
*** DMERC Claim Record
VAR 1 4411 REC

Durable medical equipment (DME) regional carrier (DMERC) claim record for version I of the NCH.

STANDARD ALIAS : DMERC_CLM_REC
SYSTEM ALIAS : UTLDMERI

1. DMERC Claim Fixed Group
341 1 341 GRP

Fixed portion of the durable medical equipment regional carrier (DMERC) claim record for version I of the NCH.

STANDARD ALIAS : DMERC_CLM_FIX_GRP

2. Claim Record Identification Group
8 1 8 GRP

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

3. Record Length Count
3 1 3 PACK

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).

DB2 ALIAS : REC_LNGTH_CNT
SAS ALIAS : REC_LEN
STANDARD ALIAS : REC_LNGTH_CNT

LENGTH : 5 SIGNED : Y

SOURCE : NCH

4. NCH Near-Line Record Version Code
1 4 4 CHAR

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

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

TITLE ALIAS : NCH_VERSION

LENGTH : 1

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

SOURCE : NCH

CODE TABLE : NCH_NEAR_LINE_REC_VRSN_TB

5. NCH Near Line Record Identification Code
1 5 5 CHAR

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

LENGTH : 1

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

SOURCE : NCH

CODE TABLE : NCH_NEAR_LINE_RIC_TB

6. NCH MQA RIC Code
1 6 6 CHAR

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

LENGTH : 1

SOURCE : NCH QA PROCESS

CODE TABLE : NCH_MQA_RIC_TB

7. NCH Claim Type Code
2 7 8 CHAR

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

NOTE1: During the Version H conversion this field was

populated with data throughout history (back to
service year 1991).

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

DB2 ALIAS : NCH_CLM_TYPE_CD
SAS ALIAS : CLM_TYPE
STANDARD ALIAS : NCH_CLM_TYPE_CD
TITLE ALIAS : CLAIM_TYPE

LENGTH : 2

DERIVATIONS :
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

DERIVATION RULES:

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

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

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

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

SET CLM_TYPE_CD TO 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 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 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 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).

SOURCE : NCH

CODE TABLE : NCH_CLM_TYPE_TB

8. Carrier/DMERC Claim Link Group
   125 9 133 GRP

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

STANDARD ALIAS : CARR_DMERC_CLM_LINK_GRP

9. Claim Locator Number Group
11 9 19 GRP

This number uniquely identifies the beneficiary in
the NCH Nearline.

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

10. Beneficiary Claim Account Number
9 9 17 CHAR

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

LENGTH : 9

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.

11. NCH Category Equatable Beneficiary Identification Code
2 18 19 CHAR

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

LENGTH : 2

COMMENTS :
Prior to Version H this field was named:
CTGRY_EQTBL_BENE_IDENT_CD.

SOURCE : BIC EQUATE MODULE

CODE TABLE : CTGRY_EQTBL_BENE_IDENT_TB

12. Beneficiary Identification Code
2 20 21 CHAR

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

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

LENGTH : 2

SOURCE : SSA/RRB

EDIT RULES :
EDB REQUIRED FIELD

CODE TABLE : BENE_IDENT_TB

13. NCH State Segment Code
1 22 22 CHAR

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

LENGTH : 1

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

SOURCE : NCH

CODE TABLE : NCH_STATE_SGMT_TB

14. Beneficiary Residence SSA Standard State Code
2 23 24 CHAR

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

LENGTH : 2

COMMENTS :
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

EDIT RULES :
OPTIONAL: MAY BE BLANK

CODE TABLE : GEO_SSA_STATE_TB

15. Claim From Date
8 25 32 NUM

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

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

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

16. Claim Through Date
8 33 40 NUM

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.

DB2 ALIAS : CLM_THRU_DT
SAS ALIAS : THRU_DT
STANDARD ALIAS : CLM_THRU_DT
TITLE ALIAS : THRU_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

17. NCH Weekly Claim Processing Date
8 41 48 NUM

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.

DB2 ALIAS : NCH_WKLY_PROC_DT
SAS ALIAS : WKLY_DT
STANDARD ALIAS : NCH_WKLY_PROC_DT
TITLE ALIAS : NCH_PROCESS_DT

LENGTH : 8 SIGNED : N

COMMENTS :
Prior to Version H this field was named: HCFA_CLM_PROC_DT.

SOURCE : NCH

EDIT RULES :
YYYYMMDD

18. CWF Claim Accretion Date
8 49 56 NUM

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.

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

19. CWF Claim Accretion Number
2 57 58 PACK

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.

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

LENGTH : 3 SIGNED : Y

SOURCE : CWF

20. Carrier Claim Control Number
15 59 73 CHAR

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

LENGTH : 15

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

SOURCE : CWF

EDIT RULES :
LEFT JUSTIFY

21. FILLER CHAR
38 74 111
LENGTH : 38

22. NCH Daily Process Date
8 112 119 NUM

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.

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

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :
YYYYMMDD

23. NCH Segment Link Number
5 120 124 PACK

Effective with Version 'I', the system gen- erated 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).

DB2 ALIAS : NCH_SGMT_LINK_NUM
SAS ALIAS : LINK_NUM
STANDARD ALIAS : NCH_SGMT_LINK_NUM
TITLE ALIAS : LINK_NUM

LENGTH : 9 SIGNED : Y

SOURCE : NCH

24. Claim Total Segment Count
2 125 126 NUM

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.

DB2 ALIAS : TOT_SGMT_CNT
SAS ALIAS : SGMT_CNT

STANDARD ALIAS : CLM_TOT_SGMT_CNT
TITLE ALIAS : SEGMENT_COUNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

25. Claim Segment Number
2 127 128 NUM

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.

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

LENGTH : 2 SIGNED : N

SOURCE : CWF

26. Claim Total Line Count
3 129 131 NUM

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.

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

LENGTH : 3 SIGNED : N

SOURCE : CWF

27. Claim Segment Line Count
2 132 133 NUM

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.

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

LENGTH : 2 SIGNED : N

SOURCE : CWF

28. Carrier/DMERC Claim Common 2 Group
194 134 327 GRP

Information common to both carrier and
DMERC claims for version I of NCH.

STANDARD ALIAS : CARR_DMERC_CLM_CMN_2_GRP

29. FILLER CHAR
5 134 138
LENGTH : 5

30. Carrier Claim Entry Code
1 139 139 CHAR

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

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : CARR_CLM_ENTRY_TB

31. FILLER CHAR
1 140 140
LENGTH : 1

32. Claim Disposition Code
2 141 142 CHAR

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

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_DISP_TB

33. NCH Edit Disposition Code
2 143 144 CHAR

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

LENGTH : 2

SOURCE : NCH QA Process

CODE TABLE : NCH_EDIT_DISP_TB

34. NCH Claim BIC Modify H Code
1 145 145 CHAR

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

LENGTH : 1

SOURCE : NCH QA Process

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

35. Beneficiary Residence SSA Standard County Code
3 146 148 CHAR

The SSA standard county code of a beneficiary's residence.

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

TITLE ALIAS : BENE_COUNTY_CD

LENGTH : 3

SOURCE : SSA/EDB

EDIT RULES :
OPTIONAL: MAY BE BLANK

36. Carrier Claim Receipt Date

8 149 156 NUM

The date the carrier receives the non-institutional claim.

DB2 ALIAS : CARR_CLM_RCPT_DT
SAS ALIAS : RCPT_DT

LENGTH : 8 SIGNED : N

COMMENTS :
Prior to Version 'H' this field was named: FICARR_CLM_RCPT_DT.

SOURCE : CWF

EDIT RULES :
YYYYMMDD

LENGTH : 8 SIGNED : N

8 157 164

38. CWF Forwarded Date

8 165 172 NUM

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.

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

39. Carrier Number

5 173 177 CHAR

The identification number assigned by CMS to a carrier authorized to process claims from a physician or supplier.

DB2 ALIAS : CARR_NUM
SAS ALIAS : CARR_NUM

STANDARD ALIAS : CARR_NUM
TITLE ALIAS : CARRIER

LENGTH : 5

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

SOURCE : CWF

CODE TABLE : CARR_NUM_TB

40. FILLER CHAR
8 178 185
LENGTH : 8

41. CWF Transmission Batch Number
4 186 189 CHAR

Effective with Version H, the number assigned
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.

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

LENGTH : 4

SOURCE : CWF

42. Beneficiary Mailing Contact ZIP Code
9 190 198 CHAR

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

LENGTH : 9

SOURCE : EDB

43. Beneficiary Sex Identification Code
1 199 199 CHAR

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
TITLE ALIAS : SEX_CD

LENGTH : 1

SOURCE : SSA,RRB,EDB

EDIT RULES :
REQUIRED FIELD

CODE TABLE : BENE_SEX_IDENT_TB

44. Beneficiary Race Code
1 200 200 CHAR

The race of a beneficiary.

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

LENGTH : 1

SOURCE : SSA

CODE TABLE : BENE_RACE_TB

45. Beneficiary Birth Date
8 201 208 NUM

The beneficiary's date of birth.

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

46. CWF Beneficiary Medicare Status Code
2 209 210 CHAR

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
TITLE ALIAS : MSC

LENGTH : 2

DERIVATIONS :
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:

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.

COMMENTS :
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

CODE TABLE : BENE_MDCR_STUS_TB

47. Claim Patient 6 Position Surname
6 211 216 CHAR

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

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

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

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

LENGTH : 6

SOURCE : CWF

48. Claim Patient 1st Initial Given Name
1 217 217 CHAR

The first initial of the Medicare patient's given name (first name) as reported by the

provider on the claim.

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

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

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

LENGTH : 1

SOURCE : CWF

49. Claim Patient First Initial Middle Name
1 218 218 CHAR

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

LENGTH : 1

SOURCE : CWF

50. Beneficiary CWF Location Code
1 219 219 CHAR

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

TITLE ALIAS : CWF_HOST

LENGTH : 1

SOURCE : CWF

CODE TABLE : BENE_CWF_LOC_TB

51. Claim Principal Diagnosis Code
5 220 224 CHAR

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

LENGTH : 5

SOURCE : CWF

EDIT RULES :
ICD-9-CM

52. FILLER CHAR
1 225 225
LENGTH : 1

53. Carrier Claim Payment Denial Code
1 226 226 CHAR

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

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : CARR_CLM_PMT_DNL_TB

54. Claim Excepted/Nonexcepted Medical Treatment Code
1 227 227 CHAR

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

LENGTH : 1

SOURCE : CWF

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

55. Claim Payment Amount

6 228 233 PACK

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). After 4/1/03, the payment amount could also include a "new technology" add-on amount. 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 any other payer reimbursement.

Under IRFPPS, inpatient rehabilitation services are paid based on a predetermined rate per discharge, using the Case Mix Group (CMG) classification system and the PRICER program. From the CMG on the IRF PPS claim, payment is based on a standard payment amount for operating and capital cost for that facility (including routine and ancillary services). The payment is adjusted for wage, the % of low-income patients (LIP), locality, transfers, interrupted stays, short stay cases, deaths, and high cost outliers. Some or all of these adjustments could

apply. The CMG payment does NOT include certain pass-through costs (i.e. bad debts, approved education activities); beneficiary-paid amounts, other payer reimbursement,and other services outside of the scope of PPS.

Under LTCH PPS, long term care hospital services are paid based on a predetermined rate per discharge based on the DRG and the PRICER program. Payments are based on a single standard Federal rate for both inpatient operating and capital-related costs (including routine and ancillary services), but do NOT include certain pass-through costs (i.e. bad debts, direct medical education, new technologies and blood clotting factors). Adjustments to the payment may occur due to short-stay outliers, interrupted stays, high cost outliers, wage index, and cost of living adjustments.

Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center code = '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount.

Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total claim payment. The payment amount also includes the outlier payment and interest.

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. The payment may also include outlier payments.

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.

COMMON ALIAS : REIMBURSEMENT
DB2 ALIAS : CLM_PMT_AMT
SAS ALIAS : PMT_AMT
STANDARD ALIAS : CLM_PMT_AMT
TITLE ALIAS : REIMBURSEMENT

LENGTH : 9.2 SIGNED : Y

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

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.

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

LENGTH : 9.2 SIGNED : Y

6 234 239

57. FILLER CHAR

1 240 240

LENGTH : 1

58. DMERC Claim Ordering Physician UPIN Number

6 241 246 CHAR

Effective with Version G, the unique physician identification number (UPIN) of the physician ordering the Part B services/DMEPOS item.

DB2 ALIAS : ORDRG_PHYSN_UPIN
SAS ALIAS : ORD_UPIN
STANDARD ALIAS : DMERC_CLM_ORDRG_PHYSN_UPIN_NUM
TITLE ALIAS : ORDRG_UPIN

LENGTH : 6

COMMENTS :
Prior to Version H this field was named:
CWFB_CLM_ORDRG_PHYSN_UPIN_NUM.

SOURCE : CWF

59. DMERC Claim Ordering Physician NPI Number
10 247 256 CHAR

A placeholder field (effective with Version H)
for storing the NPI assigned to the physician
ordering the Part B services/DMEPOS item.

COMMON ALIAS : ORDERING_PHYSICIAN_NPI
DB2 ALIAS : ORDRG_PHYSN_NPI
SAS ALIAS : ORD_NPI
STANDARD ALIAS : DMERC_CLM_ORDRG_PHYSN_NPI_NUM
TITLE ALIAS : ORDRG_NPI

LENGTH : 10

SOURCE : CWF

60. Carrier Claim Provider Assignment Indicator Switch
1 257 257 CHAR

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

LENGTH : 1

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

SOURCE : CWF

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

61. NCH Claim Provider Payment Amount
6 258 263 PACK

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.

DB2 ALIAS : NCH_PRVDR_PMT_AMT
SAS ALIAS : PROV_PMT

STANDARD ALIAS : NCH_CLM_PRVDR_PMT_AMT
TITLE ALIAS : PRVDR_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

62. NCH Claim Beneficiary Payment Amount
6 264 269 PACK

Effective with Version H, the total payments made to the beneficiary for this claim (sum of line payment amounts to the beneficiary.)

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

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

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

63. Carrier Claim Beneficiary Paid Amount
6 270 275 PACK

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

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

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

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

64. NCH Carrier Claim Submitted Charge Amount
6 276 281 PACK

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).

DB2 ALIAS : CARR_SBMT_CHRG_AMT
SAS ALIAS : SBMTCHRG

STANDARD ALIAS : NCH_CARR_SBMT_CHRG_AMT
TITLE ALIAS : SBMT_CHRG

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

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

65. NCH Carrier Claim Allowed Charge Amount
6 282 287 PACK

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).

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

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

EDIT RULES :
$$$$$$$CC

66. Carrier Claim Cash Deductible Applied Amount
6 288 293 PACK

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.

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

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

67. Carrier Claim HCPCS Year Code
1 294 294 NUM

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.

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

LENGTH : 1 SIGNED : N

SOURCE : CWF

68. Carrier Claim MCO Override Indicator Code
1 295 295 CHAR

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : CARR_CLM_MCO_OVRRD_IND_TB

69. Carrier Claim Hospice Override Indicator Code
1 296 296 CHAR

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

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

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : CARR_CLM_HOSPC_OVRRD_IND_TB

70. FILLER CHAR
31 297 327
LENGTH : 31

71. DMERC NCH Edit Code Count
2 328 329 NUM

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

DB2 ALIAS : DMERC_EDIT_CD_CNT
SAS ALIAS : DEDCNT
STANDARD ALIAS : DMERC_NCH_EDIT_CD_CNT

LENGTH : 2 SIGNED : N

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

SOURCE : NCH

72. DMERC NCH Patch Code Count
2 330 331 NUM

Effective with Version H, the count of the number of HCFA patch codes annotated to the DMERC claim during the Nearline maintenance process. The purpose of this count is to indicate how many NCH patch trailers are present.
NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : DMERC_PATCH_CD_CNT
SAS ALIAS : DPATCNT
STANDARD ALIAS : DMERC_NCH_PATCH_CD_I_CNT

LENGTH : 2 SIGNED : N

SOURCE : NCH

73. DMERC MCO Period Count
1 332 332 NUM

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

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

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

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 2

74. DMERC Claim Health PlanID Count
1 333 333 NUM

A placeholder field (effective with Version H) for storing the count of the number of Health PlanIDs reported on the DMERC 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: DMERC_CLM_PAYERID_CNT.

DB2 ALIAS : DMERC_PLANID_CNT
SAS ALIAS : DPLNCNT
STANDARD ALIAS : DMERC_CLM_HLTH_PLANID_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 3

75. DMERC Claim Demonstration ID Count
1 334 334 NUM

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

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

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

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 5

76. DMERC Claim Diagnosis Code Count
1 335 335 NUM

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

DB2 ALIAS : DMERC_DGNS_CD_CNT
SAS ALIAS : DDGNCNT

STANDARD ALIAS : DMERC_CLM_DGNS_CD_CNT

LENGTH : 1 SIGNED : N

COMMENTS :
Prior to Version H this field was named:
CLM_DGNS_CD_CNT.

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 4

77. DMERC Claim Line Count
2 336 337 NUM

The count of the number of line items reported on the DMERC claim. The purpose of this count is to indicate how many line item trailers are present.

DB2 ALIAS : DMERC_CLM_LINE_CNT
SAS ALIAS : DLINECNT
STANDARD ALIAS : DMERC_CLM_LINE_CNT

LENGTH : 2 SIGNED : N

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

SOURCE : CWFB CLAIMS

EDIT RULES :
RANGE: 1 TO 13

78. FILLER CHAR
4 338 341
LENGTH : 4

79. DMERC Claim Variable Group
VAR 342 4411 GRP

Variable portion of the durable medical equipment (DME) regional carrier (DMERC) claim record for version I of the NCH.

STANDARD ALIAS : DMERC_CLM_VAR_GRP

80. NCH Edit Group
5 342 346 GRP

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

STANDARD ALIAS : NCH_EDIT_GRP

OCCURS MIN: 0 OCCURS MAX: 13

DEPENDING ON : DMERC_NCH_EDIT_CD_CNT

81. NCH Edit Trailer Indicator Code

1 342 342 CHAR

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

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH_EDIT_TRLR_IND_TB

82. NCH Edit Code

4 343 346 CHAR

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

LENGTH : 4

SOURCE : NCH QA EDIT PROCESS

CODE TABLE : NCH_EDIT_TB

83. NCH Patch Group

11 1 11 GRP

STANDARD ALIAS : NCH_PATCH_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : DMERC_NCH_PATCH_CD_I_CNT

84. NCH Patch Trailer Indicator Code

1 1 1 CHAR

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

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_PATCH_TRLR_IND_TB

85. NCH Patch Code
2 2 3 CHAR

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

LENGTH : 2

SOURCE : NCH

CODE TABLE : NCH_PATCH_TB

86. NCH Patch Applied Date
8 4 11 NUM

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

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

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :
YYYYMMDD

87. MCO Period Group
37 1 37 GRP

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.

STANDARD ALIAS : MCO_PRD_GRP

OCCURS MIN: 0 OCCURS MAX: 2

DEPENDING ON : DMERC_MCO_PRD_CNT

88. NCH MCO Trailer Indicator Code
1 1 1 CHAR

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

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

COBOL ALIAS : MCO_IND
DB2 ALIAS : MCO_TRLR_IND_CD
SAS ALIAS : MCOIND
STANDARD ALIAS : NCH_MCO_TRLR_IND_CD
TITLE ALIAS : MCO_INDICATOR

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH_MCO_TRLR_IND_TB

89. MCO Contract Number
5 2 6 CHAR

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

LENGTH : 5

SOURCE : CWF

90. MCO Option Code
1 7 7 CHAR

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : MCO_OPTN_TB

91. MCO Period Effective Date
8 8 15 NUM

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.

DB2 ALIAS : MCO_PRD_EFCTV_DT
SAS ALIAS : MCOEFFDT
STANDARD ALIAS : MCO_PRD_EFCTV_DT
TITLE ALIAS : MCO_PERIOD_EFF_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

92. MCO Period Termination Date
8 16 23 NUM

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.

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

93. MCO Health PLANID Number
14 24 37 CHAR

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

LENGTH : 14

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

SOURCE : CWF

94. Claim Health PlanID Group
16 1 16 GRP

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.

STANDARD ALIAS : CLM_HLTH_PLANID_GRP

OCCURS MIN: 0 OCCURS MAX: 3

DEPENDING ON : DMERC_CLM_HLTH_PLANID_CNT

95. NCH Health PlanID Trailer Indicator Code
1 1 1 CHAR

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

LENGTH : 1

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

SOURCE : NCH

CODE TABLE : NCH_HLTH_PLANID_TRLR_IND_TB

96. Claim Health PlanID Code
1 2 2 CHAR

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

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : CLM_HLTH_PLANID_TB

97. Claim Health PlanID Number
14 3 16 CHAR

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

LENGTH : 14

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

SOURCE : CWF

98. Claim Demonstration Identification Group
18 1 18 GRP

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

STANDARD ALIAS : CLM_DEMO_ID_GRP

OCCURS MIN: 0 OCCURS MAX: 5

DEPENDING ON : DMERC_CLM_DEMO_ID_CNT

99. NCH Demonstration Trailer Indicator Code
1 1 1 CHAR

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

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_DEMO_TRLR_IND_TB

100. Claim Demonstration Identification Number
2 2 3 CHAR

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

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

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

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

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

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

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

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

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

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

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

04 = United Mine Workers of America (UMWA) Managed Care Demo -- testing risk sharing for Part A services, paying special capitation rates for all UMWA beneficiaries residing in 13 designated counties in 3 states. Under the demo, UMWA will waive the 3-day qualifying hospital stay for a SNF admission. The claims contain TOB '18X','21X','28X' and '51X'; condition code = W0; claim MCO paid switch = not '0'; and MCO contract # = '90091'.

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

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

NOTE1: Effective for all claim types with NCH weekly process date after 7/31/97 -- CWF adds Demo ID '05' to claim based on the presence of the MCO Plan Contract #. ***Demonstration was terminated 12/31/2000.***

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 terminated in 1998.***

NOTE2: During the Version H conversion, any claims where Medicare is the primary payer that were not already identified as Demo ID '06' (stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4, Version G) were annotated based on the following criteria: Inpatient - presence of DRG '106' or '107' and a provider number=220897, 150897, 380897,450897,110082,230156 or 360085 for specified service dates; noninstitutional - presence of HCPCS modifier (initial and/or second) = 'Q2' and a carrier number =00700/31143 00630,01380,00900,01040/00511,00710,00623, or 13630 for specified service dates.

07 = Virginia Cardiac Surgery Initiative (VCSI) (formerly referred to as Medicare Quality Partnerships Demo) -- this is a voluntary consortium of the cardiac surgery physician groups and the non-Veterans Administration hospitals providing open heart surgical services in the Commonwealth of Virginia. The goal of the demo is to share data on quality and process innovations in an attempt to improve the care for all cardiac patients. The demonstration only affects those FIs that process claims from hospitals in Virginia and the carriers that process claims from physicians providing inpatient services at those hospitals. The hospitals will be reimbursed on a global payment basis for selected cardiac surgical diagnosis related groups (DRGs). The inpatient claims will contain a DRG '104', '105', '106', '107', '109'; the related physician/supplier claims will contain the claim payment denial reason code = 'D'.

NOTE: The implementation date for this demo is 4/1/03. The FI will annotate the claim with the demo id add Demo ID '07' to claim. For carrier claims, the Standard Systems will annotate the claim with the '07' demo number.

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

in the Northeast and Mid-Atlantic regions may participate in the demo.

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

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

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

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

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

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

37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries improve outcomes of care and reduce Medicare expenditures under Part A and Part B. There will be at least 16 Coordinated Care Entities (CCEs). The selected entities will be assigned a provider number specifically for the demonstration services.

NOTE: All claims will be processed by two carriers; no FI processing.

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.

40 = Payment of Physician and Nonphysician Services in certain Indian Providers -- the purpose of this demo is to extend payment for services of physician and nonphysician practitioners furnished in hospitals and ambulatory care clinics. Prior to the legislation change in BIPA, reimbursement for Medicare services provided in IHS facilities was limited to services provided in hospitals and skilled nursing facilities. This change will allow payment for IHS, Tribe and Tribal Organization providers under the Medicare physician fee schedule.

NOTE: Effective July 1, 2001 for institutional and carrier claims.

DB2 ALIAS : CLM_DEMO_ID_NUM
SAS ALIAS : DEMONUM
STANDARD ALIAS : CLM_DEMO_ID_NUM
TITLE ALIAS : DEMO_ID

LENGTH : 2

SOURCE : CWF

101. Claim Demonstration Information Text
15 4 18 CHAR

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

LENGTH : 15

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

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

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

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

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

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

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

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

SOURCE : CWF

OCCURS MIN: 0 OCCURS MAX: 4

7 1 7

DEPENDING ON : DMERC_CLM_DGNS_CD_CNT

103. NCH Diagnosis Trailer Indicator Code
1 1 1 CHAR

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

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_DGNS_TRLR_IND_TB

104. Claim Diagnosis Code
5 2 6 CHAR

The ICD-9-CM based code identifying the beneficiary's principal or other diagnosis (including E code).

NOTE:
Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM_PRNCPAL_DGNS_CD was added as the first occurrence.

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

LENGTH : 5

COMMENTS :
Prior to Version H this field was named: CLM_OTHR_DGNS_CD.

EDIT RULES :
ICD-9-CM

105. FILLER CHAR
1 7 7
LENGTH : 1

106. DMERC Line Item Group
264 1 264 GRP

The DMERC line item trailer group may occur multiple times in one DMERC claim.

STANDARD ALIAS : DMERC_LINE_GRP

OCCURS MIN: 0 OCCURS MAX: 13

DEPENDING ON : DMERC_CLM_LINE_CNT

107. NCH Line Item Trailer Indicator Code
1 1 1 CHAR

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

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_LINE_TRLR_IND_TB

108. DMERC Line Supplier Provider Number
10 2 11 CHAR

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

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

LENGTH : 10

COMMENTS :
Prior to Version H this field was named: CWFB_SUPLR_PRVDR_NUM.

SOURCE : CWF

109. DMERC Line Item Supplier NPI Number
10 12 21 CHAR

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

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

LENGTH : 10

SOURCE : CWF

110. DMERC Line Pricing State Code

2 22 23 CHAR

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

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

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

LENGTH : 2

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

SOURCE : CWF/NCH

CODE TABLE : GEO_SSA_STATE_TB

111. DMERC Line Provider State Code

2 24 25 CHAR

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

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

DB2 ALIAS : DMERC_PRVDR_STATE
SAS ALIAS : PRVSTATE
STANDARD ALIAS : DMERC_LINE_PRVDR_STATE_CD
TITLE ALIAS : DMERC_PRVDR_STATE_CD

LENGTH : 2

COMMENTS :
Prior to Version H this field was named: CWFB_DME_PRVDR_STATE_CD.

SOURCE : CWF/NCH

CODE TABLE : GEO_SSA_STATE_TB

112. DMERC Line Supplier Type Code

1 26 26 CHAR

Code identifying the type of supplier furnishing the line item service on the DMERC claim.

DB2 ALIAS : SUPLR_TYPE_CD
SAS ALIAS : SUP_TYPE
STANDARD ALIAS : DMERC_LINE_SUPLR_TYPE_CD
TITLE ALIAS : SUPLR_TYPE

LENGTH : 1

COMMENTS :
Prior to Version H this field on the DMERC claim was named: CWFB_PRVDR_TYPE_CD.

SOURCE : CWF

CODE TABLE : DMERC_LINE_SUPLR_TYPE_TB

113. Line Provider Tax Number
10 27 36 CHAR

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

LENGTH : 10

COMMENTS :
Prior to Version H this field was named: CWFB_PRVDR_TAX_NUM.

SOURCE : CWF

114. Line HCFA Provider Specialty Code
2 37 38 CHAR

CMS 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

LENGTH : 2

COMMENTS :
Prior to Version H this field was named: CWFB_HCFA_PRVDR_SPCLTY_CD.

SOURCE : CWF

CODE TABLE : HCFA_PRVDR_SPCLTY_TB

115. Line Provider Participating Indicator Code
1 39 39 CHAR

Code indicating whether or not a provider is 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

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : LINE_PRVDR_PRTCPTG_IND_TB

116. Line Service Count
2 40 41 PACK

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

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

LENGTH : 3 SIGNED : Y

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

SOURCE : CWF

117. Line HCFA Type Service Code
1 42 42 CHAR

Code indicating the type of service, as defined in the CMS 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
TITLE ALIAS : HCFA_TYPE_SRVC

LENGTH : 1

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

SOURCE : CWF

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.

CODE TABLE : CMS_TYPE_SRVC_TB

118. Line Place Of Service Code
2 43 44 CHAR

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

LENGTH : 2

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

SOURCE : CWF

CODE TABLE : LINE_PLC_SRVC_TB

119. Line First Expense Date
8 45 52 NUM

Beginning date (1st expense) for this line item service on the noninstitutional claim.

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

LENGTH : 8 SIGNED : N

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

SOURCE : CWF

EDIT RULES :
YYYYMMDD

120. Line Last Expense Date
8 53 60 NUM

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

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

LENGTH : 8 SIGNED : N

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

SOURCE : CWF

EDIT RULES :
YYYYMMDD

121. Line HCPCS Code
5 61 65 CHAR

The Health Care 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

LENGTH : 5

COMMENTS :
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 CMS/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, Third Edition (CDT-3). 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 CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

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

122. Line HCPCS Initial Modifier Code
2 66 67 CHAR

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

LENGTH : 2

COMMENTS :
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

EDIT RULES :
CARRIER INFORMATION FILE

123. Line HCPCS Second Modifier Code
2 68 69 CHAR

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

LENGTH : 2

COMMENTS :

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

SOURCE : CWF

EDIT RULES :
CARRIER INFORMATION FILE

124. DMERC Line HCPCS Third Modifier Code
2 70 71 CHAR

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

DB2 ALIAS : HCPCS_3RD_MDFR_CD
SAS ALIAS : MDFR_CD3
STANDARD ALIAS : DMERC_LINE_HCPCS_3RD_MDFR_CD
TITLE ALIAS : HCPCS_3RD_MDFR

LENGTH : 2

COMMENTS :
Prior to Version H this field was named:
HCPCS_3RD_MDFR_CD.

SOURCE : CWF

125. DMERC Line HCPCS Fourth Modifier Code
2 72 73 CHAR

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

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

LENGTH : 2

COMMENTS :
Prior to Version H this field was named:
HCPCS_4TH_MDFR_CD.

SOURCE : CWF

126. Line NCH BETOS Code
3 74 76 CHAR

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
TITLE ALIAS : BETOS

LENGTH : 3

DERIVATIONS :
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.

SOURCE : NCH

CODE TABLE : BETOS_TB

127. Line IDE Number
7 77 83 CHAR

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

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

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

LENGTH : 7

SOURCE : CWF

128. DMERC Line Not Otherwise Classified HCPCS Code Text
14 84 97 CHAR

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

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

LENGTH : 14

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

SOURCE : CWF

129. Line National Drug Code
11 98 108 CHAR

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

LENGTH : 11

SOURCE : CWF

130. Line NCH Payment Amount
6 109 114 PACK

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.

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

LENGTH : 9.2 SIGNED : Y

COMMENTS :
Prior to Version H this line item field was named:
CLM_PMT_AMT and the size of this field was
S9(7)V99.

SOURCE : NCH

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

131. Line Beneficiary Payment Amount
6 115 120 PACK

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

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

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

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

132. Line Provider Payment Amount
6 121 126 PACK

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.

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

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

133. Line Beneficiary Part B Deductible Amount
6 127 132 PACK

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

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

LENGTH : 9.2 SIGNED : Y

COMMENTS :
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

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

134. Line Beneficiary Primary Payer Code
1 133 133 CHAR

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

LENGTH : 1

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

SOURCE : CWF,VA,DOL,SSA

CODE TABLE : BENE_PRMRY_PYR_TB

135. Line Beneficiary Primary Payer Paid Amount
6 134 139 PACK

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.

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

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

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

136. Line Coinsurance Amount
6 140 145 PACK

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.

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

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

137. Line Interest Amount
6 146 151 PACK

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.

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

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

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

138. Line Primary Payer Allowed Charge Amount
6 152 157 PACK

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.

DB2 ALIAS : PRMRY_PYR_ALOW_AMT
SAS ALIAS : PRPYALOW
STANDARD ALIAS : LINE_PRMRY_PYR_ALOW_CHRG_AMT
TITLE ALIAS : PRMRY_PYR_ALOW_CHRG

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

139. Line 10% Penalty Reduction Amount
6 158 163 PACK

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

DB2 ALIAS : TENPCT_PNLTY_AMT
SAS ALIAS : PNLTYAMT
STANDARD ALIAS : LINE_10PCT_PNLTY_RDCTN_AMT
TITLE ALIAS : TENPCT_PNLTY

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

140. Line Submitted Charge Amount
6 164 169 PACK

The amount of submitted charges for the line
item service on the noninstitutional claim.

DB2 ALIAS : LINE_SBMT_CHRG_AMT
SAS ALIAS : LSBMTCHG
STANDARD ALIAS : LINE_SBMT_CHRG_AMT
TITLE ALIAS : SBMT_CHRG

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

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

141. Line Allowed Charge Amount
6 170 175 PACK

The accumulation of all 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.

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

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

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

142. DMERC Line Screen Savings Amount
6 176 181 PACK

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

DB2 ALIAS : LINE_SCRN_SVGS_AMT
SAS ALIAS : SCRNSVGS
STANDARD ALIAS : DMERC_LINE_SCRN_SVGS_AMT
TITLE ALIAS : SCRN_SVGS

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

143. Line DME Purchase Price Amount
6 182 187 PACK

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.

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

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

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

144. Line Processing Indicator Code
1 188 188 CHAR

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

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : LINE_PRCSG_IND_TB

145. Line Payment 80%/100% Code
1 189 189 CHAR

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

LENGTH : 1

COMMENTS :
Prior to Version H this field was named:
CWFB_PMT_80_100_CD.

SOURCE : CWF

CODE TABLE : LINE_PMT_80_100_TB

146. Line Service Deductible Indicator Switch
1 190 190 CHAR

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

LENGTH : 1

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

SOURCE : CWF

CODES :
0 = Service subject to deductible

1 = Service not subject to deductible

147. Line Payment Indicator Code
1 191 191 CHAR

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

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : LINE_PMT_IND_TB

148. DMERC Line Miles/Time/Units/Services Count
4 192 195 PACK

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

DB2 ALIAS : DMERC_MTUS_CNT
SAS ALIAS : DME_UNIT
STANDARD ALIAS : DMERC_LINE_MTUS_CNT
TITLE ALIAS : MTUS_CNT

LENGTH : 7 SIGNED : Y

COMMENTS :
Prior to Version H this field was named: CWFB_DME_MTUS_CNT.

SOURCE : CWF

149. DMERC Line Miles/Time/Units/Services Indicator Code
1 196 196 CHAR

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

DB2 ALIAS : DMERC_MTUS_IND_CD
SAS ALIAS : UNIT_IND
STANDARD ALIAS : DMERC_LINE_MTUS_IND_CD
TITLE ALIAS : MTUS_IND

LENGTH : 1

COMMENTS :
Prior to Version H this field was named: CWFB_DME_MTUS_IND_CD.

SOURCE : CWF

CODE TABLE : DMERC_LINE_MTUS_IND_TB

150. Line Diagnosis Code
5 197 201 CHAR

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

LENGTH : 5

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

SOURCE : CWF

EDIT RULES :
ICD-9-CM

151. FILLER CHAR
5 202 206
LENGTH : 5

152. Line Additional Claim Documentation Indicator Code
1 207 207 CHAR

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

LENGTH : 1

COMMENTS :
Prior to Version H this field was named: CWFB_ADDTNL_CLM_DCMTN_IND_CD.

SOURCE : CWF

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

CODE TABLE : LINE_ADDTNL_CLM_DCMTN_IND_TB

153. DMERC Line Screen Suspension Indicator Code
4 208 211 CHAR

Effective with Version G, the code identifying

the medical review (MR) screen that caused DMERC
line item to suspend.

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

LENGTH : 4

SOURCE : CWF

CODE TABLE : DMERC_LINE_SCRN_SUSPNSN_IND_TB

154. DMERC Line Screen Result Indicator Code
1 212 212 CHAR

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

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

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : DMERC_LINE_SCRN_RSLT_IND_TB

155. DMERC Line Waiver Of Provider Liability Switch
1 213 213 CHAR

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

DB2 ALIAS : WVR_PRVDR_LBLTY_SW
SAS ALIAS : WAIVERSW
STANDARD ALIAS : DMERC_LINE_WVR_PRVDR_LBLTY_SW
TITLE ALIAS : WAIVER_LBLTY_SW

LENGTH : 1

COMMENTS :
Prior to Version H this field was named:
CWFB_DME_WVR_PRVDR_LBLTY_SW.

SOURCE : CWF

CODE TABLE : YES_NO_TB

156. DMERC Line Decision Indicator Switch
1 214 214 CHAR

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

DB2 ALIAS : DMERC_DCSN_IND_SW
SAS ALIAS : DCSN_IND
STANDARD ALIAS : DMERC_LINE_DCSN_IND_SW
TITLE ALIAS : DCSN_IND

LENGTH : 1

COMMENTS :
Prior to Version H this field was named:
CWFB_DME_DCSN_IND_SW.

SOURCE : CWF

CODE TABLE : DMERC_LINE_DCSN_IND_TB

157. FILLER CHAR
50 215 264
LENGTH : 50

158. End of Record Code
3 1 3 CHAR

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

LENGTH : 3

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

SOURCE : NCH

CODES :
EOR = End of Record/Segment
EOC= End of Claim

TS25.R_RIF_MAIN_RPT_Q,Q1,F
****

TABLE OF CODES APPENDIX FOR RECORD: DMERC_CLM_I_REC
FROM CA REPOSITORY RIF REPORT

BENE_CWF_LOC_TB Beneficiary Common Working File Location Table

B = Mid-Atlantic

C = Southwest
D = Northeast
E = Great Lakes
F = Great Western
G = Keystone
H = Southeast
I = South
J = Pacific

BENE_IDENT_TB Beneficiary Identification Code (BIC) Table

Social Security Administration:

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

DG = Aged widow (5th claimant)
DH = Aged widower (3rd claimant)
DJ = Aged widower (4th claimant)
DK = Aged widower (5th claimant)
DL = Remarried widow (4th claimant)
DM = Surviving divorced husband (2nd claimant)
DN = Remarried widow (5th claimant)
DP = Remarried widower (2nd claimant)
DQ = Remarried widower (3rd claimant)
DR = Remarried widower (4th claimant)
DS = Surviving divorced husband (3rd claimant)
DT = Remarried widower (5th claimant)
DV = Surviving divorced wife (3rd claimant)
DW = Surviving divorced wife (4th claimant)
DX = Surviving divorced husband (4th claimant)
DY = Surviving divorced wife (5th claimant)
DZ = Surviving divorced husband (5th claimant)
E = Mother (widow) (1st claimant)
E1 = Surviving divorced mother (1st claimant)
E2 = Mother (widow) (2nd claimant)
E3 = Surviving divorced mother (2nd claimant)
E4 = Father (widower) (1st claimant)
E5 = Surviving divorced father (widower) (1st claimant)
E6 = Father (widower) (2nd claimant)
E7 = Mother (widow) (3rd claimant)
E8 = Mother (widow) (4th claimant)
E9 = Surviving divorced father (widower) (2nd claimant)
EA = Mother (widow) (5th claimant)
EB = Surviving divorced mother (3rd claimant)
EC = Surviving divorced mother (4th claimant)
ED = Surviving divorced mother (5th claimant
EF = Father (widower) (3rd claimant)
EG = Father (widower) (4th claimant)
EH = Father (widower) (5th claimant)
EJ = Surviving divorced father (3rd claimant)
EK = Surviving divorced father (4th claimant)
EM = Surviving divorced father (5th claimant)
F1 = Father
F2 = Mother
F3 = Stepfather
F4 = Stepmother
F5 = Adopting father
F6 = Adopting mother
F7 = Second alleged father
F8 = Second alleged mother
J1 = Primary prouty entitled to HIB (less than 3 Q.C.) (general fund)
J2 = Primary prouty entitled to HIB

(over 2 Q.C.) (RSI trust fund)
J3 = Primary prouty not entitled to HIB (less than 3 Q.C.) (general fund)
J4 = Primary prouty not entitled to HIB (over 2 Q.C.) (RSI trust fund)
K1 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)
K2 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)
K3 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)
K4 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)
K5 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)
K6 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)
K7 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)
K8 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)
K9 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)
KA = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)
KB = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)
KC = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)
KD = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (4th claimant)
KE = Prouty wife entitled to HIB (over 2 Q.C (4th claimant)
KF = Prouty wife not entitled to HIB (less than 3 Q.C.)(4th claimant)
KG = Prouty wife not entitled to HIB (over 2 Q.C.)(4th claimant)
KH = Prouty wife entitled to HIB (less than 3 Q.C.)(5th claimant)
KJ = Prouty wife entitled to HIB (over 2 Q.C.) (5th claimant)
KL = Prouty wife not entitled to HIB (less than 3 Q.C.)(5th claimant)
KM = Prouty wife not entitled to HIB (over 2 Q.C.) (5th claimant)
M = Uninsured-not qualified for deemed HIB
M1 = Uninsured-qualified but refused HIB
T = Uninsured-entitled to HIB under deemed or renal provisions
TA = MQGE (primary claimant)
TB = MQGE aged spouse (first claimant)
TC = MQGE disabled adult child (first claimant)
TD = MQGE aged widow(er) (first claimant)
TE = MQGE young widow(er) (first claimant)
TF = MQGE parent (male)
TG = MQGE aged spouse (second claimant)

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

Railroad Retirement Board:

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

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)

BENE_MDCR_STUS_TB CWF Beneficiary Medicare Status Table

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

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)

Prior to 12/90

Y = Other secondary payer investigation
shows Medicare as primary payer
Z = Medicare is primary payer

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

BENE_RACE_TB Beneficiary Race Table

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

BENE_SEX_IDENT_TB Beneficiary Sex Identification Table

1 = Male
2 = Female
0 = Unknown

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 - hysterectomy
P1F = Major procedure - explor/decompr/excisdisc
P1G = Major procedure - Other
P2A = Major procedure, cardiovascular-CABG
P2B = Major procedure, cardiovascular-Aneurysm repair
P2C = Major Procedure, cardiovascular-Thromboendarterectomy
P2D = Major procedure, 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 of retinal lesions
P4E = Eye procedure - other
P5A = Ambulatory procedures - skin
P5B = Ambulatory procedures - musculoskeletal
P5C = Ambulatory procedures - inguinal hernia repair
P5D = Ambulatory procedures - lithotripsy
P5E = Ambulatory procedures - other
P6A = Minor procedures - skin
P6B = Minor procedures - musculoskeletal
P6C = Minor procedures - other (Medicare fee schedule)
P6D = Minor procedures - other (non-Medicare fee schedule)
P7A = Oncology - radiation therapy
P7B = Oncology - other
P8A = Endoscopy - arthroscopy
P8B = Endoscopy - upper gastrointestinal
P8C = Endoscopy - sigmoidoscopy
P8D = Endoscopy - colonoscopy
P8E = Endoscopy - cystoscopy
P8F = Endoscopy - bronchoscopy
P8G = Endoscopy - laparoscopic cholecystectomy
P8H = Endoscopy - laryngoscopy
P8I = Endoscopy - other
P9A = Dialysis services (medicare fee schedule)
P9B = Dialysis services (non-medicare fee schedule)
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 - other
I3A = Echography - eye
I3B = Echography - abdomen/pelvis
I3C = Echography - heart
I3D = Echography - carotid arteries
I3E = Echography - prostate, transrectal
I3F = Echography - other
I4A = Imaging/procedure - heart including cardiac catheterization
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
D1G = Drugs Administered through DME
O1A = Ambulance
O1B = Chiropractic
O1C = Enteral and parenteral
O1D = Chemotherapy
O1E = Other drugs
O1F = Vision, hearing and speech services
O1G = Immunizations/Vaccinations
Y1 = Other - Medicare fee schedule
Y2 = Other - non-Medicare fee schedule
Z1 = Local codes
Z2 = Undefined codes

CARR_CLM_ENTRY_TB Carrier Claim Entry Table

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)

CARR_CLM_HOSPC_OVRRD_IND_TB Carrier Claim Hospice Override Indicator Table

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

CARR_CLM_MCO_OVRRD_IND_TB Carrier Claim MCO Override Indicator Table

0 = No Investigation
1 = MCO Investigation does not apply to this
claim.

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)

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 = Louisiana - Arkansas BS (eff. 1984)
00542 = California BS (eff. 1983; term. 1996)
00550 = Colorado BS (eff. 1983; term. 1994)
00570 = Delaware - Pennsylvania BS (eff. 1983; term. 1997)
00580 = District of Columbia - Pennsylvania BS (eff. 1983; term. 1997)
00590 = Florida BS (eff. 1983)
00591 = Connecticut - Florida BS (eff. 2000)

00621 = Illinois BS - HCSC (eff. 1983; term. 1998)
00623 = Michigan - Illinois Blue Shield (eff. 1995) (term. 1998)
00630 = Indiana - Indiana BS (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 = Western Missouri - Kansas BS (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/South 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 - HGSAdministrators (eff. 1983)
00870 = Rhode Island BS (eff. 1983)
00880 = South Carolina BS (eff. 1983)
00882 = RRB - South Carolina PGBA (eff. 2000)
00883 = Ohio - South Carolina BS (eff. 2002)
00884 = West Virginia - South Carolina BS (eff. 2002)
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 = Puerto Rico - Triple S, Inc. (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 - CIGNA (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 = DMERC A - Travelers Insurance Co.
(eff. 1993) (term. 2000)
11260 = General American Life of Missouri
(eff. 1983; term. 1998)
14330 = New York - GHI (eff. 1983)
16360 = Ohio - Nationwide Insurance Co. (eff. 1983)
(term. 2002)
16510 = West Virginia - Nationwide Insurance Co.
(eff. 1983) (term. 2002)
21200 = Maine - Massachusetts BS
(eff. 1983) (term. 1998)
31140 = California - National Heritage Ins.
(eff. 1997)
31142 = Maine - National Heritage Ins.
(eff. 1998)
31143 = Massachusetts - National Heritage Ins.
(eff. 1998)
31144 = New Hampshire - National Heritage Ins.
(eff. 1998)
31145 = Vermont - National Heritage Ins.
(eff. 1998)
31146 = So. California - NHIC (eff. 2000)
80884 = Contractor ID for Physician Risk Adjust-
ment Data (data not sent through CWF;
but through Palmetto)

CLM_DISP_TB Claim Disposition Table

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

(automatic adjustment)
63 = *Conversion code: cancel accepted

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

CLM_HLTH_PLANID_TB Claim Health PlanID Table

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

CMS_TYPE_SRVC_TB CMS 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)

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

DMERC_LINE_DCSN_IND_TB DMERC Line Decision Indicator Table

O = Original MR determination
R = MR determination after reversal of original decision

DMERC_LINE_MTUS_IND_TB DMERC Line Miles/Time/Units Indicator Table

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

DMERC_LINE_SCRN_RSLT_IND_TB DMERC Line Screen Result Indicator Table

A = Denied for lack of medical necessity; highest level of review was automated level I review
B = Reduced (partially denied) for lack of medical necessity; highest level of review was automated level I review
C = Denied as statutorily noncovered; highest level of review was automated level I review
D = Reserved for future use
E = Paid after automated level I review
F = Denied for lack of medical necessity; highest level of review was manual level I review
G = Reduced (partially denied) for lack of medical necessity; highest level of review was manual level I review
H = Denied as statutorily noncovered; highest level of review was manual level I review
I = Denied for coding/unbundling reasons; highest level of review was manual level I review
J = Paid after manual level I review
K = Denied for lack of medical necessity; highest level of review was manual level II review
L = Reduced (partially denied) for lack of medical necessity; highest level of review was manual level II review
M = Denied as statutorily noncovered; highest level of review was manual level II review
N = Denied for coding/unbundling reasons; highest level of review was manual level II review

O = Paid after manual level II review
P = Denied for lack of medical necessity; highest level of review was manual level III review
Q = Reduced (partially denied) for lack of medical necessity; highest level of review was manual level III review
R = Denied as statutorily noncovered; highest level of review was manual level III review
S = Denied for coding/unbundling reasons; highest level of review was manual level III review
T = Paid after manual level III review

DMERC_LINE_SCRN_SUSPNSN_IND_TB DMERC Line Screen Suspension Indicator Table

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

DMERC_LINE_SUPLR_TYPE_TB DMERC Line Supplier Type Table

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

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

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

HCFA_PRVDR_SPCLTY_TB HCFA Provider Specialty Table

00 = Carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology
04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Interventional Pain Management (IPM) (eff. 4/1/03)
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 = Anesthesiologist Assistants (eff. 4/1/03--previously grouped with Certified Registered Nurse Anesthetists (CRNA))
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 (eff. 1/87) (Anesthesiologist Assistants were removed from this specialty 4/1/03)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology (eff 5/92)
47 = Independent Diagnostic Testing Facility (IDTF) (eff. 6/98)
48 = Podiatry
49 = Ambulatory surgical center (formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics)
52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics)
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
54 = Medical supply company not included in 51, 52, or 53. (Revised 10/93 to mean medical supply company for DMERC)
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-orthotist
58 = Individuals not included in 55, 56, or 57 (revised 10/93 to mean medical supply company with registered pharmacist)
59 = Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc.
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.g., National Cancer Society, National Heart Associiation,

Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier
64 = Audiologist (billing independently)
65 = Physical therapist (private practice added 4/1/03)
(independently practicing removed 4/1/03)
66 = Rheumatology (eff 5/92)
Note: during 93/94 DMERC also used this
to mean medical supply company with
respiratory therapist
67 = Occupational therapist (private practice added 4/1/03)
(independently practicing removed 4/1/03)
68 = Clinical psychologist
69 = Clinical laboratory (billing
independently)
70 = Multispecialty clinic or group
practice
71 = Registered Dietician/Nutrition Professional (eff. 1/1/02)
72 = Pain Management (eff. 1/1/02)
73 = Mass Immunization Roster Biller (eff. 4/1/03)
74 = Radiation Therapy Centers (added to differentiate
them from Independent Diagnostic Testing Facilities
(IDTF --eff. 4/1/03)
74 = Occupational therapy (GPPP)
(not to be assigned after 5/92)
75 = Slide Preparation Facilities (added to differentiate
them from Independent Diagnostic Testing Facilites
(IDTFs -- eff. 4/1/03)
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 code 88 eff 10/93)

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

LINE_PLC_SRVC_TB Line Place Of Service Table

03 = School (eff. 1/1/03
04 = Homeless Shelter (eff. 1/1/03)
11 = Office
12 = Home
15 = Mobile Unit (eff. 1/1/03)
20 = Urgent Care Facility (eff. 1/1/03)
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
99 = Other unlisted facility

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)

LINE_PMT_80_100_TB Line Payment 80%/100% Table

0 = 80%
1 = 100%
3 = 100% Limitation of liability only

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)

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.

MCO_OPTN_TB MCO Option Table

*****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

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
50 = Hospice claim
60 = Inpatient claim
61 = Inpatient 'Full-Encounter' claim

71 = RIC O local carrier non-DMEPOS claim
72 = RIC O local carrier DMEPOS claim
81 = RIC M DMERC non-DMEPOS claim
82 = RIC M DMERC DMEPOS claim

NCH_DEMO_TRLR_IND_TB NCH Demonstration Trailer Indicator Table

D = Demo trailer present

NCH_DGNS_TRLR_IND_TB NCH Diagnosis Trailer Indicator Table

Y = Diagnosis code trailer present

NCH_EDIT_DISP_TB NCH Edit Disposition Table

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

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)
A009 = (C) TYPE OF BILL RECEIVED IS 41A, 41B, OR 41D
A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
A031 = (C) HOSPITAL CLAIMS--CLAIM SHOWS SERVICES WERE PAID
BY AN HMO AND CODITION CODE '04' IS NOT PRESENT.
(TOB '11' & '12')
A041 = (C) HHA CLAIMS--TOB 32X OR 33X WITH >4 VISITS; DATE
OF SERVICE > 9/30/00 AND LUPA IND IS PRESENT.
BYPASS FOR NON-PAYMENT CODE B, C, Q, T-Y.
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
D5X7 = (C) FROM DATE > 3/31/98 W/HCPCS Q0163-Q0181
J8510, J8521, J8530, J8560, J8600,
J8610, J8999 RANGE
D5X8 = (C) TWO ANTI-EMETIC DRUGS PRESENT ON SAME CLAIM
WITH IDENTICAL DATES OF SERVICE.
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
D922 = (C) THERAPEUTIC SHOE CODES 'A5505-A5501'
W/MODIFIER 'LT' OR 'RT' MUST HAVE
UNITS = '001'
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
0022 = (C) TOB '32X' OR '33X' W/DATES OF SERVICE >9/30/00
AND HAS CANCEL ONLY CODE OTHER THAN A,B,E,F
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
0403 = (C) TOB '41X'/PRVDR # 1990-1999) OR TOB '51X'/
PRVDR #6990-6999, TRANS CODE SHOULD BE
'0' OR '3'
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
041A = (C) TOB '11A' OR '11D' AND DEMO #'07' OR '08'
NOT PRESENT
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
0416 = (C) REVENUE CENTER '0022', TOB MUST BE '21X'
0417 = (C) REVENUE CENTER '0023', TOB MUST BE '32X'
OR '33X'
0418 = (C) HHA--TOB '3X5' AND DATES OF SERVICE
>9/30/00
0419 = (C) HHA--RIC 'W' MUST HAVE VALUE CODE '63'/
RIC 'V' MUST HAVE VALUE CODE '62' AND
RIC 'U' MUST HAVE VALUE CODES '62' AND
'63' PRESENT FOR DATES OF SERVICE >
9/30/00.
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
0706 = (C) REVENUE CENTER CODE 0403 AND HCPCS CODE
76092 ARE PRESENT AND BENEFICIARY IS
< 35 YEARS OLD
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
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-DAYS, NO VAL 08,10/PD/DEN>CUR+27
2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
2604 = (C) PPS BILL, NO DAY OUTLIER
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
28XA = (C) UTIL DAYS > FROM TO BENEF EXH
28XB = (C) BENEFITS EXH DATE > FROM DATE
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN = (C) INVALID OCC CODE
28XO = (C) AN 'N' NO-PAY CODE IS PRESENT AND OCCURRENCE
CODE '23' OR '42' IS NOT PRESENT AND THE
DATE ASSOCIATED WITH CODE IS MISSING OR NOT
EQUAL TO THRU DATE.
28XP = (C) THE OCCURRENCE CODE 23 DATE DOES NOT EQUAL THE
THRU DATE
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
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

4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
4201 = (C) BLOOD PINTS UNREPLACED INVALID
4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED
4203 = (C) INVALID CPO PROVIDER NUMBER
4301 = (C) BLOOD DEDUCTABLE INVALID
4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
4304 = (C) BLOOD DEDUCT > 3 - REPLACED
4501 = (C) PRIMARY DIAGNOSIS INVALID
46XA = (C) MSP VET AND VET AT MEDICARE
46XB = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
46XC = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
46XG = (C) VALU CODE 20 INVALID
46XN = (C) VALUE CODE 37,38,39 INVALID
46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSNG
46XP = (C) BLD UNREP VS REV CDS AND/OR UNITS
46XQ = (C) VALUE CDE 37=39 AND 38 IS PRESENT
46XR = (C) BLD FIELDS VS REV CDE 380,381,382
46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT
46XT = (C) CABG/PCOE,VC<>Y1,Y2,Y3,Y4,VA NOT>0
46X1 = (C) VALUE AMOUNT INVALID
46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61
46X7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
4601 = (C) CABG/PCOE, MSP CODE PRESENT
4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
4901 = (C) PCOE/CABG,DEN CD NOT D
4902 = (C) PCOE/CABG BUT DME
50X1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
50X2 = (C) REV CD=054X,MOD NOT = QM,QN
5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
51XA = (C) HCPCS EYEWARE & REV CODE NOT 274
51XC = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51XD = (C) HCPCS REQUIRES UNITS > ZERO
51XE = (C) HCPCS REQUIRES REVENUE CODE 636
51XF = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51XG = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
51XH = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044
51XI = (C) TOB 21X/P82<>2/3/4:REV CD>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
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
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
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
9999 = (U) MAIN SPELL TRAILER NUMBER DOES NOT MATCH SPELL

NCH_EDIT_TRLR_IND_TB NCH Edit Trailer Indicator Table

E = Edit code trailer present

NCH_HLTH_PLANID_TRLR_IND_TB NCH Health PlanID Trailer Table

I = Health PlanID trailer present

NCH_LINE_TRLR_IND_TB NCH Line Item Trailer Indicator Table

L = Line Item trailer present
Blank = No trailer present

NCH_MCO_TRLR_IND_TB NCH Managed Care Organization (MCO) Trailer Indicator Table

M = MCO trailer present

NCH_MQA_RIC_TB NCH MQA Record Identification Code Table

1 = Inpatient
2 = SNF

3 = Hospice
4 = Outpatient
5 = Home Health Agency
6 = Physician/Supplier
7 = Durable Medical Equipment

NCH_NEAR_LINE_REC_VRSN_TB NCH Near Line Record Version Table

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

NCH_NEAR_LINE_RIC_TB NCH Near-Line Record Identification Code Table

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

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

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

14 = SNF claims incorrectly identified as Inpatient Encounter claims -- SNF claims matching the Inpatient encounter data criteria were incorrectly identified as Inpatient encounter claims (claim type code = '61' instead of '20' or '30'). NOTE: if the SNF claims were identified the MCO paid switch was set to '1'. The patch was applied to correctly identify these claims as a '20' or '30'. The MCO paid switch will be set to '0' as there is no way to recover the original value. The problem occurred in claims with an NCH Weekly Process Date ranging from 7/7/2000 - 1/26/2001. The patch applied date is 03/30/2001.

15 = HHA Part A claims with overlaid revenue center lines - During the Version 'I' conversion, NCH made each segment of a claim contains a maximum of 45 revenue lines. During the month of June 2000 our CWFMQA had to be ready to except the new expanded format, but the NCH was not ready. CWFMQA converted these 'I' claims back to Version 'H', a typo in the code caused the additional revenue lines to overlay some of the revenue lines on the base/initial record/segment. The problem occurred in claims with NCH Weekly Process dates from 6/16/00, 6/23/00, 6/30/00 and 7/7/00 (both Version 'H' & 'I' files).

In the Version 'I' files, the annual service year 2000 files, service year 1999 and 1998 trickles were patched. The 18-month service year 1999 was also patched (the service year 2000 SAF was created after the fix was applied).

The patch applied date is 06/29/2001.

NCH_PATCH_TRLR_IND_TB NCH Patch Trailer Indicator Table

P = Patch code trailer present

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

YES_NO_TB Yes/No Table

Y = Yes
N = No

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LIMITATIONS APPENDIX FOR RECORD: DMERC_CLM_I_REC
AS OF: 04/07/2003

CHOICES_DEMO_LIM
FULL NAME: Choices Demonstration Limitation
DESCRIPTION :
A programming error created an 'INVALID' indication in the demo text field for CHOICES claims.
BACKGROUND :
In 6/00, the CWFMQA front-end editing revealed that some CHOICES demo claims were coming in with a valid 'H' number in the fixed portion of the claims, but in the first occurrence MCO trailer a numeric packed field (value hex '0100000C') was moved to the MCO Contract Number/Option Code fields. This created an invalid period check of number/code to MCO effective date, resulting in an INVALID indication in the demo info text field.
CORRECTIVE ACTION :
The problem was forwarded to the CWF BSOG staff for further investigation.
SOURCE:
CONTACT : OIS/EDG/DMUDD

PMT_AMT_EXCEDG_CHRG_AMT_LIM
FULL NAME: Claim Payment Amount Exceeding Total Charge Amount Limitation
DESCRIPTION :
Approximately 75 Inpatient claims had a reimbursement amount exceed $500,000 which was at least 25 times the total charge amount. There were also claims where the reimbursement was less than $500,000 but greater than the total charges.
BACKGROUND :
In November of 1999, it was brought to the attention of the HDUG that large reimbursement amounts were being paid in Pennsylvania. There were 75 inpatient claims provided where the reimbursement amount was over $500,000 and at least 25 times the total charge amount. These claims were processed between 9/29/98 and 10/1/98. There were also claims identified with

reimbursement less than $500,000 but greater than total charge. It was later discovered that the source of the problem was an error in entering an MSA; the decimal point was off by 2 positions.

Because there were no changes in utilization, the claims were corrected and the correct payments distributed, but the new payment amounts were never sent to CWF (not in NCH). There is currently no requirement that FIs and carriers update CWF with final payment information by submitting payment only adjustments. It was noted that there is no expectation that CWF wll have final payment information for claims.

CORRECTIVE ACTION :

According to Veritus (FI), the problem was caught in their system using a pre-payment edit prior to sending out the payments. The erroneous MSA value was corrected and the claims were then sent to PRICER again and paid correctly.

The claims were corrected and correct payments were made but these new payment amounts were never sent to CWF and are not reflected in the NCH.

SOURCE:

CONTACT OIS/EDG/DMUDD

TS25.R_RIF_LIM_RPT_Q,F
04/07/2003

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