT TITLE ALIAS: PSYCH_OT_PT_LIMIT COMMENT:

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

SOURCE:
CWF

136. 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

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS

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

137. 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.

NOTE: Beginning with NCH weekly process date

				10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: PRMRY_PYR_ALOW_AMT SAS ALIAS: PRPYALOW STANDARD ALIAS: LINE_PRMRY_PYR_ALOW_CHRG_AMT TITLE ALIAS: PRMRY_PYR_ALOW_CHRG SOURCE: CWF
138.	Line 10% Penalty Reduction Amount	PACK	6	Effective with Version H, the 10% payment reduction amount (applicable to a late filing claim) for the line item service. on the noninstitutional claim. 9.2 DIGITS SIGNED DB2 ALIAS: TENPCT_PNLTY_AMT SAS ALIAS: PNLTYAMT STANDARD ALIAS: LINE_10PCT_PNLTY_RDCTN_AMT TITLE ALIAS: TENPCT_PNLTY SOURCE: CWF
139.	Carrier Line Blood Deductible Pints Quantity	PACK	2	The blood pints quantity (deductible) for the line item on the carrier claim (non-DMERC). 3 DIGITS SIGNED DB2 ALIAS: LINE_BLOOD_DDCTBL SAS ALIAS: LBLD_DED STANDARD ALIAS: CARR_LINE_BLOOD_DDCTBL_QTY TITLE ALIAS: BLOOD_DDCTBL

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				EDIT-RULES: NUMERIC COMMENT: Prior to Version H this field was named: CWFB_LINE_BLOOD_DDCTBL_QTY. SOURCE: CWF
140. Line Submitted Charge Amount	PACK	6		The amount of submitted charges for the line item service on the noninstitutional claim. 9.2 DIGITS SIGNED DB2 ALIAS: LINE_SBMT_CHRG_AMT SAS ALIAS: LSBMTCHG STANDARD ALIAS: LINE_SBMT_CHRG_AMT TITLE ALIAS: SBMT_CHRG EDIT-RULES: $$$$$$$$$CC COMMENT: Prior to Version H this field was named: CWFB_SBMT_CHRG_AMT and the field size was S9(5)V99. SOURCE: CWF
141. Line Allowed Charge Amount	PACK	6		The amount of allowed charges for the line item service on the noninstitutional claim. This charge is used to compute pay to providers or reimbursement to beneficiaries. **NOTE: The

allowed charge is determined by the lower of three charges: prevailing, customary or actual.

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_ALOW_CHRG_AMT
SAS ALIAS: LALOWCHG
STANDARD ALIAS: LINE_ALOW_CHRG_AMT
TITLE ALIAS: ALOW_CHRG

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

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

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
142.	Carrier Line Clinical Lab Number	CHAR	10		The identification number assigned to the clinical laboratory providing services for the line item on the carrier claim (non-DMERC).

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

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

SOURCE:

CWF

143. Carrier Line Clinical Lab Charge Amount   PACK   6

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

9.2 DIGITS SIGNED

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

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

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

SOURCE:
CWF

144. Line Processing Indicator Code   CHAR   1

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

DB2 ALIAS: LINE_PRCSG_IND_CD
SAS ALIAS: PRCNGIND
STANDARD ALIAS: LINE_PRCSG_IND_CD
TITLE ALIAS: PRCSG_IND

CODES:
REFER TO: LINE_PRCSG_IND_TB
IN THE CODES APPENDIX

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

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
				SOURCE: CWF
145. Line Payment 80%/100% Code	CHAR	1		The code indicating that the amount shown in the payment field on the noninstitutional line item represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only. COMMON ALIAS: REIMBURSEMENT_IND DB2 ALIAS: LINE_PMT_80_100_CD SAS ALIAS: PMTINDSW STANDARD ALIAS: LINE_PMT_80_100_CD TITLE ALIAS: REINBURSEMENT_IND CODES: 0 = 80% 1 = 100% 3 = 100% Limitation of liability only COMMENT: Prior to Version H this field was named: CWFB_PMT_80_100_CD. SOURCE: CWF
146. Line Service Deductible Indicator Switch	CHAR	1		Switch indicating whether or not the line item service on the noninstitutional claim is subject to a deductible. DB2 ALIAS: SRVC_DDCTBL_SW SAS ALIAS: DED_SW STANDARD ALIAS: LINE_SRVC_DDCTBL_IND_SW

TITLE ALIAS: SRVC_DED_IND

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

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

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
147.	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

	NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
148.	Carrier Line Miles/Time/Units/Services	PACK	2		The count of the total units associated with services needing unit reporting such as

	Count			transportation, miles, anesthesia time units, number of services, volume of oxygen or blood units. This is a line item field on the carrier claim (non-DMERC) and is used for both allowed and denied services. 3 DIGITS SIGNED DB2 ALIAS: LINE_MTUS_CNT SAS ALIAS: MTUS_CNT STANDARD ALIAS: CARR_LINE_MTUS_CNT TITLE ALIAS: MTUS_CNT EDIT-RULES: For CARR_LINE_MTUS_IND_CD equal to 2 (anesthesia time units) there is one implied decimal point. COMMENT: Prior to Version H this field was named: CWFB_MTUS_CNT. SOURCE: CWF
149.	Carrier Line Miles/Time/Units/Services Indicator Code	CHAR	1	Code indicating the units associated with services needing unit reporting on the line item for the carrier claim (non-DMERC). DB2 ALIAS: LINE_MTUS_IND_CD SAS ALIAS: MTUS_IND STANDARD ALIAS: CARR_LINE_MTUS_IND_CD TITLE ALIAS: MTUS_IND CODES: 0 = Values reported as zero (no allowed activities) 1 = Transportation (ambulance) miles 2 = Anesthesia time units 3 = Services 4 = Oxygen units

5 = Units of blood

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
					6 = Anesthesia base and time units (prior to 1991; from BMAD) COMMENT: Prior to Version H this field was named: CWFB_MTUS_IND_CD. SOURCE: CWF
150. Line Diagnosis Code	CHAR	5			The ICD-9-CM code indicating the diagnosis supporting this line item procedure/service on the noninstitutional claim. DB2 ALIAS: LINE_DGNS_CD SAS ALIAS: LINEDGNS STANDARD ALIAS: LINE_DGNS_CD TITLE ALIAS: DGNS_CD EDIT-RULES: ICD-9-CM COMMENT: Prior to Version H this field was named: CWFB_LINE_DGNS_CD. SOURCE: CWF
151. FILLER	CHAR	1			
152. Carrier Line Anesthesia Base Unit Count	PACK	2			The base number of units assigned to the line item anesthesia procedure on the carrier claim

(non-DMERC).

3 DIGITS SIGNED

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

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

SOURCE:
CWF

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
153. Carrier Line CLIA Alert Indicator Code	CHAR	1		Effective with Version G, the alert code (resulting from CLIA editing) added by CWF as a line item on the carrier claim (non-DMERC).

NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS

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

CODES:
(Effective 9/92 but not stored until 10/93)
0 = No Alert
1 = 77X9
2 = 77XA
3 = 77X5
4 = 77X6
5 = 77X7
6 = 77X8

#	Name	Type	Length	Description
				7 = 77XB COMMENT: Prior to Version H this field was named: CWFB_CLIA_ALERT_IND_CD. SOURCE: CWF
154.	Line Additional Claim Documentation Indicator Code	CHAR	1	Effective 5/92, the code indicating additional claim documentation was submitted for this line item service on the noninstitutional claim. COMMON ALIAS: DOCUMENT_IND DB2 ALIAS: ADDTNL_DCMTN_CD SAS ALIAS: DCMTN_CD STANDARD ALIAS: LINE_ADDTNL_CLM_DCMTN_IND_CD TITLE ALIAS: ADDTNL_DCMTN_IND EDIT-RULES: In any case where more than one value is applicable, highest number is shown. CODES: REFER TO: LINE_ADDTNL_CLM_DCMTN_IND_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_ADDTNL_CLM_DCMTN_IND_CD. SOURCE: CWF
155.	Carrier Line DME Coverage Period Start Date	NUM	8	Effective 5/92 through 6/94, as line item on the carrier claim (non-DMERC), the date durable medical equipment (DME) coverage period started per certificate of medical necessity, prescription, other documentation or carrier determination. This field is applicable to line items involving DME,

prosthetic, orthotic and supply items, immuno-

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
					suppressive drugs, pen, ESRD and oxygen items referred to as DMEPOS). 8 DIGITS UNSIGNED DB2 ALIAS: DME_CVRG_STRT_DT SAS ALIAS: DMEST_DT STANDARD ALIAS: CARR_LINE_DME_CVRG_PRD_STRT_DT TITLE ALIAS: DME_CVRG_START_DT EDIT-RULES: YYYYMMDD COMMENT: Prior to Version H this field was named: CWFB_DME_CVRG_PRD_STRT_DT. SOURCE: CWF LIMITATIONS: When the revised DME processing was implemented (phased in between 10/93-6/94), this field was not included on the new DMERC claim; it is being reported on the certificate of medical necessity (CMN) transaction. HCFA does not receivee CMN transaction from CWF.
156. Line DME Purchase Price Amount	PACK	6			Effective 5/92, the amount representing the lower of fee schedule for purchase of new or used DME, or actual charge. In case of rental DME, this amount represents the purchase cap; rental payments can only be made until the

cap is met. This line item field is applicable
to non-institutional claims involving DME,
prosthetic, orthotic and supply items,
immunosuppressive drugs, pen, ESRD and oxygen
items referred to as DMEPOS.

9.2 DIGITS SIGNED

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

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

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

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
						SOURCE: CWF
157.	Carrier Line DME Medical Necessity Month Count	PACK	2			Effective 5/92 through 6/94, as line item on the carrier claim (non-DMERC), the count determined by the carrier showing the length of need (medical necessity for DME in months from the start date through the determined period of need. This field is applicable to line items involving DME, prosthetic, orthotic and supply items, immuno-suppressive drugs, pen, ESRD and oxygen items referred to as DMEPOS).

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

3 DIGITS SIGNED

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

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

SOURCE:
CWF

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

158. FILLER	CHAR	50	
159. End of Record Code	CHAR	3	Effective with Version 'I', the code used to identify the end of a record/segment or the end of the claim. DB2 ALIAS: END_REC_CD SAS ALIAS: EOR STANDARD ALIAS: END_REC_CD TITLE ALIAS: END_OF_REC

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
					CODES: EOR = End of Record/Segment EOC= End of Claim COMMENT: Prior to Version I this field was named: END_REC_CNSTNT. SOURCE: NCH

1 BENE_IDENT_TB — Beneficiary Identification Code (BIC) Table

Social Security Administration:

A = Primary claimant
B = Aged wife, age 62 or over (1st claimant)
B1 = Aged husband, age 62 or over (1st claimant)
B2 = Young wife, with a child in her care (1st claimant)
B3 = Aged wife (2nd claimant)
B4 = Aged husband (2nd claimant)
B5 = Young wife (2nd claimant)
B6 = Divorced wife, age 62 or over (1st claimant)
B7 = Young wife (3rd claimant)
B8 = Aged wife (3rd claimant)
B9 = Divorced wife (2nd claimant)
BA = Aged wife (4th claimant)
BD = Aged wife (5th claimant)

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                                   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)
                                   DC = Surviving divorced husband (1st 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)
1       BENE_IDENT_TB                       Beneficiary Identification Code (BIC) Table
        -------------                       -------------------------------------------
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DN = Remarried widow (5th claimant)
DP = Remarried widower (2nd claimant)
DQ = Remarried widower (3rd claimant)
DR = Remarried widower (4th claimant)
DS = Surviving divorced husband (3rd claimant)
DT = Remarried widower (5th claimant)
DV = Surviving divorced wife (3rd claimant)
DW = Surviving divorced wife (4th claimant)
DX = Surviving divorced husband (4th claimant)
DY = Surviving divorced wife (5th claimant)
DZ = Surviving divorced husband (5th claimant)
E = Mother (widow) (1st claimant)
E1 = Surviving divorced mother (1st claimant)
E2 = Mother (widow) (2nd claimant)
E3 = Surviving divorced mother (2nd claimant)
E4 = Father (widower) (1st claimant)
E5 = Surviving divorced father (widower) (1st claimant)
E6 = Father (widower) (2nd claimant)
E7 = Mother (widow) (3rd claimant)
E8 = Mother (widow) (4th claimant)
E9 = Surviving divorced father (widower) (2nd claimant)
EA = Mother (widow) (5th claimant)
EB = Surviving divorced mother (3rd claimant)
EC = Surviving divorced mother (4th claimant)
ED = Surviving divorced mother (5th claimant
EF = Father (widower) (3rd claimant)
EG = Father (widower) (4th claimant)
EH = Father (widower) (5th claimant)
EJ = Surviving divorced father (3rd

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

                              J4 = Primary prouty not entitled to HIB
                                   (over 2 Q.C.) (RSI trust fund)
                              K1 = Prouty wife entitled to HIB (less than
                                   3 Q.C.) (general fund) (1st claimant)
                              K2 = Prouty wife entitled to HIB (over 2
                                   Q.C.) (RSI trust fund) (1st claimant)
                              K3 = Prouty wife not entitled to HIB (less
                                   than 3 Q.C.) (general fund) (1st
                                   claimant)
                              K4 = Prouty wife not entitled to HIB (over
                                   2 Q.C.) (RSI trust fund) (1st
                                   claimant)
                              K5 = Prouty wife entitled to HIB (less than
                                   3 Q.C.) (general fund) (2nd claimant)
                              K6 = Prouty wife entitled to HIB (over 2
                                   Q.C.) (RSI trust fund) (2nd claimant)
                              K7 = Prouty wife not entitled to HIB (less
                                   than 3 Q.C.) (general fund) (2nd
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claimant)
K8 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)
K9 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)
KA = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)
KB = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)
KC = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)
KD = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (4th claimant)
KE = Prouty wife entitled to HIB (over 2 Q.C (4th claimant)
KF = Prouty wife not entitled to HIB (less than 3 Q.C.)(4th claimant)
KG = Prouty wife not entitled to HIB (over 2 Q.C.)(4th claimant)
KH = Prouty wife entitled to HIB (less than 3 Q.C.)(5th claimant)
KJ = Prouty wife entitled to HIB (over 2 Q.C.) (5th claimant)
KL = Prouty wife not entitled to HIB (less than 3 Q.C.)(5th claimant)
KM = Prouty wife not entitled to HIB (over 2 Q.C.) (5th claimant)
M = Uninsured-not qualified for deemed HIB
M1 = Uninsured-qualified but refused HIB
T = Uninsured-entitled to HIB under deemed or renal provisions
TA = MQGE (primary claimant)
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)

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

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

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

1 BENE_IDENT_TB — Beneficiary Identification Code (BIC) Table

Pensioner: a person who retired prior to 03/01/37 and was included in the railroad retirement act

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
15 = Parent of annuitant
85 = Parent of pensioner
11 = Survivor joint annuitant
(reduced benefits taken to insure benefits
for surviving spouse)

1 BENE_PRMRY_PYR_TB — 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 = MSP cost avoided - IEQ contractor
    (eff. 7/96 carrier claims only)

U = MSP cost avoided - HMO rate cell adjust-
    ment contractor (eff. 7/96 carrier claims
    only)

V = MSP cost avoided - litigation settlement
    contractor (eff. 7/96 carrier claims
    only)

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

Prior to 12/90

Y = Other secondary payer investigation
    shows Medicare as primary payer

1 BENE_PRMRY_PYR_TB Beneficiary Primary Payer Table

Z = Medicare is primary payer

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

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
M5D = Specialist - other
M6  = Consultations
P0  = Anesthesia
P1A = Major procedure - breast
P1B = Major procedure - colectomy
P1C = Major procedure - cholecystectomy
P1D = Major procedure - turp
P1E = Major procedure - hysterctomy
P1F = Major procedure - explor/decompr/excisdisc
P1G = Major procedure - Other
P2A = Major procedure, cardiovascular-CABG
P2B = Major procedure, cardiovascular-Aneurysm repair
P2C = Major Procedure, cardiovascular-Thromboendarterectomy
P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA)
P2E = Major procedure, cardiovascular-Pacemaker insertion
P2F = Major procedure, cardiovascular-Other
P3A = Major procedure, orthopedic - Hip fracture repair
P3B = Major procedure, orthopedic - Hip replacement
P3C = Major procedure, orthopedic - Knee replacement
P3D = Major procedure, orthopedic - other
P4A = Eye procedure - corneal transplant
P4B = Eye procedure - cataract removal/lens insertion
P4C = Eye procedure - retinal detachment
P4D = Eye procedure - treatment
P4E = Eye procedure - other
```

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                                          P5A = Ambulatory procedures - skin
                                          P5B = Ambulatory procedures - musculoskeletal
                                          P5C = Ambulatory procedures - inguinal hernia repair
                                          P5D = Ambulatory procedures - lithotripsy
                                          P5E = Ambulatory procedures - other
                                          P6A = Minor procedures - skin
                                          P6B = Minor procedures - musculoskeletal
                                          P6C = Minor procedures - other (Medicare fee schedule)
                                          P6D = Minor procedures - other (non-Medicare fee schedule)
                                          P7A = Oncology - radiation therapy
                                          P7B = Oncology - other
                                          P8A = Endoscopy - arthroscopy
                                          P8B = Endoscopy - upper gastrointestinal
                                          P8C = Endoscopy - sigmoidoscopy
                                          P8D = Endoscopy - colonoscopy
                                          P8E = Endoscopy - cystoscopy
                                          P8F = Endoscopy - bronchoscopy
                                          P8G = Endoscopy - laparoscopic cholecystectomy
                                          P8H = Endoscopy - laryngoscopy
                                          P8I = Endoscopy - other
                                          P9A = Dialysis services
1          BETOS_TB                                                  BETOS Table
           --------                                                  -----------

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

1 CARR_CLM_PMT_DNL_TB — Carrier Claim Payment Denial Table

```
0 = Denied
1 = Physician/supplier
```

2 = Beneficiary
3 = Both physician/supplier and beneficiary
4 = Hospital (hospital based physicians)
5 = Both hospital and beneficiary
6 = Group practice prepayment plan
7 = Other entries (e.g. Employer, union)
8 = Federally funded
9 = PA service
A = Beneficiary under limitation of liability
B = Physician/supplier under limitation of liability
D = Denied due to demonstration involvement (eff. 5/97)
E = MSP cost avoided IRS/SSA/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

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For Physician/Supplier (RIC O) Claims:

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

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

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

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

1CARR_LINE_RDCD_PHYSN_ASTNT_TB — Carrier Line Part B Reduced Physician Assistant Table

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

1 CARR_NUM_TB — Carrier Number Table

00510 = Alabama BS (eff. 1983)
00511 = Georgia - Alabama BS (eff. 1998)
00512 = Mississippi - Alabama BS (eff. 2000)
00520 = Arkansas BS (eff. 1983)

00521 = New Mexico - Arkansas BS (eff. 1998)
00522 = Oklahoma - Arkansas BS (eff. 1998)
00523 = Missouri - Arkansas BS (eff. 1999)
00528 = Louisianna - Arkansas BS (eff. 1984)
00542 = California BS (eff. 1983; term. 1996)
00550 = Colorado BS (eff. 1983; term. 1994)
00570 = Delaware - Pennsylvania BS (eff. 1983;
term. 1997)
00580 = District of Columbia - Pennsylvania BS
(eff. 1983; term. 1997)
00590 = Florida BS (eff. 1983)
00591 = Connecticut - Florida BS (eff. 2000)
00621 = Illinois BS - HCSC (eff. 1983; term. 1998)
00623 = Michigan - Illinois Blue Shield (eff. 1995)
(term. 1998)
00630 = Indiana - Administar (eff. 1983)
00635 = DMERC-B (Administar Federal, Inc.)
(eff. 1993)
00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)
00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)
00650 = Kansas BS (eff. 1983)
00655 = Nebraska - Kansas BS (eff. 1988)
00660 = Kentucky - Administar (eff. 1983)
00690 = Maryland BS (eff. 1983; term. 1994)
00700 = Massachusetts BS (eff. 1983; term. 1997)
00710 = Michigan BS (eff. 1983; term. 1994)
00720 = Minnesota BS (eff. 1983; term. 1995)
00740 = Missouri - BS Kansas City (eff. 1983)
00751 = Montana BS (eff. 1983)
00770 = New Hampshire/Vermont Physician Services
(eff. 1983; term. 1984)
00780 = New Hampshire/Vermont - Massachusetts BS
(eff. 1985; term. 1997)
00801 = New York - Western BS (eff. 1983)
00803 = New York - Empire BS (eff. 1983)
00805 = New Jersey - Empire BS (eff. 3/99)
00811 = DMERC (A) - Western New York BS (eff. 2000)
00820 = North Dakota - North Dakota BS (eff. 1983)
00824 = Colorado - North Dakota BS (eff. 1995)
00825 = Wyoming - North Dakota BS (eff. 1990)

00826 = Iowa - North Dakota BS (eff. 1999)
00831 = Alaska - North Dakota BS (eff. 1998)
00832 = Arizona - North Dakota BS (eff. 1998)
00833 = Hawaii - North Dakota BS (eff. 1998)
00834 = Nevada - North Dakota BS (eff. 1998)
00835 = Oregon - North Dakota BS (eff. 1998)
00836 = Washington - North Dakota BS (eff. 1998)
00860 = New Jersey - Pennsylvania BS (eff. 1988; term. 1999)
00865 = Pennsylvania BS (eff. 1983)
00870 = Rhode Island BS (eff. 1983)
00880 = South Carolina BS (eff. 1983)
00882 = RRB - South Carolina PGBA (eff. 2000)

00885 = DMERC C - Palmetto (eff. 1993)
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

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

1 CLM_DISP_TB Claim Disposition Table

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

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

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


                                  NCH BIC             SSA Categories
                                  -------             --------------

                                  A  = A;J1;J2;J3;J4;M;M1;T;TA
                                  B  = B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6;
                                       TB(F);TD(F);TE(F);TW(F)
                                  B1 = B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M)
                                       TD(M);TE(M);TW(M)
                                  B3 = B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2
                                       W7;TG(F);TL(F);TR(F);TX(F)
                                  B4 = B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG(M)
                                       TL(M);TR(M);TX(M)
                                  B8 = B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4
                                       W8;TH(F);TM(F);TS(F);TY(F)
                                  BA = BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9
                                       WC;TJ(F);TN(F);TT(F);TZ(F)
                                  BD = BD;BL;BQ;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WF
                                       WJ;TK(F);TP(F);TU(F);TV(F)
                                  BG = BG;DH;DQ;DS;EF;EJ;W5;TH(M);TM(M);TS(M)
                                       TY(M)
                                  BH = BH;DJ;DR;DX;EG;EK;WB;TJ(M);TN(M);TT(M)
```

```
      TZ(M)
BJ = BJ;DK;DT;DZ;EH;EM;WG;TK(M);TP(M);TU(M)
      TV(M)
C1 = C1;TC
C2 = C2;T2
C3 = C3;T3
C4 = C4;T4
C5 = C5;T5
C6 = C6;T6
C7 = C7;T7
C8 = C8;T8
C9 = C9;T9
F1 = F1;TF
F2 = F2;TQ
F3-F8 = Equatable only to itself (e.g., F3 IS
        equatable to F3)
CA-CZ = Equatable only to itself.  (e.g., CA is
        only equatable to CA)

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

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

1 GEO_SSA_STATE_TB — State Table

01 = Alabama

02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island

42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = Asia
56 = Canada & Islands
57 = Central America and West Indies

1 GEO_SSA_STATE_TB State Table

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

1 HCFA_PRVDR_SPCLTY_TB HCFA Provider Specialty Table

Prior to 5/92

01 = General practice

02 = General surgery
03 = Allergy (revised 10/91 to mean allergy/ immunology)
04 = Otology, laryngology, rhinology revised 10/91 to mean otolaryngology)
05 = Anesthesiology
06 = Cardiovascular disease (revised 10/91 to mean cardiology)
07 = Dermatology
08 = Family practice
09 = Gynecology--osteopaths only (deleted 10/91; changed to '16')
10 = Gastroenterology
11 = Internal medicine
12 = Manipulative therapy (osteopaths only) (revised 10/91 to mean osteopathic manipulative therapy)
13 = Neurology
14 = Neurological surgery (revised 10/91 to mean neurosurgery)
15 = Obstetrics--osteopaths only (deleted 10/91; changed to '16')
16 = OB-gynecology
17 = Ophthalmology, otology, laryngology rhinology--osteopaths only (deleted 10/91; changed to '18' if physicians practice is more than 50% ophthalmology or to '04' if physician's practice is more than 50% otolaryngology. If practice is 50/50, choose specialty with greater allowed charges.
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Pathologic anatomy, clinical pathology-osteopaths only (deleted 10/91; changed to '22')
22 = Pathology
23 = Peripheral vascular disease or surgery (deleted 10/91; changed to '76')

24 = Plastic surgery (revised to mean plastic and reconstructive surgery).
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Psychiatry, neurology (osteopaths only) (deleted 10/91; changed to '86')
28 = Proctology (revised 10/91 to mean colorectal surgery).
29 = Pulmonary disease
30 = Radiology (revised 10/91 to mean diagnostic radiology)
31 = Roentgenology, radiology (osteopaths) (deleted 10/91; changed to '30')
32 = Radiation therapy--osteopaths (deleted

10/91; changed to '92')
33 = Thoracic surgery
34 = Urology
35 = Chiropractor, licensed (revised 10/91 to mean chiropractic)
36 = Nuclear medicine
37 = Pediatrics (revised 10/91 to mean pediatric medicine)
38 = Geriatrics (revised 10/91 to mean geriatric medicine)
39 = Nephrology
40 = Hand surgery
41 = Optometrist - services related to condition of aphakia (revised 10/91 to mean optometrist)
42 = Certified nurse midwife (added 7/88)
43 = Certified registered nurse anesthetist (revised 10/91 to mean CRNA, anesthesia assistant)
44 = Infectious disease
46 = Endocrinology (added 10/91)
48 = Podiatry - surgery chiropody (revised 10/91 to mean podiatry)

49 = Miscellaneous (include ASCS)
51 = Medical supply company with C.O. certification (certified orthotist - certified by American Board for Certification in Prosthetics and Orthotics.
52 = Medical supply company with C.P. certification (certified prosthetist - certified by American Board for Certification in Prosthetics and Orthotics).
53 = Medical supply company with C.P.O. certification (certified prosthetist - orthotist - certified by American Board for Certification in Prosthetics and Orthotics).
54 = Medical supply company not included in 51, 52, or 53.
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist - orthotist
58 = Individuals not included in 55,56 or 57
59 = Ambulance service supplier (e.g. private ambulance companies, funeral homes, etc.)
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities)
62 = Psychologist--billing independently
63 = Portable X-ray supplier--billing independently (revised 10/91 to mean portable X-ray supplier)
64 = Audiologist (billing independently)

65 = Physical therapist (independent practice)
66 = Rheumatology (added 10/91)

67 = Occupational therapist--independent
practice
68 = Clinical psychologist
69 = Independent laboratory--billing
independently (revised 10/91 to mean
independent clinical laboratory --
billing independently)
70 = Clinic or other group practice, except
Group Practice Prepayment Plan (GPPP)
71 = Group Practice Prepayment Plan - diagnostic
X-ray (do not use after 1/92)
72 = Group Practice Prepayment Plan - diagnostic
laboratory (do not use after 1/92)
73 = Group Practice Prepayment Plan -
physiotherapy (do not use after 1/92)
74 = Group Practice Prepayment Plan - occupational
therapy (do not use after 1/92)
75 = Group Practice Prepayment Plan - other
medical care (do not use after 1/92)
76 = Peripheral vascular disease
(added 10/91)
77 = Vascular surgery (added 10/91)
78 = Cardiac surgery (added 10/91)
79 = Addiction medicine (added 10/91)
80 = Clinical social worker (1991)
81 = Critical care-intensivists (added 10/91)
82 = Ophthalmology, cataracts specialty
(added 10/91; used only until 5/92)
83 = Hematology/oncology (added 10/91)
84 = Preventive medicine (added 10/91)
85 = Maxillofacial surgery (added 10/91)
86 = Neuropsychiatry (added 10/91)
87 = All other (e.g. drug and department
stores) (revised 10/91 to mean all
other suppliers)
88 = Unknown (revised 10/91 to mean
physician assistant)
90 = Medical oncology (added 10/91)
91 = Surgical oncology (added 10/91)
92 = Radiation oncology (added 10/91)

93 = Emergency medicine (added 10/91)
94 = Interventional radiology (added 10/91)
95 = Independent physiological laboratory (added 10/91)
96 = Unknown physician specialty (added 10/91)
99 = Unknown--incl. social worker's psychiatric services (revised 10/91 to mean unknown supplier/provider)

Effective 5/92

00 = Carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology

04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Gynecology (osteopaths only) (discontinued 5/92 use code 16)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative therapy
13 = Neurology
14 = Neurosurgery
15 = Obstetrics (osteopaths only) (discontinued 5/92 use code 16)
16 = Obstetrics/gynecology
17 = Ophthalmology, otology, laryngology, rhinology (osteopaths only) (discontinued 5/92 use codes 18 or 04 depending on percentage of practice)
18 = Ophthalmology
19 = Oral surgery (dentists only)

```
20 = Orthopedic surgery
21 = Pathologic anatomy, clinical
     pathology (osteopaths only)
     (discontinued 5/92 use code 22)
22 = Pathology
23 = Peripheral vascular disease, medical
     or surgical (osteopaths only)
     (discontinued 5/92 use code 76)
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Psychiatry, neurology (osteopaths
     only) (discontinued 5/92 use code 86)
28 = Colorectal surgery (formerly
     proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Roentgenology, radiology (osteopaths
     only) (discontinued 5/92 use code 30)
32 = Radiation therapy (osteopaths only)
     (discontinued 5/92 use code 92)
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry (revised 10/93 to
     mean optometrist)
42 = Certified nurse midwife (eff 1/87)
43 = Crna, anesthesia assistant
     (eff 1/87)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology (eff 5/92)
```

1 HCFA_PRVDR_SPCLTY_TB HCFA Provider Specialty Table

47 = Independent Diagnostic Testing Facility
(IDTF) (eff. 6/98)
48 = Podiatry
49 = Ambulatory surgical center
(formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with
certified orthotist (certified by
American Board for Certification in
Prosthetics And Orthotics)
52 = Medical supply company with
certified prosthetist
(certified by American Board for
Certification In Prosthetics And
Orthotics)
53 = Medical supply company with
certified prosthetist-orthotist
(certified by American Board for
Certification in Prosthetics
and Orthotics)
54 = Medical supply company not included
in 51, 52, or 53. (Revised 10/93
to mean medical supply company for DMERC)
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-
orthotist
58 = Individuals not included in 55, 56,
or 57 (revised 10/93 to mean medical
supply company with registered
pharmacist)
59 = Ambulance service supplier, e.G.,
private ambulance companies, funeral
homes, etc.
60 = Public health or welfare agencies
(federal, state, and local)
61 = Voluntary health or charitable
agencies (e.G., National Cancer
Society, National Heart Associiation,
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)

1 HCFA_PRVDR_SPCLTY_TB HCFA Provider Specialty Table

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

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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)

1 LINE_ADDTNL_CLM_DCMTN_IND_TB — Line Additional Claim Documentation Indicator Table

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

1 LINE_PLC_SRVC_TB — Line Place Of Service Table

Prior To 1/92

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

Effective 1/92

11 = Office
12 = Home
21 = Inpatient hospital
22 = Outpatient hospital
23 = Emergency room - hospital
24 = Ambulatory surgical center
25 = Birthing center
26 = Military treatment facility
31 = Skilled nursing facility
32 = Nursing facility
33 = Custodial care facility
34 = Hospice
35 = Adult living care facilities (ALCF) (eff. NYD - added 12/3/97)
41 = Ambulance - land
42 = Ambulance - air or water
50 = Federally qualified health centers (eff. 10/1/93)
51 = Inpatient psychiatric facility
52 = Psychiatric facility partial hospitalization

53 = Community mental health center
54 = Intermediate care facility/mentally
     retarded
55 = Residential substance abuse treatment
     facility
56 = Psychiatric residential treatment
     center
60 = Mass immunizations center (eff. 9/1/97)
61 = Comprehensive inpatient rehabilitation
     facility
62 = Comprehensive outpatient rehabilitation
     facility
65 = End stage renal disease treatment facility
71 = State or local public health clinic
72 = Rural health clinic
81 = Independent laboratory

1 LINE_PLC_SRVC_TB — Line Place Of Service Table

99 = Other unlisted facility

1 LINE_PMT_IND_TB — Line Payment Indicator Table

1 = Actual charge
2 = Customary charge
3 = Prevailing charge (adjusted, unadjusted
    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_PRCSG_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 — Line Provider Participating Indicator Table

1 = Participating
2 = All or some covered and allowed expenses applied to deductible Participating
3 = Assignment accepted/non-participating

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

1 NCH_CLM_TYPE_TB NCH Claim Type Table

10 = HHA claim
20 = Non swing bed SNF claim
30 = Swing bed SNF claim
40 = Outpatient claim
41 = Outpatient 'Full-Encounter' claim (available in NMUD)
42 = Outpatient 'Abbreviated-Encounter' claim (available in NMUD)
50 = Hospice claim
60 = Inpatient claim
61 = Inpatient 'Full-Encounter' claim
62 = Inpatient 'Abbreviated-Encounter claim (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
D6X1 = (C) DME SUPPLIER NUMBER MISSING
D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1
D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6
XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1
Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
Y003 = (C) HCPCS R0075/UNITS=SERVICES
Y010 = (C) TOB=13X/14X AND T.C.>$7,500
Y011 = (C) INP CLAIM/REIM > $75,000
Z001 = (C) RVNU 820-859 REQ COND CODE 71-76
Z002 = (C) CC M2 PRESENT/REIMB > $150,000

Z003 = (C) CC M2 PRESENT/UNITS > 150
Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX
Z005 = (C) REIMB>99999 AND REIMB<150000
Z006 = (C) UNITS>99 AND UNITS<150
Z237 = (E) HOSPICE OVERLAP - DATE ZERO
0011 = (C) ACTION CODE INVALID
0013 = (C) CABG/PCOE AND INVALID ADMIT DATE
0014 = (C) DEMO NUM NOT=01-06,08,15,31
0015 = (C) ESRD PLAN BUT DEMO ID NOT = 15
0016 = (C) INVALID VA CLAIM
0017 = (C) DEMO=31,TOB<>11 OR SPEC<>08
0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
0020 = (C) CANCEL ONLY CODE INVALID
0021 = (C) DEMO COUNT > 1
0301 = (C) INVALID HI CLAIM NUMBER

0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK
04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)
04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
0401 = (C) BILL TYPE/PROVIDER INVALID
0402 = (C) BILL TYPE/REV CODE/PROVR RANGE
0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092
0407 = (C) RESPITE CARE BILL TYPE 34X,NO REV 66
0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974
0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636
0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES
0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS
0414 = (C) VALU CD 61,MSA AMOUNT MISSING
0415 = (C) HOME HEALTH INCORRECT ALPHA RIC
05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE
05X5 = (C) UPIN REQUIRED FOR DME HCPCS
0501 = (C) UNIQUE PHY IDEN. (UPIN) BLANK
0502 = (C) UNIQUE PHY IDEN. (UPIN) INVALID
0601 = (C) GENDER INVALID
0701 = (C) CONTRACTOR INVALID CARRIER/ETC
0702 = (C) PROVIDER NUMBER INCONSISTANT
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
0704 = (C) INVALID CONT FOR CABG DEMO

0705 = (C) INVALID CONT FOR PCOE DEMO
0901 = (C) INVALID DISP CODE OF 02
0902 = (C) INVALID DISP CODE OF SPACES
0903 = (C) INVALID DISP CODE
1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE
13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
1301 = (C) LINE COUNT NOT NUMERIC OR > 13
1302 = (C) RECORD LENGTH INVALID
1401 = (C) INVALID MEDICARE STATUS CODE
1501 = (C) ADMIT DATE/ENTRY CODE INVALID
1502 = (C) ADMIT DATE > STAY FROM DATE
1503 = (C) ADMIT DATE INVALID WITH THRU DATE
1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
1505 = (C) HCPCS W SERVICE DATES > 09-30-94
1601 = (C) INVESTIGATION IND INVALID
1701 = (C) SPLIT IND INVALID
1801 = (C) PAY-DENY CODE INVALID
1802 = (C) HEADER AMT AND NOT DENIED CLAIM
1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME
1901 = (C) AB CROSSOVER IND INVALID
2001 = (C) HOSPICE OVERRIDE INVALID
2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
2102 = (C) FROM/THRU DATE OR KRON/PAT STAT
2201 = (C) FROM/THRU DATE OR HCPCS YR INVAL
2202 = (C) STAY-FROM DATE > THRU-DATE
2203 = (C) THRU DATE INVALID
2204 = (C) FROM DATE BEFORE EFFECTIVE DATE
2205 = (C) DATE YEARS DIFFERENT ON OUTPAT
2207 = (C) MAMMOGRAPHY BEFORE 1991
2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID
2302 = (C) COVERED DAYS INVALID OR INCONSIST
2303 = (C) COST REPORT DAYS > ACCOMIDATION
2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL
2305 = (C) UTIL DAYS = INCONSISTENCIES
2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT
2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09

2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO

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2401 = (C) NON-UTIL DAYS INVALID
2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL
2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
2504 = (C) COINSURANCE AMOUNT EXCESSIVE
2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT
2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST
2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR
2508 = (C) COINSURANCE DAYS INVALID FOR TRAN
2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
2602 = (C) LR-DYS, NO VAL 08,10/PD/DEN>CUR+27
2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
2604 = (C) PPS BILL, NO DAY OUTLIER
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
28XA = (C) UTIL DAYS > FROM TO BENEF EXH
28XB = (C) BENEFITS EXH DATE > FROM DATE
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN = (C) INVALID OCC CODE
28X0 = (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
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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
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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
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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>8999<9045
51XJ = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
51XK = (C) TOB 21X/P82=2/3/4,REV CD = NNX
51XL = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83
51XM = (C) 21X,RC>9041/<9045,RC<>4/234
51XN = (C) 21X,RC>9032/<9042,RC<>4/234
51XP = (C) HHA RC DATE OF SRVC MISSING
51XQ = (C) NO RC 0636 OR DTE INVALID
51XR = (C) DEMO ID=01,RIC NOT=2
51XS = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21
51X0 = (C) REV CENTER CODE INVALID
51X1 = (C) REV CODE CHECK
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51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
51X3 = (C) UNITS MUST BE > 0
51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR
51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
51X9 = (C) HCPCS/REV CODE/BILL TYPE
5100 = (U) TRANSITION SPELL / SNF
5160 = (U) LATE CHG HSP BILL STAY DAYS > 0
5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT
5169 = (U) PROVIDER NE TO WORK PROVIDER
5177 = (U) PROVIDER NE TO WORK PROVIDER
5178 = (U) HOSPICE BILL THRU < DOLBA
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
5200 = (E) ENTITLEMENT EFFECTIVE DATE
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
5202 = (U) HOSPICE TRAILER ERROR
5203 = (E) ENTITLEMENT HOSPICE PERIODS
5203 = (U) HOSPICE START DATE ERROR
5204 = (U) HOSPICE DATE DIFFERENCE NE 90
5205 = (U) HOSPICE DATE DISCREPANCY
5206 = (U) HOSPICE DATE DISCREPANCY
5207 = (U) HOSPICE THRU > TERM DATE 2ND
5208 = (U) HOSPICE PERIOD NUMBER BLANK
5209 = (U) HOSPICE DATE DISCREPANCY
5210 = (E) ENTITLEMENT FRM/TRU/END DATES
5211 = (E) ENTITLEMENT DATE DEATH/THRU
5212 = (E) ENTITLEMENT DATE DEATH/THRU
5213 = (E) ENTITLEMENT DATE DEATH MBR
5220 = (E) ENTITLEMENT FROM/EFF DATES
5225 = (E) ENT INP PPS SPAN 70 DATES
5232 = (E) ENTL HMO NO HMO OVERRIDE CDE
5233 = (E) ENTITLEMENT HMO PERIODS
5234 = (E) ENTITLEMENT HMO NUMBER NEEDED
5235 = (E) ENTITLEMENT HMO HOSP+NO CC07
5236 = (E) ENTITLEMENT HMO HOSP + CC07

5237 = (E) ENTITLEMENT HOSP OVERLAP
5238 = (U) HOSPICE CLAIM OVERLAP > 90
5239 = (U) HOSPICE CLAIM OVERLAP > 60
524Z = (E) HOSP OVERLAP NO OVD NO DEMO
5240 = (U) HOSPICE DAYS STAY+USED > 90
5241 = (U) HOSPICE DAYS STAY+USED > 60
5242 = (C) INVALID CARRIER FOR RRB
5243 = (C) HMO=90091,INVALID SERVICE DTE
5244 = (E) DEMO CABG/PCOE MISSING ENTL
5245 = (C) INVALID CARRIER FOR NON RRB
525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO
5250 = (U) HOSPICE DOEBA/DOLBA
5255 = (U) HOSPICE DAYS USED
5256 = (U) HOSPICE DAYS USED > 999
526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0
526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0
527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0
527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
5299 = (U) HOSPICE PERIOD NUMBER ERROR

5320 = (U) BILL > DOEBA AND IND-1 = 2
5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
5355 = (U) HOSPICE DAYS USED SECONDARY
5378 = (C) SERVICE DATE < AGE 50
5399 = (U) HOSPICE PERIOD NUM MATCH
5410 = (U) INPAT DEDUCTABLE
5425 = (U) PART B DEDUCTABLE CHECK
5430 = (U) PART B DEDUCTABLE CHECK
5450 = (U) PART B COMPARE MED EXPENSE
5460 = (U) PART B COMPARE MED EXPENSE
5499 = (U) MED EXPENSE TRAILER MISSING
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS
5510 = (U) COIN DAYS/SNF COIN DAYS
5515 = (U) FULL DAYS/COIN DAYS
5516 = (U) SNF FULL DAYS/SNF COIN DAYS
5520 = (U) LIFE RESERVE DAYS
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS
5540 = (U) HH VISITS NE AFT PT B TRLR

5550 = (E) SNF LESS THAN PT A EFF DATE
5600 = (D) LOGICAL DUPE, COVERED
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123
5602 = (D) LOGICAL DUPE, PANDE C, E OR I
5603 = (D) LOGICAL DUPE, COVERED
5605 = (D) POSS DUPE, OUTPAT REIMB
5606 = (D) POSS DUPE, HOME HEALTH COVERED U
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
59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R
5901 = (U) ERROR CODE OF Q
60X1 = (C) ASSIGN IND INVALID

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6000 = (U) ADJUSTMENT BILL SPELL DATA
6020 = (U) CURRENT SPELL DOEBA < 1990
6030 = (U) ADJUSTMENT BILL SPELL DATA
6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA
61X1 = (C) PAY PROCESS IND INVALID
61X2 = (C) DENIED CLAIM/NO DENIED LINE
61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
61X4 = (C) RATE MISSING OR NON-NUMERIC
6100 = (C) REV 0001 NOT PRESENT ON CLAIM
6101 = (C) REV COMPUTED CHARGES NOT=TOTAL
6102 = (C) REV COMPUTED NON-COVERED/NON-COV
6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER
62XA = (C) PSYC OT PT/REIM/TYPE
62X1 = (C) DME/DATE/100% OR INVAL REIMB IND
62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED
62X8 = (C) KIDNEY DONO/TYPE/100%
62X9 = (C) PNEUM VACCINE/TYPE/100%
6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV
6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE
6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA
6260 = (U) HOSPICE ADJUSTMENT STAY DAYS
6261 = (U) HOSPICE ADJUSTMENT DAYS USED
6265 = (U) HOSPICE ADJUSTMENT DAYS USED
6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)
63X1 = (C) DEDUCT IND INVALID
63X2 = (C) DED/HCFA COINS IN PCOE/CABG
6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS
6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)
64X1 = (C) PROVIDER IND INVALID
6430 = (U) PART B DEDUCTABLE CHECK
65X1 = (C) PAYSCREEN IND INVALID
66?? = (D) POSS DUPE, CR/DB, DOC-ID
66XX = (D) POSS DUPE, CR/DB, DOC-ID
66X1 = (C) UNITS AMOUNT INVALID
66X2 = (C) UNITS IND > 0; AMT NOT VALID
66X3 = (C) UNITS IND = 0; AMT > 0
66X4 = (C) MT INDICATOR/AMOUNT
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6600 = (U) ADJUSTMENT BILL FULL DAYS
6610 = (U) ADJUSTMENT BILL COIN DAYS
6620 = (U) ADJUSTMENT BILL LIFE RESERVE
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
67X1 = (C) UNITS INDICATOR INVALID
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0
67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS
68X1 = (C) INVALID HCPCS CODE
68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092
68X3 = (C) TYPE OF SERVICE = G /PROC CODE
68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE
68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC
68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC
68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.
68X8 = (C) LINE ITEM INCORRECT OR DATE INVAL.

69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
69X3 = (C) PROC CODE MOD = LL / TYPE = R
69X6 = (C) PROC CODE MOD/NOT CAPPED
69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL
6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO
6902 = (C) KRON IND AND NO-PAY CODE B OR N
6903 = (C) KRON IND AND INPATIENT DEDUCT = 0
6904 = (C) KRON IND AND TRANS CODE IS 4
6910 = (C) REV CODES ON HOME HEALTH
6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY
6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO
6913 = (C) REV CODE INVAL FOR OXYGEN
6914 = (C) REV CODE INVAL FOR DME
6915 = (C) PURCHASE OF RENT DME INVAL ON DATES
6916 = (C) PURCHASE OF RENT DME INVAL ON DATES
6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000

6918 = (C) HCPCS INVALID ON DATE RANGES
6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89
6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33
6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X
6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274
6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291
6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL
6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X
6929 = (U) ADJUSTMENT BILL LIFE RESERVE
6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
7000 = (U) INVALID DOEBA/DOLBA
7002 = (U) LESS THAN 60/61 BETWEEN SPELLS
7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD
71X1 = (C) SUBMITTED CHARGES INVALID
71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG
72X1 = (C) ALLOWED CHGS INVALID
72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
72X3 = (C) DENIED LINE/ALLOWED CHARGES
73X1 = (C) SS NUMBER INVALID
73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING
74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT
76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL
77X1 = (C) PLACE OF SERVICE INVALID
77X2 = (C) PHYS THERAPY/PLACE
77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE
77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND
77X6 = (C) TOS=F, PL OF SER NOT = 24
7701 = (C) INCORRECT MODIFIER
7777 = (D) POSS DUPE, PART B DOC-ID
78XA = (C) MAMMOGRAPHY BEFORE 1991
78X1 = (C) THRU DATE INVALID
78X3 = (C) FROM DATE GREATER THAN THRU DATE
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY
78X5 = (C) FROM DATE > PAID DATE/TYPE/100%
78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE
79X3 = (C) THRU DATE>RECD DATE/NOT DENIED
79X4 = (C) THRU DATE>PAID DATE/NOT DENIED
8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90
8028 = (E) NO ENTITLEMENT
8029 = (U) HH BEFORE PERIOD NOT PRESENT

8030 = (U) HH BILL VISITS > PT A REMAINING
8031 = (U) HH PT A REMAINING > 0

8032 = (U) HH DOLBA+59 NOT GT FROM-DATE
8050 = (U) HH QUALIFYING INDICATOR = 1
8051 = (U) HH # VISITS NE AFT PT B APPLIED
8052 = (U) HH # VISITS NE AFT TRAILER
8053 = (U) HH BENEFIT PERIOD NOT PRESENT
8054 = (U) HH DOEBA/DOLBA NOT > 0
8060 = (U) HH QUALIFYING INDICATOR NE 1
8061 = (U) HH DATE NE DOLBA IN AFT TRLR
8062 = (U) HH NE PT-A VISITS REMAINING
81X1 = (C) NUM OF SERVICES INVALID
83X1 = (C) DIAGNOSIS INVALID
8301 = (C) HCPCS/GENDER DIAGNOSIS
8302 = (C) HCPCS G0101 V-CODE/SEX CODE
8304 = (C) BILL TYPE INVALID FOR G0123/4
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
84X2 = (C) INVALID DME START DATE
84X3 = (C) INVALID DME START DATE W/HCPCS
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
84X5 = (C) HCPCS CODE WITH INV DIAG CODE
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD
9000 = (U) DOEBA/DOLBA CALC
9005 = (U) FULL/COINS HOSP DAYS CALC
9010 = (U) FULL/COINS SNF DAYS CALC
9015 = (U) LIFE RESERVE DAYS CALC
9020 = (U) LIFE PSYCH DAYS CALC
9030 = (U) INPAT 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 DEDUCTABLE INVALID
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
93X4 = (C) FROM DATE/CASH DEDUCTIBLE
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
9300 = (C) UPIN OTHER, NOT PRESENT
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
94A1 = (C) NON-COVERED FROM DATE INVALID
94A2 = (C) NON-COVERED FROM > THRU DATE
94A3 = (C) NON-COVERED THRU DATE INVALID
94A4 = (C) NON-COVERED THRU DATE > ADMIT
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
94C1 = (C) PR-PSYCH DAYS INVALID
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
94F1 = (C) REIMBURSEMENT AMOUNT INVALID
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
94G1 = (C) NO-PAY CODE INVALID

94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
94G4 = (C) NO PAY CODE = R & REIMB PRESENT
94X1 = (C) BLOOD LIMIT INVALID
94X2 = (C) TYPE/BLOOD DEDUCTIBLE
94X3 = (C) TYPE/DATE/LIMIT AMOUNT
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
9401 = (C) BLOOD DEDUCTIBLE AMT > 3
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
9404 = (C) INVALID GENDER CODE ON PRO-PAY
9407 = (C) INVALID DRG NUMBER
9408 = (C) INVALID DRG NUMBER (GLOBAL)

9409 = (C) HCFA DRG<>DRG ON BILL
9410 = (C) CABG/PCOE,INVALID DRG
95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
95X2 = (C) MSP AMOUNT APPLIED INVALID
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
95X5 = (C) MSP CODE = G/DATE BEFORE 1987
95X6 = (C) MSP CODE = X AND NOT AVOIDED
95X7 = (C) MSP CODE VALID, CABG/PCOE
96X1 = (C) OTHER AMOUNTS INVALID
96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB
97X1 = (C) OTHER AMOUNTS INDICATOR INVALID
97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0
98X1 = (C) COINSURANCE INVALID
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
99XX = (D) 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 EXCEDES MAMMOGRAPHY LIMIT
9940 = (C) EDIT 9940 (NEW)
9942 = (C) EDIT 9942 (NEW)
9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
9945 = (C) SERVICE DATE < 98001
9946 = (C) INVALID DIAGNOSIS CODE
9947 = (C) INVALID DIAGNOSIS CODE
9948 = (C) STAY FROM>96365,DIAG=V725
9960 = (C) MED CHOICE BUT HMO DATA MISSING
9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER

1 NCH_NEAR_LINE_RIC_TB — NCH Near-Line Record Identification Code Table

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

1 NCH_PATCH_TB — NCH Patch Table

01 = RRB Category Equatable BIC - changed (all claim types) -- applied during the Nearline 'G' conversion to claims with NCH weekly process date before 3/91. Prior to Version 'H', patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 2.
02 = Claim Transaction Code made consistent with NCH payment/edit RIC code (OP and HHA) -- effective 3/94, CWFMQA began patch. During 'H' conversion, patch applied to claims with NCH weekly process date prior to 3/94. Prior to version 'H', patch indicator stored in redefined Claim Edit Group, 4th occurrence, position 1.
03 = Garbage/nonnumeric Claim Total Charge Amount

set to zeroes (Instnl) -- during the Version
'G' conversion, error occurred in the deriva-
tion 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' ocnversion, 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' con-

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

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

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

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

13 = Inconsistent Claim MCO Paid Switch made consistent

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

1 NCH_STATE_SGMT_TB — NCH State Segment Table

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
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = Asia
56 = Canada
57 = Central America & West Indies

58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = US Possessions
97 = Saipan - MP
98 = Guam

99 = American Samoa

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