FI HHA Claim Record -- 08/2002

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	FI HHA Claim Record	REC	VAR			Fiscal intermediary home health agency claim record for Version I of the NCH. STANDARD ALIAS: FI_HHA_CLM_REC SYSTEM ALIAS: UTLHHAI
****	DESY Header Group	GROUP	50	1	50	DESY header for whole record output.
1.	DESY System User	CHAR	30	1	30	A user-defined field that holds the description of the request. For example, "Cross-referenced HICS". STANDARD ALIAS: DSY_SYSTEM_USER
2.	Filler	CHAR	11	31	41	Filler STANDARD ALIAS: DSY_TBD
3.	DESY Sort Key	CHAR	9	42	50	This field contains the key to tie claims together for one beneficiary regardless of HICAN. STANDARD ALIAS: DSY_SORT_KEY
****	FI HHA Claim Fixed Group	GROUP	569	51	619	Fixed portion of the fiscal intermediary home health agency claim record for Version 'I' of the NCH. STANDARD ALIAS: FI_HHA_CLM_FIX_GRP
****	Claim Record Identification Group	GROUP	8	51	58	Effective with Version 'I' the record length, version code, record identification, code and NCH derived claim type code were moved to this group for internal NCH processing. STANDARD ALIAS: CLM_REC_IDENT_GRP
4.	Record Length Count	PACK	3	51	53	Effective with Version H, the count (in bytes)

of the length of the claim record.

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

5 DIGITS SIGNED

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

SOURCE:
NCH

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	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
5.	NCH Near-Line Record Version Code	CHAR	1	54	54	The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored. DB2 ALIAS: NCH_REC_VRSN_CD SAS ALIAS: REC_LVL STANDARD ALIAS: NCH_NEAR_LINE_REC_VRSN_CD TITLE ALIAS: NCH_VERSION CODES: A = Record format as of January 1991 B = Record format as of April 1991 C = Record format as of May 1991 D = Record format as of January 1992 E = Record format as of March 1992 F = Record format as of May 1992 G = Record format as of October 1993 H = Record format as of September 1998 I = Record format as of July 2000 COMMENT: Prior to Version H this field was named:

CLM_NEAR_LINE_REC_VRSN_CD.

SOURCE:
NCH

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
6.	NCH Near Line Record Identification Code	CHAR	1	55	55	A code defining the type of claim record being processed. COMMON ALIAS: RIC DB2 ALIAS: NEAR_LINE_RIC_CD SAS ALIAS: RIC_CD STANDARD ALIAS: NCH_NEAR_LINE_RIC_CD TITLE ALIAS: RIC CODES: REFER TO: NCH_NEAR_LINE_RIC_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: RIC_CD. SOURCE: NCH
7.	NCH MQA RIC Code	CHAR	1	56	56	Effective with Version H, the code used (for internal editing purposes) to identify the record being processed through HCFA's CWFMQA system. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

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

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

SOURCE:
NCH QA PROCESS

8. NCH Claim Type Code	CHAR	2	57	58	The code used to identify the type of claim record being processed in NCH.

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

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

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

DERIVATION:
FFS CLAIM TYPE CODES DERIVED FROM:
  NCH CLM_NEAR_LINE_RIC_CD
  NCH PMT_EDIT_RIC_CD
  NCH CLM_TRANS_CD
  NCH PRVDR_NUM

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

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					MCO_OPTN_CD MCO_PRD_EFCTV_DT MCO_PRD_TRMNTN_DT INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM
					INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD. PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) CARR_NUM CLM_DEMO_ID_NUM OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD DERIVATION RULES: SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
2. PMT_EDIT_RIC_CD EQUAL 'F'
3. CLM_TRANS_CD EQUAL '5'

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

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

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

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

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

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED' ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1. FI_NUM = 80881
2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_

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     CLSFCTN_TYPE_CD = '2', '3' OR '4' &
     CLM_FREQ_CD = 'Z', 'Y' OR 'X'

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

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

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

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

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1.   FI_NUM = 80881 AND
2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
     TYPE_CD = '1'; CLM_FREQ_CD = 'Z'
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NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'O' 2. HCPCS_CD not on DMEPOS table SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'O' 2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table). SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CARR_NUM = 80882 AND 2. CLM_DEMO_ID_NUM = 38 SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD not on DMEPOS table SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table). CODES: REFER TO: NCH_CLM_TYPE_TB IN THE CODES APPENDIX SOURCE: NCH
**** Fiscal Intermediary Claim	GROUP	125	59	183	Effective with Version 'I', this group

	Link Group					contains those fields necessary to keep records/ segments together (a claim may have up 10 records/ segments due to the increase in number of revenue center trailers (up to 450). It is also used to house fields necessary for sorting and final action processing. STANDARD ALIAS: FI_CLM_LINK_GRP
****	Claim Locator Number Group	GROUP	11	59	69	This number uniquely identifies the beneficiary in the NCH Nearline. COMMON ALIAS: HIC STANDARD ALIAS: CLM_LCTR_NUM_GRP TITLE ALIAS: HICAN

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
9.	Beneficiary Claim Account Number	CHAR	9	59	67	The number identifying the primary beneficiary under the SSA or RRB programs submitted. COMMON ALIAS: CAN DA3 ALIAS: CLAIM_ACCOUNT_NUMBER DB2 ALIAS: BENE_CLM_ACNT_NUM SAS ALIAS: CAN STANDARD ALIAS: BENE_CLM_ACNT_NUM TITLE ALIAS: CAN SOURCE: SSA,RRB LIMITATIONS: RRB-issued numbers contain an overpunch in the first position that may appear as a plus zero or A-G. RRB-formatted numbers may cause matching problems on non-IBM machines.
10.	NCH Category Equatable Beneficiary Identification Code	CHAR	2	68	69	The code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner.

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

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

CODES:
REFER TO: CTGRY_EQTBL_BENE_IDENT_TB
IN THE CODES APPENDIX

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

SOURCE:
BIC EQUATE MODULE

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
11.	Beneficiary Identification Code	CHAR	2	70	71	The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary.

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

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

OPTIONAL: MAY BE BLANK

CODES:
REFER TO: GEO_SSA_STATE_TB
IN THE CODES APPENDIX

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					COMMENT: 1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement. 2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish. 3. Also used for special studies. SOURCE: SSA/EDB
14. Claim From Date	NUM	8	75	82	The first day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date'). NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match. 8 DIGITS UNSIGNED DB2 ALIAS: CLM_FROM_DT SAS ALIAS: FROM_DT STANDARD ALIAS: CLM_FROM_DT TITLE ALIAS: FROM_DATE EDIT-RULES: YYYYMMDD

						SOURCE: CWF
15.	Claim Through Date	NUM	8	83	90	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date'). NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match. 8 DIGITS UNSIGNED DB2 ALIAS: CLM_THRU_DT SAS ALIAS: THRU_DT STANDARD ALIAS: CLM_THRU_DT TITLE ALIAS: THRU_DATE EDIT-RULES: YYYYMMDD SOURCE: CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
16.	NCH Weekly Claim Processing Date	NUM	8	91	98	The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date. 8 DIGITS UNSIGNED DB2 ALIAS: NCH_WKLY_PROC_DT SAS ALIAS: WKLY_DT STANDARD ALIAS: NCH_WKLY_PROC_DT TITLE ALIAS: NCH_PROCESS_DT

					EDIT-RULES: YYYYMMDD COMMENT: Prior to Version H this field was named: HCFA_CLM_PROC_DT. SOURCE: NCH
17. CWF Claim Accretion Date	NUM	8	99	106	The date the claim record is accreted (posted/ processed) to the beneficiary master record at the CWF host site and authorization for payment is returned to the fiscal interme- diary or carrier. 8 DIGITS UNSIGNED DB2 ALIAS: CWF_CLM_ACRTN_DT SAS ALIAS: ACRTN_DT STANDARD ALIAS: CWF_CLM_ACRTN_DT TITLE ALIAS: ACCRETION_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
18. CWF Claim Accretion Number	PACK	2	107	108	The sequence number assigned to the claim record when accreted (posted/processed) to the beneficiary master record at the CWF host site on a given date. This element indicates the position of the claim within that day's processing at the CWF host. **(Exception: If the claim record is missing the accretion date HCFA's CWFMQA system places a zero in the accretion number.

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
						3 DIGITS SIGNED DB2 ALIAS: CWF_CLM_ACRTN_NUM SAS ALIAS: ACRTN_NM STANDARD ALIAS: CWF_CLM_ACRTN_NUM TITLE ALIAS: ACCRETION_NUMBER SOURCE: CWF
19.	FI Document Claim Control Number	CHAR	23	109	131	Unique control number assigned by an intermediary to an institutional claim. COMMON ALIAS: ICN DB2 ALIAS: DOC_CLM_CNTL_NUM SAS ALIAS: CLM_CNTL STANDARD ALIAS: FI_DOC_CLM_CNTL_NUM TITLE ALIAS: ICN SOURCE: CWF
20.	FI Original Claim Control Number	CHAR	23	132	154	Effective with Version G, the original intermediary control number (ICN) which is present on adjustment claims, representing the ICN of the original transaction now being adjusted. COMMON ALIAS: ORIGINAL_ICN DB2 ALIAS: ORIG_CLM_CNTL_NUM SAS ALIAS: ORIGCNTL STANDARD ALIAS: FI_ORIG_CLM_CNTL_NUM TITLE ALIAS: ORIGINAL_ICN SOURCE: CWF
21.	Claim Query Code	CHAR	1	155	155	Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator).

DB2 ALIAS: CLM_QUERY_CD
SAS ALIAS: QUERY_CD
STANDARD ALIAS: CLM_QUERY_CD
TITLE ALIAS: QUERY_CD

CODES:
0 = Credit adjustment
1 = Interim bill
2 = Home Health Agency (HHA) benefits
    exhausted (obsolete 7/98)
3 = Final bill
4 = Discharge notice (obsolete 7/98)
5 = Debit adjustment

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						SOURCE: CWF
22.	Provider Number	CHAR	6	156	161	The identification number of the institutional provider certified by Medicare to provide services to the beneficiary. DB2 ALIAS: PRVDR_NUM SAS ALIAS: PROVIDER STANDARD ALIAS: PRVDR_NUM TITLE ALIAS: PROVIDER_NUMBER CODES: REFER TO: PRVDR_NUM_TB IN THE CODES APPENDIX SOURCE: OSCAR
23.	NCH Daily Process Date	NUM	8	162	169	Effective with Version H, the date the claim record was processed by HCFA's CWFMQA system (used for internal editing purposes).

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

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

SOURCE:
NCH

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

9 DIGITS SIGNED

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

SOURCE:
NCH

25. Claim Total Segment Count	NUM	2	175	176	Effective with Version I, the count used to identify the total number of segments associated with a given claim. Each claim could have up to 10 segments. NOTE: During the Version I conversion, this field was populated with data throughout history (back to service year 1991). For institutional claims, the count for claims prior to 7/00 will be 1 or 2 (1 if 45 or less revenue center lines on a claim and 2 if more than 45 revenue center lines on a claim). For noninstitutional claims, the count will always be 1. 2 DIGITS UNSIGNED DB2 ALIAS: TOT_SGMT_CNT SAS ALIAS: SGMT_CNT STANDARD ALIAS: CLM_TOT_SGMT_CNT TITLE ALIAS: SEGMENT_COUNT SOURCE: CWF
26. Claim Segment Number	NUM	2	177	178	Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim. NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). For institutional claims prior to 7/00, this number will be either 1 or 2. For noninstitutional claims, the number will

always be 1.

2 DIGITS UNSIGNED

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					DB2 ALIAS: CLM_SGMT_NUM SAS ALIAS: SGMT_NUM STANDARD ALIAS: CLM_SGMT_NUM TITLE ALIAS: SEGMENT_NUMBER SOURCE: CWF
27. Claim Total Line Count	NUM	3	179	181	Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim. NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). Prior to Version 'I', the maximum line count will be no more than 58. Effective with Version 'I', the maximum line count could be 450. 3 DIGITS UNSIGNED DB2 ALIAS: TOT_LINE_CNT SAS ALIAS: LINECNT STANDARD ALIAS: CLM_TOT_LINE_CNT TITLE ALIAS: TOTAL_LINE_COUNT SOURCE: CWF
28. Claim Segment Line Count	NUM	2	182	183	Effective with Version I, the count used to identify the number of revenue center lines on a record/segment.

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

2 DIGITS UNSIGNED
DB2 ALIAS: SGMT_LINE_CNT
SAS ALIAS: SGMTLINE
STANDARD ALIAS: CLM_SGMT_LINE_CNT
TITLE ALIAS: SEGMENT_LINE_COUNT

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	FI Claim Common Group	GROUP	359	184	542	Information common to fiscal intermediary (FI) claims (inpatient/SNF, outpatient, HHA & hospice), for version I of NCH Nearline file. STANDARD ALIAS: FI_CLM_CMN_GRP

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
29.	NCH Payment and Edit Record Identification Code	CHAR	1	184	184	The code used for payment and editing purposes that indicates the type of institutional claim record. DB2 ALIAS: PMT_EDIT_RIC_CD SAS ALIAS: PE_RIC STANDARD ALIAS: NCH_PMT_EDIT_RIC_CD TITLE ALIAS: NCH_PAYMENT_EDIT_RIC CODES: C = Inpatient hospital, SNF D = Outpatient E = Religious Nonmedical Health Care Institutions (eff. 8/00 Christian Science, prior to 7/00 F = Home Health Agency (HHA) G = Discharge notice (obsoleted 7/98)

						I = Hospice COMMENT: Prior to Version H this field was named: PMT_EDIT_RIC_CD. SOURCE: NCH QA Process
30.	Claim Transaction Code	CHAR	1	185	185	The code derived by CWF to indicate the type of claim submitted by an institutional provider. DB2 ALIAS: CLM_TRANS_CD SAS ALIAS: TRANS_CD STANDARD ALIAS: CLM_TRANS_CD SYSTEM ALIAS: LTCLTRAN TITLE ALIAS: TRANSACTION_CODE CODES: REFER TO: CLM_TRANS_TB IN THE CODES APPENDIX SOURCE: CWF
****	Claim Bill Type Group	GROUP	2	186	187	Effective with Version H, the claim facility type code plus the claim service classification type code. (The first two positions of the ('type of bill'). During the Version H conversion, this grouping was created throughout history. STANDARD ALIAS: CLM_BILL_TYPE_CD_GRP SYSTEM ALIAS: LTBILLCD CODES: REFER TO: CLM_BILL_TYPE_TB IN THE CODES APPENDIX

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

31. Claim Facility Type Code	CHAR	1	186	186	The first digit of the type of bill (TOB1) submitted on an institutional claim used to identify the type of facility that provided care to the beneficiary. COMMON ALIAS: TOB1 DB2 ALIAS: CLM_FAC_TYPE_CD SAS ALIAS: FAC_TYPE STANDARD ALIAS: CLM_FAC_TYPE_CD TITLE ALIAS: TOB1 CODES: REFER TO: CLM_FAC_TYPE_TB IN THE CODES APPENDIX SOURCE: CWF
32. Claim Service Classification Type Code	CHAR	1	187	187	The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification of the type of service provided to the beneficiary. COMMON ALIAS: TOB2 DB2 ALIAS: SRVC_CLSFCTN_CD SAS ALIAS: TYPESRVC STANDARD ALIAS: CLM_SRVC_CLSFCTN_TYPE_CD TITLE ALIAS: TOB2 CODES: REFER TO: CLM_SRVC_CLSFCTN_TYPE_TB IN THE CODES APPENDIX SOURCE: CWF
33. Claim Frequency Code	CHAR	1	188	188	The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care. COMMON ALIAS: TOB3 DB2 ALIAS: CLM_FREQ_CD SAS ALIAS: FREQ_CD STANDARD ALIAS: CLM_FREQ_CD SYSTEM ALIAS: LTFREQ

TITLE ALIAS: FREQUENCY_CD

CODES:
REFER TO: CLM_FREQ_TB
IN THE CODES APPENDIX

SOURCE:
CWF

34. FILLER CHAR 1 189 189

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
35. NCH MQA Query Patch Code	CHAR	1	190	190	Effective with Version H, a code used (for internal editing purposes) to indicate that the CWFMQA process changed the query code submitted on the claim record. 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: MQA_QUERY_PATCH_CD SAS ALIAS: MQAQUERY STANDARD ALIAS: NCH_MQA_QUERY_PATCH_CD TITLE ALIAS: MQA_QUERY_PATCH_IND CODES: Y = MQA changed bill query code on a action code 6 (force action code 2) bill to a zero. (Eff. 10/12/93) Z = MQA changed bill query code on a action code 4 (cancel only adjustment) bill to zero. (Eff. 5/16/94) SOURCE: NCH QA Process
36. Claim Disposition Code	CHAR	2	191	192	Code indicating the disposition or outcome of the processing of the claim record.

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

CODES:
REFER TO: CLM_DISP_TB
IN THE CODES APPENDIX

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
37.	NCH Edit Disposition Code	CHAR	2	193	194	Effective with Version H, a code used (for internal editing purposes) to indicate the disposition of the claim after editing in the CWFMQA process. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: NCH_EDIT_DISP_CD SAS ALIAS: EDITDISP STANDARD ALIAS: NCH_EDIT_DISP_CD TITLE ALIAS: NCH_EDIT_DISP

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

SOURCE:
NCH QA Process

38. NCH Claim BIC Modify H Code	CHAR	1	195	195	Effective with Version H, the code used (for internal editing purposes) to identify a claim record that was submitted with an incorrect HA, HB, or HC BIC. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: NCH_BIC_MDFY_CD SAS ALIAS: BIC_MDFY STANDARD ALIAS: NCH_CLM_BIC_MDFY_CD TITLE ALIAS: BIC_MODIFY_CD CODES: H = BIC submitted by CWF = HA, HB or HC blank = No HA, HB or HC BIC present SOURCE: NCH QA Process
39. Beneficiary Residence SSA Standard County Code	CHAR	3	196	198	The SSA standard county code of a beneficiary's residence. DA3 ALIAS: SSA_STANDARD_COUNTY_CODE DB2 ALIAS: BENE_SSA_CNTY_CD SAS ALIAS: CNTY_CD STANDARD ALIAS: BENE_RSDNC_SSA_STD_CNTY_CD TITLE ALIAS: BENE_COUNTY_CD EDIT-RULES: OPTIONAL: MAY BE BLANK SOURCE: SSA/EDB
40. FI Claim Receipt Date	NUM	8	199	206	The date the fiscal intermediary received the institutional claim from the provider. 8 DIGITS UNSIGNED

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
						DB2 ALIAS: FI_CLM_RCPT_DT SAS ALIAS: RCPT_DT STANDARD ALIAS: FI_CLM_RCPT_DT TITLE ALIAS: RECEIPT_DT EDIT-RULES: YYYYMMDD COMMENT: Prior to Version H this field was named: FICARR_CLM_RCPT_DT. SOURCE: CWF
41.	FI Claim Scheduled Payment Date	NUM	8	207	214	The scheduled date of payment to the institutional provider, as reflected on the claim record transmitted to the CWF host. Note: This date is considered to be the date paid since no additional information as to the actual payment date is available. 8 DIGITS UNSIGNED DB2 ALIAS: FI_SCHLD_PMT_DT SAS ALIAS: SCHLD_DT STANDARD ALIAS: FI_CLM_SCHLD_PMT_DT TITLE ALIAS: SCHEDULED_PMT_DT EDIT-RULES: YYYYMMDD COMMENT: Prior to Version H this field was named: FICARR_CLM_PMT_DT. SOURCE: CWF
42.	CWF Forwarded Date	NUM	8	215	222	Effective with Version H, the date CWF forwarded the claim

record to HCFA (used for internal editing purposes).

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						SOURCE: CWF
43.	FI Number	CHAR	5	223	227	The identification number assigned by HCFA to a fiscal intermediary authorized to process institutional claim records. DB2 ALIAS: FI_NUM SAS ALIAS: FI_NUM STANDARD ALIAS: FI_NUM SYSTEM ALIAS: LTFI TITLE ALIAS: INTERMEDIARY CODES: REFER TO: FI_NUM_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: FICARR_IDENT_NUM. SOURCE:

						CWF
44.	CWF Claim Assigned Number	CHAR	8	228	235	Effective with Version H, the number assigned to an institutional claim record by CWF (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 spaces in this field. DB2 ALIAS: CWF_CLM_ASGN_NUM SAS ALIAS: ASGN_NUM STANDARD ALIAS: CWF_CLM_ASGN_NUM TITLE ALIAS: ASSIGNED_NUM SOURCE: CWF
45.	CWF Transmission Batch Number	CHAR	4	236	239	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

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
						SOURCE: CWF
46.	Beneficiary Mailing Contact	CHAR	9	240	248	The ZIP code of the mailing address where the

	ZIP Code					beneficiary may be contacted. DB2 ALIAS: BENE_MLG_ZIP_CD SAS ALIAS: BENE_ZIP STANDARD ALIAS: BENE_MLG_CNTCT_ZIP_CD TITLE ALIAS: BENE_ZIP SOURCE: EDB
47.	Beneficiary Sex Identification Code	CHAR	1	249	249	The sex of a beneficiary. COMMON ALIAS: SEX_CD DA3 ALIAS: SEX_CODE DB2 ALIAS: BENE_SEX_IDENT_CD SAS ALIAS: SEX STANDARD ALIAS: BENE_SEX_IDENT_CD SYSTEM ALIAS: LTSEX TITLE ALIAS: SEX_CD EDIT-RULES: REQUIRED FIELD CODES: 1 = Male 2 = Female 0 = Unknown SOURCE: SSA,RRB,EDB
48.	Beneficiary Race Code	CHAR	1	250	250	The race of a beneficiary. DA3 ALIAS: RACE_CODE DB2 ALIAS: BENE_RACE_CD SAS ALIAS: RACE STANDARD ALIAS: BENE_RACE_CD SYSTEM ALIAS: LTRACE TITLE ALIAS: RACE_CD CODES: 0 = Unknown 1 = White

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = North American Native
						SOURCE: SSA
49.	Beneficiary Birth Date	NUM	8	251	258	The beneficiary's date of birth. 8 DIGITS UNSIGNED DB2 ALIAS: BENE_BIRTH_DT SAS ALIAS: BENE_DOB STANDARD ALIAS: BENE_BIRTH_DT TITLE ALIAS: BENE_BIRTH_DATE EDIT-RULES: YYYYMMDD SOURCE: CWF
50.	CWF Beneficiary Medicare Status Code	CHAR	2	259	260	The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM_THRU_DT). COBOL ALIAS: MSC COMMON ALIAS: MSC DB2 ALIAS: BENE_MDCR_STUS_CD SAS ALIAS: MS_CD STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD SYSTEM ALIAS: LTMSC TITLE ALIAS: MSC DERIVATION:

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

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

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

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

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					COMMENT: Prior to Version H this field was named: BENE_MDCR_STUS_CD. The name has been changed to distinguish this CWF-derived field from the EDB-derived MSC (BENE_MDCR_STUS_CD). SOURCE: CWF
51. Claim Patient 6 Position Surname	CHAR	6	261	266	The first 6 positions of the Medicare patient's surname (last name) as reported by the provider on the claim.

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

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

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

SOURCE:
CWF

52. Claim Patient 1st Initial Given Name	CHAR	1	267	267	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

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						SOURCE: CWF
53.	Claim Patient First Initial Middle Name	CHAR	1	268	268	The first initial of the Medicare patient's middle name as reported by the provider on the claim. NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types. NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field. COMMON ALIAS: PATIENT_MIDDLE_NAME DB2 ALIAS: 1ST_INITL_MDL_NAME SAS ALIAS: MDL_INIT STANDARD ALIAS: CLM_PTNT_1ST_INITL_MDL_NAME TITLE ALIAS: PATIENT_MIDDLE_INITIAL SOURCE: CWF
54.	Beneficiary CWF Location Code	CHAR	1	269	269	The code that identifies the Common Working File (CWF) location (the host site) where a beneficiary's Medicare utilization records are maintained. COMMON ALIAS: CWF_HOST DB2 ALIAS: BENE_CWF_LOC_CD SAS ALIAS: CWFLOCCD STANDARD ALIAS: BENE_CWF_LOC_CD SYSTEM ALIAS: LTCWFLOC TITLE ALIAS: CWF_HOST CODES:

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

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
55.	Claim Principal Diagnosis Code	CHAR	5	270	274	The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided. NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer. DB2 ALIAS: PRNCPAL_DGNS_CD SAS ALIAS: PDGNS_CD STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD TITLE ALIAS: PRINCIPAL_DIAGNOSIS EDIT-RULES: ICD-9-CM SOURCE: CWF
56.	FILLER	CHAR	1	275	275	
57.	Claim Medicare Non Payment Reason Code	CHAR	1	276	276	The reason that no Medicare payment is made for services on an institutional claim.

NOTE: Effective with Version I, this field was put on all institutional claim types. Prior to Version I, this field was present only on inpatient/SNF claims.

DB2 ALIAS: MDCR_NPMT_RSN_CD
SAS ALIAS: NOPAY_CD
STANDARD ALIAS: CLM_MDCR_NPMT_RSN_CD
SYSTEM ALIAS: LTNPMT
TITLE ALIAS: NON_PAYMENT_REASON

EDIT-RULES:
OPTIONAL

CODES:
REFER TO: CLM_MDCR_NPMT_RSN_TB
IN THE CODES APPENDIX

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
58.	Claim Excepted/Nonexcepted Medical Treatment Code	CHAR	1	277	277	Effective with Version I, the code used to identify whether or not the medical care or treatment received by a beneficiary, who has elected care from a Religious Nonmedical Health Care Institution (RNHCI), is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is required under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted.

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

CODES:
0 = No Entry

					1 = Excepted 2 = Nonexcepted SOURCE: CWF
59. Claim Payment Amount	PACK	6	278	283	Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. **NOTE: In some situations, a negative claim payment amount may be present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.) Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). It does NOT include the pass thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement. Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center code = '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount. Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total payment. The

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					Medicare payment amount takes into account the wage index adjustment and the beneficiary deductible and coinsurance amounts. NOTE: There is no CWF edit check to validate that the revenue center Medicare payment amount equals the claim level Medicare payment amount.
					Under Home Health PPS, beneficiaries will be classified into an appropriate case mix category known as the Home Health Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG). For the RAP, the PRICER will determine the payment amount appropriate to the HIPPS code by computing 60% (for first episode) or 50% (for subsequent episodes) of the case mix episode payment. The payment is then wage index adjusted. For the final claim, PRICER calculates 100% of the amount due, because the final claim is processed as an adjustment to the RAP, reversing the RAP payment in full. Although final claim will show 100% payment amount, the provider will actually receive the 40% or 50% payment. Exceptions: For claims involving demos and BBA encounter data, the amount reported in this field may not just represent the actual provider payment. For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included. For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO. For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services.

To identify what the conventional provider Part A payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

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

9.2 DIGITS SIGNED

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

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

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

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

SOURCE:
CWF

LIMITATIONS:
Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM_DISP_CD of '02', the amount shown as the Medicare reimbursement does not take into consideration

						any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over or under the actual Medicare payment amount.
60.	NCH Primary Payer Claim Paid Amount	PACK	6	284	289	The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on an institutional, carrier, or DMERC claim. 9.2 DIGITS SIGNED DB2 ALIAS: PRMRY_PYR_PD_AMT SAS ALIAS: PRPAYAMT STANDARD ALIAS: NCH_PRMRY_PYR_CLM_PD_AMT TITLE ALIAS: PRIMARY_PAYER_AMOUNT EDIT-RULES: $$$$$$$$$CC COMMENT: Prior to Version H this field was named: BENE_PRMRY_PYR_CLM_PMT_AMT and the field size was S9(7)V99. SOURCE: NCH
61.	NCH Primary Payer Code	CHAR	1	290	290	The code, on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's health insurance bills. DB2 ALIAS: NCH_PRMRY_PYR_CD SAS ALIAS: PRPAY_CD STANDARD ALIAS: NCH_PRMRY_PYR_CD TITLE ALIAS: PRIMARY_PAYER_CD

			POSITIONS		
NAME	TYPE	LENGTH	BEG	END	CONTENTS

				DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT DERIVATION RULES SET NCH_PRMRY_PYR_CD TO 'A' WHERE THE CLM_VAL_CD = '12' SET NCH_PRMRY_PYR_CD TO 'B' WHERE THE CLM_VAL_CD = '13' SET NCH_PRMRY_PYR_CD TO 'C' WHERE THE CLM_VAL_CD = '16' and CLM_VAL_AMT is zeroes SET NCH_PRMRY_PYR_CD TO 'D' WHERE THE CLM_VAL_CD = '14' SET NCH_PRMRY_PYR_CD TO 'E' WHERE THE CLM_VAL_CD = '15' SET NCH_PRMRY_PYR_CD TO 'F' WHERE THE CLM_VAL_CD = '16' (CLM_VAL_AMT not equal to zeroes) SET NCH_PRMRY_PYR_CD TO 'G' WHERE THE CLM_VAL_CD = '43' SET NCH_PRMRY_PYR_CD TO 'H' WHERE THE CLM_VAL_CD = '41' SET NCH_PRMRY_PYR_CD TO 'I' WHERE THE CLM_VAL_CD = '42' SET NCH_PRMRY_PYR_CD TO 'L' (or prior to 4/97 set code to 'J') WHERE THE CLM_VAL_CD = '47' CODES: REFER TO: BENE_PRMRY_PYR_TB IN THE CODES APPENDIX

						COMMENT: Prior to Version H this field was named: BENE_PRMRY_PYR_CD. SOURCE: NCH
62.	FI Requested Claim Cancel Reason Code	CHAR	1	291	291	The reason that an intermediary requested cancelling a previously submitted institutional claim.

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
						DB2 ALIAS: RQST_CNCL_RSN_CD SAS ALIAS: CANCELCD STANDARD ALIAS: FI_RQST_CLM_CNCL_RSN_CD TITLE ALIAS: CANCEL_CD CODES: REFER TO: FI_RQST_CLM_CNCL_RSN_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: INTRMDRY_RQST_CLM_CNCL_RSN_CD. SOURCE: CWF
63.	FI Claim Action Code	CHAR	1	292	292	The type of action requested by the intermediary to be taken on an institutional claim. DB2 ALIAS: FI_CLM_ACTN_CD SAS ALIAS: ACTIONCD STANDARD ALIAS: FI_CLM_ACTN_CD TITLE ALIAS: ACTION_CD CODES: REFER TO: FI_CLM_ACTN_TB

IN THE CODES APPENDIX

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

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
64.	FI Claim Process Date	NUM	8	293	300	The date the fiscal intermediary completes processing and releases the institutional claim to the CWF host. 8 DIGITS UNSIGNED DB2 ALIAS: FI_CLM_PROC_DT SAS ALIAS: APRVL_DT STANDARD ALIAS: FI_CLM_PROC_DT TITLE ALIAS: FI_PROCESS_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
65.	NCH Provider State Code	CHAR	2	301	302	Effective with Version H, the two position SSA state code where provider facility is located. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). DB2 ALIAS: NCH_PRVDR_STATE_CD SAS ALIAS: PRSTATE STANDARD ALIAS: NCH_PRVDR_STATE_CD TITLE ALIAS: PROVIDER_STATE_CD

						DERIVATION: DERIVED FROM: NCH PRVDR_NUM DERIVATION RULES: SET NCH_PRVDR_STATE_CD TO PRVDR_NUM POS1-2. FOR PRVDR_NUM POS1-2 EQUAL '55 SET NCH_PRVDR_STATE_CD TO '05'. FOR PRVDR_NUM POS1-2 EQUAL '67 SET NCH_PRVDR_STATE_CD TO '45'. FOR PRVDR_NUM POS1-2 EQUAL '68 SET NCH_PRVDR_STATE_CD TO '10'. CODES: REFER TO: GEO_SSA_STATE_TB IN THE CODES APPENDIX SOURCE: NCH
66.	Organization NPI Number	CHAR	10	303	312	A placeholder field (effective with Version H) for storing the NPI assigned to the institutional provider. DB2 ALIAS: ORG_NPI_NUM SAS ALIAS: ORGNPINM STANDARD ALIAS: ORG_NPI_NUM TITLE ALIAS: ORG_NPI SOURCE: CWF
****	Attending Physician ID Group	GROUP	24	313	336	Name and identification numbers associated with the primary care physician. STANDARD ALIAS: ATNDG_PHYSN_ID_GRP
67.	Claim Attending Physician UPIN Number	CHAR	6	313	318	On an institutional claim, the unique physician identification number (UPIN) of the physician who would normally be expected to certify and recertify the medical necessity of the services

rendered and/or who has primary responsibility for the beneficiary's medical care and treatment (attending physician).

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						COMMON ALIAS: ATTENDING_PHYSICIAN_UPIN DB2 ALIAS: ATNDG_UPIN SAS ALIAS: AT_UPIN STANDARD ALIAS: CLM_ATNDG_PHYSN_UPIN_NUM TITLE ALIAS: ATTENDING_PHYSICIAN COMMENT: Prior to Version H this field was named: CLM_PRMRY_CARE_PHYSN_IDENT_NUM and contained 10 positions (6-position UPIN and 4-position physician surname). SOURCE: CWF
68.	Claim Attending Physician NPI Number	CHAR	10	319	328	A placeholder field (effective with Version H) for storing the NPI assigned to the attending physician. COMMON ALIAS: ATTENDING_PHYSICIAN_NPI DB2 ALIAS: ATNDG_NPI SAS ALIAS: AT_NPI STANDARD ALIAS: CLM_ATNDG_PHYSN_NPI_NUM TITLE ALIAS: ATNDG_NPI SOURCE: CWF
69.	Claim Attending Physician Surname	CHAR	6	329	334	Effective with Version H, the last name of the attending physician (used for internal editing purpose in 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: ATNDG_SRNM SAS ALIAS: AT_SRNM STANDARD ALIAS: CLM_ATNDG_PHYSN_SRNM_NAME TITLE ALIAS: ANDG_PHYSN_SURNAME SOURCE: CWF
70.	Claim Attending Physician Given Name	CHAR	1	335	335	Effective with Version H, the first name of the attending physician (used for internal editing purposes in 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.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						DB2 ALIAS: ATNDG_GVN_NAME SAS ALIAS: AT_GVNNM STANDARD ALIAS: CLM_ATNDG_PHYSN_GVN_NAME TITLE ALIAS: ATNDG_PHYSN_FIRSTNAME SOURCE: CWF
71.	Claim Attending Physician Middle Initial Name	CHAR	1	336	336	Effective with Version H, the middle initial of the attending physician (used for internal editing purposes in 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: ATNDG_MI_NAME SAS ALIAS: AT_MDL STANDARD ALIAS: CLM_ATNDG_PHYSN_MDL_INITL_NAME TITLE ALIAS: ATNDG_PHYSN_MI SOURCE: CWF
****	Operating Physician ID Group	GROUP	24	337	360	Name and identification numbers associated with the physician who performed the principal procedure. STANDARD ALIAS: OPRTG_PHYSN_ID_GRP
72.	Claim Operating Physician UPIN Number	CHAR	6	337	342	On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgi-cal procedure. DB2 ALIAS: OPRTG_UPIN SAS ALIAS: OP_UPIN STANDARD ALIAS: CLM_OPRTG_PHYSN_UPIN_NUM TITLE ALIAS: OPRTG_UPIN COMMENT: Prior to Version H this field was named: CLM_PRNCPAL_PRCDR_PHYSN_NUM and contained 10 positions (6-position UPIN and 4-position physician surname. NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces.

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS

					SOURCE: CWF
73. Claim Operating Physician NPI Number	CHAR	10	343	352	A placeholder field (effective with Version H) for storing the NPI assigned to the operating physician. DB2 ALIAS: OPRTG_NPI SAS ALIAS: OP_NPI STANDARD ALIAS: CLM_OPRTG_PHYSN_NPI_NUM TITLE ALIAS: OPRTG_NPI SOURCE: CWF
74. Claim Operating Physician Surname	CHAR	6	353	358	Effective with Version H, the last name of the operating physician (used for internal editing purposes in HCFA's CWFMQA system.) NOTE: Beginning with the 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: OPRTG_SRNM SAS ALIAS: OP_SRNM STANDARD ALIAS: CLM_OPRTG_PHYSN_SRNM_NAME TITLE ALIAS: OPRTG_PHYSN_SURNAME SOURCE: CWF
75. Claim Operating Physician Given Name	CHAR	1	359	359	Effective with Version H, the first name of the operating physician (used for internal editing purposes in 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: OPRTG_GVN_NAME

						SAS ALIAS: OP_GVN STANDARD ALIAS: CLM_OPRTG_PHYSN_GVN_NAME TITLE ALIAS: OPRTG_PHYSN_FIRSTNAME SOURCE: CWF
76.	Claim Operating Physician Middle Initial Name	CHAR	1	360	360	Effective with Version H, the middle initial of the operating physician (used for internal editing purposes in HCFA's CWFMQA system.)

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: OPRTG_MI_NAME SAS ALIAS: OP_MDL STANDARD ALIAS: CLM_OPRTG_PHYSN_MDL_INITL_NAME TITLE ALIAS: OPRTG_PHYSN_MI SOURCE: CWF
****	Other Physician ID Group	GROUP	24	361	384	Name and identification numbers associated with the other physician. STANDARD ALIAS: OTHR_PHYSN_ID_GRP
77.	Claim Other Physician UPIN Number	CHAR	6	361	366	On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim. DB2 ALIAS: OTHR_UPIN SAS ALIAS: OT_UPIN STANDARD ALIAS: CLM_OTHR_PHYSN_UPIN_NUM

						TITLE ALIAS: OTH_PHYSN_UPIN COMMENT: Prior to Version H this field was named: CLM_OTHR_PHYSN_IDENT_NUM and contained 10 positions (6-position UPIN and 4-position other physician surname). NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces. SOURCE: CWF
78.	Claim Other Physician NPI Number	CHAR	10	367	376	A placeholder field (effective with Version H for storing the NPI assigned to the other physician. DB2 ALIAS: OTHR_NPI SAS ALIAS: OT_NPI STANDARD ALIAS: CLM_OTHR_PHYSN_NPI_NUM SOURCE: CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
79.	Claim Other Physician Surname	CHAR	6	377	382	Effective with Version H, the last name of the other physician (used for internal editing purposes in HCFA's CWFMQA system.) NOTE: Beginning with the 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: OTHR_SRNM

						SAS ALIAS: OT_SRNM STANDARD ALIAS: CLM_OTHR_PHYSN_SRNM_NAME TITLE ALIAS: OTH_PHYSN_SURNAME SOURCE: CWF
80.	Claim Other Physician Given Name	CHAR	1	383	383	Effective with Version H, the first name of the other physician (used for internal editing purposes in 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: OTHR_GVN_NAME SAS ALIAS: OT_GVN STANDARD ALIAS: CLM_OTHR_PHYSN_GVN_NAME TITLE ALIAS: OTH_PHYSN_FIRSTNAME SOURCE: CWF
81.	Claim Other Physician Middle Initial Name	CHAR	1	384	384	Effective with Version H, the middle initial of the other physician (used for internal editing purposes in 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: OTHR_MI_NAME SAS ALIAS: OT_MDL STANDARD ALIAS: CLM_OTHR_PHYSN_MDL_INITL_NAME TITLE ALIAS: OTH_PHYSN_MI SOURCE: CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
82.	Medicaid Provider Identification Number	CHAR	13	385	397	A unique identification number assigned to each provider by the state Medicaid agency. This unique provider number is used to ensure proper payment of providers and to maintain claims history on individual providers for surveillance and utilization review. DB2 ALIAS: MDCD_PRVDR_NUM SAS ALIAS: MDCD_PRV STANDARD ALIAS: MDCD_PRVDR_IDENT_NUM TITLE ALIAS: MEDICAID_PROVIDER COMMENT: Prior to Version H the field size was X(12). SOURCE: CWF
83.	Claim Medicaid Information Code	CHAR	4	398	401	Effective with Version G, code identifying Medicaid information supplied by the contractor to Medicaid. DB2 ALIAS: CLM_MDCD_INFO_CD SAS ALIAS: MDCDINFO STANDARD ALIAS: CLM_MDCD_INFO_CD TITLE ALIAS: MEDICAID_INFO SOURCE: CWF
84.	Claim MCO Paid Switch	CHAR	1	402	402	A switch indicating whether or not a Managed Care Organization (MCO) has paid the provider for an institutional claim. COBOL ALIAS: MCO_PD_IND DB2 ALIAS: CLM_MCO_PD_SW SAS ALIAS: MCOPDSW STANDARD ALIAS: CLM_MCO_PD_SW TITLE ALIAS: MCO_PAID_SW CODES:

1 = MCO has paid the provider for a claim
Blank or 0 = MCO has not paid the provider
for a claim

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

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
85.	Claim Treatment Authorization Number	CHAR	18	403	420	The number assigned by the medical reviewer and reported by the provider to identify the medical review (treatment authorization) action taken after review of the beneficiary's case. It designates that treatment covered by the bill has been authorized by the payer. This number is used by the intermediary and the Peer Review Organization. NOTE: Under HH PPS this field will be used to link claims to the OASIS assessment used as the basis of payment. This eighteen character string consists of the start of care date, the OASIS assessment date and the two digit reason for assessment code. COMMON ALIAS: TAN DB2 ALIAS: TRTMT_AUTHRZTN_NUM SAS ALIAS: AUTHRZTN STANDARD ALIAS: CLM_TRTMT_AUTHRZTN_NUM TITLE ALIAS: TREATMENT_AUTHORIZATION SOURCE: CWF
86.	Patient Control Number	CHAR	20	421	440	The unique alphanumeric identifier assigned by the

						provider to the institutional claim to facilitate retrieval of individual case records and posting of payments. DB2 ALIAS: PTNT_CNTL_NUM SAS ALIAS: PTNTCNTL STANDARD ALIAS: PTNT_CNTL_NUM TITLE ALIAS: PATIENT_CONTROL_NUM SOURCE: CWF
87.	Claim Medical Record Number	CHAR	17	441	457	The number assigned by the provider to the beneficiary's medical record to assist in record retrieval. DB2 ALIAS: CLM_MDCL_REC_NUM SAS ALIAS: MDCL_REC STANDARD ALIAS: CLM_MDCL_REC_NUM TITLE ALIAS: MEDICAL_RECORD_NUM SOURCE: CWF
88.	Claim PRO Control Number	CHAR	12	458	469	Effective with Version G, the unique identifier assigned by the Peer Review Organization (PRO) for control purposes.

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
						DB2 ALIAS: CLM_PRO_CNTL_NUM SAS ALIAS: PRO_CNTL STANDARD ALIAS: CLM_PRO_CNTL_NUM TITLE ALIAS: PRO_CONTROL_NUM SOURCE: CWF
89.	Claim PRO Process Date	NUM	8	470	477	Effective with Version H, the date the claim was

					used in the PRO review 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 zeroes in this field. 8 DIGITS UNSIGNED DB2 ALIAS: CLM_PRO_PROC_DT SAS ALIAS: PRO_DT STANDARD ALIAS: CLM_PRO_PROC_DT TITLE ALIAS: PRO_PROC_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
90. Patient Discharge Status Code	CHAR	2	478	479	The code used to identify the status of the patient as of the CLM_THRU_DT. COMMON ALIAS: DISCHARGE_DESTINATION/PATIENT_STATUS DB2 ALIAS: PTNT_DSCHRG_STUS SAS ALIAS: STUS_CD STANDARD ALIAS: PTNT_DSCHRG_STUS_CD SYSTEM ALIAS: LTCLMST TITLE ALIAS: PTNT_DSCHRG_STUS_CD CODES: REFER TO: PTNT_DSCHRG_STUS_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CLM_STUS_CD. SOURCE: CWF
91. Claim Diagnosis E Code	CHAR	5	480	484	Effective with Version H, the ICD-9-CM code used to identify the external cause of injury, poisoning, or other adverse affect. Redundantly

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						this field is also stored as the last occurrence of the diagnosis trailer.
						NOTE: During the Version H conversion, the data in the last occurrence of the diagnosis trailer was used to populate history. DB2 ALIAS: CLM_DGNS_E_CD SAS ALIAS: DGNS_E STANDARD ALIAS: CLM_DGNS_E_CD TITLE ALIAS: DGNS_E_CD SOURCE: CWF
92.	FILLER	CHAR	1	485	485	
93.	Claim PPS Indicator Code	CHAR	1	486	486	Effective with Version H, the code indicating whether or not the (1) claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee (MQGE). NOTE: Beginning with NCH weekly process date 10/3/97 through 5/29/98, this field was pop-ulated with only the PPS indicator. Beginning with NCH weekly process date 6/5/98, this field was additionally populated with the deemed MQGE indicator. Claims processed prior to 10/3/97 will contain spaces. COBOL ALIAS: PPS_IND DB2 ALIAS: CLM_PPS_IND_CD SAS ALIAS: PPS_IND STANDARD ALIAS: CLM_PPS_IND_CD TITLE ALIAS: PPS_IND CODES:

REFER TO: CLM_PPS_IND_TB
IN THE CODES APPENDIX

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
94.	Claim Total Charge Amount	PACK	6	487	492	Effective with Version G, the total charges for all services included on the institutional claim. This field is redundant with revenue center code 0001/total charges. 9.2 DIGITS SIGNED DB2 ALIAS: CLM_TOT_CHRG_AMT SAS ALIAS: TOT_CHRG STANDARD ALIAS: CLM_TOT_CHRG_AMT TITLE ALIAS: CLAIM_TOTAL_CHARGES COMMENT: Prior to Version H the size of this field was S9(7)V99.

SOURCE:
CWF

95.	FILLER	CHAR	50	493	542	
96.	HHA NCH Edit Code Count	NUM	2	543	544	The count of the number of edit codes annotated to the HHA claim during the HCFA's CWFMQA process. The purpose of this count is to indicate how many claim edit trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_EDIT_CD_CNT SAS ALIAS: HHEDCNT STANDARD ALIAS: HHA_NCH_EDIT_CD_CNT

						COMMENT: Prior to Version H this field was named: CLM_EDIT_CD_CNT. SOURCE: NCH
97.	HHA NCH Patch Code Count	NUM	2	545	546	Effective with Version H, the count of the number of HCFA patch codes annotated to the home health claim during the Nearline maintenance process. The purpose of this count is to indicate how many NCH patch trailers are present. NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991). NOTE2: Effective with Version 'I' the number of possible occurrences was reduced to 30. Prior to Version 'I' the number of possible occurrences was 99. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_PATCH_CD_CNT SAS ALIAS: HHPATCNT STANDARD ALIAS: HHA_NCH_PATCH_CD_I_CNT SOURCE: NCH
98.	HHA MCO Period Count	NUM	1	547	547	Effective with Version H, the count of the number of Managed Care Organization (MCO) periods reported on an home health agency claim. The purpose of this count is to indicate how many MCO period trailers are present.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

						NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 1 DIGIT UNSIGNED DB2 ALIAS: HHA_MCO_PRD_CNT SAS ALIAS: HHMCOCNT STANDARD ALIAS: HHA_MCO_PRD_CNT EDIT-RULES: RANGE: 0 TO 2 SOURCE: NCH
99.	HHA Claim Health PlanID Count	NUM	1	548	548	A placeholder field (effective with Version H) for storing the count of the number of Health PlanIDs reported on the HHA 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: HHA_CLM_PAYERID_CNT. 1 DIGIT UNSIGNED DB2 ALIAS: HHA_PLANID_CNT SAS ALIAS: HHPLANNT STANDARD ALIAS: HHA_CLM_HLTH_PLANID_CNT EDIT-RULES: RANGE: 0 TO 3 SOURCE: NCH
100.	HHA Claim Demonstration ID Count	NUM	1	549	549	Effective with Version H, the count of the number of claim demonstration IDs reported on an HHA claim. The purpose of this count is to indicate how many claim demonstration trailers are present.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						NOTE: During the Version H conversion this field was populated with data where a demo was identifiable. 1 DIGIT UNSIGNED DB2 ALIAS: HHA_DEMO_ID_CNT SAS ALIAS: HHDEMCNT STANDARD ALIAS: HHA_CLM_DEMO_ID_CNT EDIT-RULES: RANGE: 0 TO 5
101.	HHA Claim Diagnosis Code Count	NUM	2	550	551	The count of the number of diagnosis codes (both principal and other) reported on an HHA claim. The purpose of this count is to indicate how many claim diagnosis trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_DGNS_CD_CNT SAS ALIAS: HHDGNCNT STANDARD ALIAS: HHA_CLM_DGNS_CD_CNT EDIT-RULES: RANGE: 0 TO 10 COMMENT: Prior to Version H this field was named: CLM_OTHR_DGNS_CD_CNT and the principal was not included in the count. SOURCE: NCH

102.	FILLER	CHAR	2	552	553	
103.	HHA Claim Related Condition Code Count	NUM	2	554	555	The count of the number of condition codes reported on an HHA claim. The purpose of this count is to indicate how many condition code trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_COND_CD_CNT SAS ALIAS: HHCONCNT STANDARD ALIAS: HHA_CLM_RLT_COND_CD_CNT EDIT-RULES: RANGE: 0 TO 30 COMMENT: Prior to Version H this field was named: CLM_RLT_COND_CD_CNT. SOURCE: NCH
104.	HHA Claim Related Occurrence Code Count	NUM	2	556	557	The count of the number of occurrence codes reported on an HHA claim. The purpose of this count is to indicate how many occurrence code trailers are present. 2 DIGITS UNSIGNED

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					DB2 ALIAS: HHA_RLT_OCRNC_CNT SAS ALIAS: HHOCRCNT STANDARD ALIAS: HHA_CLM_RLT_OCRNC_CD_CNT EDIT-RULES: RANGE: 0 TO 30

						COMMENT: Prior to Version H this field was named: CLM_RLT_OCRNC_CD_CNT. SOURCE: NCH
105.	HHA Claim Occurrence Span Code Count	NUM	2	558	559	The count of the number of occurrence span codes reported on an HHA claim. The purpose of the count is to indicate how many span code trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_OCRNC_SPAN_CNT SAS ALIAS: HHSPNCNT STANDARD ALIAS: HHA_CLM_OCRNC_SPAN_CD_CNT COMMENT: Prior to Version H this field was named: CLM_OCRNC_SPAN_CD_CNT. SOURCE: NCH
106.	HHA Claim Value Code Count	NUM	2	560	561	The count of the number of value codes reported on an HHA claim. The purpose of the count is to indicate how many value code trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_CLM_VAL_CD_CNT SAS ALIAS: HHVALCNT STANDARD ALIAS: HHA_CLM_VAL_CD_CNT EDIT-RULES: RANGE: 0 TO 36 COMMENT: Prior to Version H this field was named: CLM_VAL_CD_CNT.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						SOURCE: NCH
107.	HHA Revenue Center Code Count	NUM	2	562	563	The count of the number of revenue codes reported on an HHA claim. The purpose of the count is to indicate how many revenue center trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: HHA_REV_CNTR_CNT SAS ALIAS: HHREVCNT STANDARD ALIAS: HHA_REV_CNTR_CD_I_CNT EDIT-RULES: RANGE: 0 TO 45 COMMENT: Prior to Version H this field was named: CLM_REV_CNTR_CD_CNT. NOTE: During the Version 'I' conversion the number of occurrences changed to 45 (per segment - 450 total for claim). For claims prior to Version 'I' the number of occurrences was 58. SOURCE: NCH
108.	FILLER	CHAR	4	564	567	
****	FI HHA Claim Specific Group	GROUP	52	568	619	Data pertaining only to fiscal intermediary HHA claims. STANDARD ALIAS: FI_HHA_CLM_SPECF_GRP
109.	Claim HHA Low Utilization	CHAR	1	568	568	Effective with Version I, the code used

	Payment Adjustment (LUPA) Indicator Code				to identify those Home Health PPS claims that have 4 visits or less in a 60-day episode. If an HHA provides 4 visits or less, they will be reimbursed based on a national standardized per visit rate instead of HHRGs. NOTE: Beginning 10/1/00, this field will be populated with data. Claims processed prior to 10/1/00 will contain spaces. DB2 ALIAS: HHA_LUPA_IND_CD SAS ALIAS: LUPAIND STANDARD ALIAS: CLM_HHA_LUPA_IND_CD TITLE ALIAS: HHA_TOT_VISITS CODES: L = LUPA Claim blank = Not a LUPA claim SOURCE: CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
110.	Claim HHA Referral Code	CHAR	1	569	569	Effective with Version 'I', the code used to identify the means by which the beneficiary was referred for Home Health services. NOTE: Beginning 10/1/00, this field will be populated with data. Claims processed prior to 10/1/00 will contain spaces in this field. DB2 ALIAS: CLM_HHA_RFRL_CD SAS ALIAS: HHA_RFRL STANDARD ALIAS: CLM_HHA_RFRL_CD SYSTEM ALIAS: LTHRFRL TITLE ALIAS: HHA_REFERRAL_CODE CODES:

REFER TO: CLM_HHA_RFRL_TB
IN THE CODES APPENDIX

SOURCE:
CWF

111. Claim HHA Total Visit Count	PACK	2	570	571	Effective with Version H, the count of the number of HHA visits as derived by CWF. NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991) using the CWF derivation rule (units associated with revenue center codes 042X, 043X, 044X, 055X, 056X, 057X, 058X and 059X. Value '999' will be displayed if the sum of the revenue center unit count equals or exceeds '999'. NOTE2: Effective 7/1/99, all HHA claims received with service from dates 7/1/99 and after will be processed as if the units field contains the 15 minute interval count; and each visit revenue code line item will be counted as ONE visit. This field is calculated correctly; but those users who derive the count themselves they will have to revise their routine. NO LONGER IS THE COUNT DERIVED BY ADDING UP THE UNITS FIELDS ASSOCIATED WITH THE HHA VISIT REVENUE CODES. 3 DIGITS SIGNED DB2 ALIAS: HHA_TOT_VISIT_CNT SAS ALIAS: VISITCNT STANDARD ALIAS: CLM_HHA_TOT_VISIT_CNT TITLE ALIAS: HHA_TOT_VISITS SOURCE: CWF

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

112.	NCH Qualified Stay From Date	NUM	8	572	579	Effective with Version H, the beginning date of the beneficiary's qualifying stay (used for internal CWFMQA editing purposes). For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization to benefits. For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission is other than 'A'. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). 8 DIGITS UNSIGNED DB2 ALIAS: QLFY_STAY_FROM_DT SAS ALIAS: QLFYFROM STANDARD ALIAS: NCH_QLFY_STAY_FROM_DT TITLE ALIAS: QLFYG_STAY_FROM_DT EDIT-RULES: YYYYMMDD DERIVATION: DERIVED FROM: CLM_OCRNC_SPAN_CD CLM_OCRNC_SPAN_FROM_DT DERIVATION RULES: Based on the presence of occurrence code 70 move the related occurrence from date to NCH_QLFY_STAY_FROM_DT. SOURCE: NCH QA Process
113.	NCH Qualify Stay Through Date	NUM	8	580	587	Effective with Version H, the ending date of the beneficiary's qualifying stay (used for internal CWFMQA editing purposes.) For inpatient claims, the date relates to the PPS portion of the inlier for

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						which there is no utilization to benefits. For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission is other than 'A'. NOTE: During the Version H, conversion this field was populated with data throughout history (back to service year 1991). 8 DIGITS UNSIGNED
						DB2 ALIAS: QLFY_STAY_THRU_DT SAS ALIAS: QLFYTHRU STANDARD ALIAS: NCH_QLFY_STAY_THRU_DT TITLE ALIAS: QLFYG_STAY_THRU_DT EDIT-RULES: YYYYMMDD DERIVATION: DERIVED FROM: CLM_OCRNC_SPAN_CD CLM_OCRNC_SPAN_THRU_DT DERIVATION RULES: Based on the presence of occurrence code 70 move the related occurrence thru date to NCH_QLFY_STAY_THRU_DT. SOURCE: NCH QA Process
114.	NCH Beneficiary Discharge Date	NUM	8	588	595	Effective with Version H, on an inpatient and HHA claim, the date the beneficiary was discharged from the facility or died (used for internal CWFMQA

editing purposes.)

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

8 DIGITS UNSIGNED

DB2 ALIAS: NCH_BENE_DSCHRG_DT
SAS ALIAS: DSCHRGDT
STANDARD ALIAS: NCH_BENE_DSCHRG_DT
TITLE ALIAS: DISCHARGE_DT

EDIT-RULES:
YYYYMMDD

DERIVATION:
DERIVED FROM:
NCH_PTNT_STUS_IND_CD
CLM_THRU_DT

DERIVATION RULES:
Based on the presence of patient discharge status code not equal to 30 (still patient), move the claim thru date to the NCH_BENE_DSCHRG_DT.

SOURCE:
NCH QA Process

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
115.	Claim HHA Care Start Date	NUM	8	596	603	Effective with Version H, the date care started for the HHA services reported on the institutional claim with a from date greater than 3/31/98. The Balanced Budget Act (BBA) required that this field be present on all HHA claims. NOTE1: Beginning with NCH weekly process date 4/3/98, this field was populated with data.

						Claims processed prior to 4/3/98 will contain zeroes in this field. NOTE2: Effective with Version 'I', the start of care date will be moved from the 1st eight positions of the Claim Treatment Authorization Number. Prior to Version 'I' this date was moved from Occurrence Code 27 date field. 8 DIGITS UNSIGNED DB2 ALIAS: HHA_CARE_STRT_DT SAS ALIAS: HHSTRTDT STANDARD ALIAS: CLM_HHA_CARE_STRT_DT TITLE ALIAS: HHA_CARE_START_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
116.	FILLER	CHAR	16	604	619	
****	FI HHA Claim Variable Group	GROUP	VAR			Variable portion of the fiscal intermediary HHA claim record for version I of the NCH. STANDARD ALIAS: FI_HHA_CLM_VAR_GRP
****	NCH Edit Group	GROUP	5			The number of claim edit trailers is determined by the claim edit code count. OCCURS: UP TO 13 TIMES DEPENDING ON HHA_NCH_EDIT_CD_CNT STANDARD ALIAS: NCH_EDIT_GRP
117.	NCH Edit Trailer Indicator Code	CHAR	1			Effective with Version H, the code indicating the presence of an NCH edit trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						DB2 ALIAS: EDIT_TRLR_IND_CD SAS ALIAS: EDITIND STANDARD ALIAS: NCH_EDIT_TRLR_IND_CD
						CODES: E = Edit code trailer present SOURCE: NCH QA Process
118.	NCH Edit Code	CHAR	4			The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies. NOTE: Prior to Version H only the highest priority code was stored. Beginning 11/98 up to 13 edit codes may be present. COMMON ALIAS: QA_ERROR_CODE DB2 ALIAS: NCH_EDIT_CD SAS ALIAS: EDIT_CD STANDARD ALIAS: NCH_EDIT_CD TITLE ALIAS: QA_ERROR_CD CODES: REFER TO: NCH_EDIT_TB IN THE CODES APPENDIX SOURCE: NCH QA EDIT PROCESS
****	NCH Patch Group	GROUP	11			OCCURS: UP TO 30 TIMES DEPENDING ON HHA_NCH_PATCH_CD_I_CNT STANDARD ALIAS: NCH_PATCH_GRP
119.	NCH Patch Trailer Indicator	CHAR	1			Effective with Version H, the code indicating

	Code				the presence of an NCH patch trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). DB2 ALIAS: PATCH_TRLR_IND_CD SAS ALIAS: PATCHIND STANDARD ALIAS: NCH_PATCH_TRLR_IND_CD CODES: P = Patch code trailer present SOURCE: NCH
120.	NCH Patch Code	CHAR	2		Effective with Version H, the code annotated to the claim indicating a patch was applied to the record during an NCH Nearline record conversion and/or during current processing.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						NOTE: Prior to Version H this field was located in the third and fourth occurrence of the CLM_EDIT_CD. DB2 ALIAS: NCH_PATCH_CD SAS ALIAS: PATCHCD STANDARD ALIAS: NCH_PATCH_CD TITLE ALIAS: NCH_PATCH CODES: REFER TO: NCH_PATCH_TB IN THE CODES APPENDIX SOURCE: NCH

121.	NCH Patch Applied Date	NUM	8	Effective with Version H, the date the NCH patch was applied to the claim. 8 DIGITS UNSIGNED DB2 ALIAS: NCH_PATCH_APPLY_DT SAS ALIAS: PATCHDT STANDARD ALIAS: NCH_PATCH_APPLY_DT TITLE ALIAS: NCH_PATCH_DT EDIT-RULES: YYYYMMDD SOURCE: NCH
****	MCO Period Group	GROUP	37	The number of managed care organization (MCO) period data trailers present is determined by the claim MCO period trailer count. This field reflects the two most current MCO periods in the CWF beneficiary history record. It may have no connection to the services on the claim. OCCURS: UP TO 2 TIMES DEPENDING ON HHA_MCO_PRD_CNT STANDARD ALIAS: MCO_PRD_GRP
122.	NCH MCO Trailer Indicator Code	CHAR	1	Effective with Version H, the code indicating the presence of a Managed Care Organization (MCO) trailer. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

			COBOL ALIAS: MCO_IND DB2 ALIAS: MCO_TRLR_IND_CD SAS ALIAS: MCOIND STANDARD ALIAS: NCH_MCO_TRLR_IND_CD TITLE ALIAS: MCO_INDICATOR CODES: M = MCO trailer present SOURCE: NCH QA Process
123. MCO Contract Number	CHAR	5	Effective with Version H, this field represents the plan contract number of the Managed Care Organization (MCO). NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: MCO_CNTRCT_NUM SAS ALIAS: MCONUM STANDARD ALIAS: MCO_CNTRCT_NUM TITLE ALIAS: MCO_NUM SOURCE: CWF
124. MCO Option Code	CHAR	1	Effective with Version H, the code indicating Managed Care Organization (MCO) lock-in enrollment status of the beneficiary. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: MCO_OPTN_CD SAS ALIAS: MCOOPTN STANDARD ALIAS: MCO_OPTN_CD TITLE ALIAS: MCO_OPTION_CD

CODES:
*****For lock-in beneficiaries****
A = HCFA to process all provider bills
B = MCO to process only in-plan
C = MCO to process all Part A and Part B bills

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

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
125. MCO Period Effective Date	NUM	8			SOURCE: CWF Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) became effective. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 8 DIGITS UNSIGNED DB2 ALIAS: MCO_PRD_EFCTV_DT SAS ALIAS: MCOEFFDT STANDARD ALIAS: MCO_PRD_EFCTV_DT TITLE ALIAS: MCO_PERIOD_EFF_DT EDIT-RULES: YYYYMMDD SOURCE: CWF

126. MCO Period Termination Date	NUM	8		Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) was terminated. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 8 DIGITS UNSIGNED DB2 ALIAS: MCO_PRD_TRMNTN_DT SAS ALIAS: MCOTRMDT STANDARD ALIAS: MCO_PRD_TRMNTN_DT TITLE ALIAS: MCO_PERIOD_TERM_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
127. MCO Health PLANID Number	CHAR	14		A placeholder field (effective with Version H) for storing the Health PlanID associated with the Managed Care Organization (MCO). Prior to Version 'I' this field was named: MCO_PAYERID_NUM.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					DB2 ALIAS: MCO_PLANID_NUM SAS ALIAS: MCOPLNID STANDARD ALIAS: MCO_HLTH_PLANID_NUM TITLE ALIAS: MCO_PLANID COMMENT: Prior to Version I this field was named: MCO_PAYERID_NUM.

				SOURCE: CWF
****	Claim Health PlanID Group	GROUP	16	The number of Health PlanID data trailers is determined by the claim Health PlanID trailer count. Prior to Version 'I' this field was named: CLM_PAYERID_GRP. OCCURS: UP TO 3 TIMES DEPENDING ON HHA_CLM_HLTH_PLANID_CNT STANDARD ALIAS: CLM_HLTH_PLANID_GRP
128.	NCH Health PlanID Trailer Indicator Code	CHAR	1	A placeholder field (effective with Version H) for storing the code that indicates the presence of a Health PlanID trailer. NOTE: Prior to Version 'I' this field was named: NCH_PAYERID_TRLR_IND_CD. DB2 ALIAS: PLANID_TRLR_CD SAS ALIAS: PLANIDIN STANDARD ALIAS: NCH_HLTH_PLANID_TRLR_IND_CD CODES: I = Health PlanID trailer present COMMENT: Prior to Version I this field was named: NCH_PAYERID_TRLR_IND_CD. SOURCE: NCH
129.	Claim Health PlanID Code	CHAR	1	A placeholder field (effective with Version H) for storing the code identifying the type of Health PlanID. Prior to Version 'I' this field was named: CLM_PAYERID-CD DB2 ALIAS: CLM_PLANID_CD SAS ALIAS: PLANIDCD STANDARD ALIAS: CLM_HLTH_PLANID_CD TITLE ALIAS: PLANID_TYPE

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						CODES: 1 = Medicare Secondary Payer 2 = Medicaid 3 = Medigap 4 = Supplemental Insurer 5 = Managed Care Organization COMMENT: Prior to Version I this field was named: CLM_PAYERID_CD. SOURCE: CWF
130.	Claim Health PlanID Number	CHAR	14			A placeholder field (effective with Version H) for storing the Health PlanID number. Prior to Version 'I' this field was named: CLM_PAYERID_NUM. DB2 ALIAS: CLM_PLANID_NUM SAS ALIAS: PLANID STANDARD ALIAS: CLM_HLTH_PLANID_NUM TITLE ALIAS: PLANID COMMENT: Prior to Version I this field was named: CLM_PAYERID_NUM. SOURCE: CWF
****	Claim Demonstration Identification Group	GROUP	18			The number of demonstration identification trailers present is determined by the claim demonstration identification trailer count. OCCURS: UP TO 5 TIMES DEPENDING ON HHA_CLM_DEMO_ID_CNT

STANDARD ALIAS: CLM_DEMO_ID_GRP

131. NCH Demonstration Trailer Indicator Code — CHAR, 1

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

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

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

CODES:
D = Demo trailer present

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

SOURCE:
NCH

132. Claim Demonstration Identification Number — CHAR, 2

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

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

01 = Nursing Home Case-Mix and Quality: NHCMQ (RUGS) Demo -- testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and

actual resources used. The claims carry a RUGS indicator and one or more revenue center codes in the 9,000 series.

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

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

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

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

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

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

03 = Telemedicine Demo -- testing covering traditionally noncovered physician services for medical consultation furnished via two-way, interactive video systems (i.e. teleconsultation)

in 4 states. The claims contain line items with 'QQ' HCPCS code.

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

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

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

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

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

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

NOTE2: During the Version H conversion, Demo ID '05' was populated back to NCH weekly process

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					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 parti-cipating hospitals. Demo ID '06' will end once Demo ID '07' is implemented.
					NOTE2: During the Version H conversion, any claims where Medicare is the primary payer that were not already identified as Demo ID '06' (stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4, Version G) were annotated based on the follow-ing criteria: Inpatient - presence of DRG '106' or '107' and a provider number=220897, 150897, 380897,450897,110082,230156 or 360085 for specified service dates; noninstitutional - presence of HCPCS modifier (initial and/or

second) = 'Q2' and a carrier number =00700/31143
00630,01380,00900,01040/00511,00710,00623, or
13630 for specified service dates.

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

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

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

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

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

NOT TRANSMIT TO HCFA (not in Nearline File).

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

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

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

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

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

NOTE: Effective October, 2000 for carrier claims.

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

SOURCE:
CWF

133. Claim Demonstration CHAR 15 Effective with Version H, the text field that

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
Information Text					contains related demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field. NOTE: During the Version H conversion this field was populated with data throughout history.

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

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

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

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

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

						Demo ID = 05 (CHOICES) -- the text field will 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'.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						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
****	Claim Diagnosis Group	GROUP	7			The number of claim diagnosis trailers is determined by the claim diagnosis code count. The principal diagnosis is the first occurrence. The 'E' code (ICD-9-CM code for the external cause

				of an injury, poisoning, or adverse affect) is stored as the last occurrence. The principal diagnosis and the 'E' code are also stored (redundantly) in the fixed portion of the record. NOTE: Prior to Version H this group was named: CLM_OTHR_DGNS_GRP and did not contain the CLM_PRNCPAL_DGNS_CD. OCCURS: UP TO 10 TIMES DEPENDING ON HHA_CLM_DGNS_CD_CNT STANDARD ALIAS: CLM_DGNS_GRP
134.	NCH Diagnosis Trailer Indicator Code	CHAR	1	Effective with Version H, the code indicating the presence of a diagnosis trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). DB2 ALIAS: DGNS_TRLR_IND_CD SAS ALIAS: DGNSIND STANDARD ALIAS: NCH_DGNS_TRLR_IND_CD CODES: Y = Diagnosis code trailer present SOURCE: NCH
135.	Claim Diagnosis Code	CHAR	5	The ICD-9-CM based code identifying the beneficiary's principal or other diagnosis (including E code).

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

				NOTE: Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM_PRNCPAL_DGNS_CD was added as the first occurrence. DB2 ALIAS: CLM_DGNS_CD SAS ALIAS: DGNS_CD STANDARD ALIAS: CLM_DGNS_CD TITLE ALIAS: DIAGNOSIS EDIT-RULES: ICD-9-CM COMMENT: Prior to Version H this field was named: CLM_OTHR_DGNS_CD.
136.	FILLER	CHAR	1	
****	Claim Related Condition Group	GROUP	3	The number of claim related condition trailers is determined by the claim related condition code count. Effective 10/93, up to 30 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported. OCCURS: UP TO 30 TIMES DEPENDING ON HHA_CLM_RLT_COND_CD_CNT STANDARD ALIAS: CLM_RLT_COND_GRP
137.	NCH Condition Trailer Indicator Code	CHAR	1	Effective with Version H, the code indicating the presence of a condition code trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). DB2 ALIAS: COND_TRLR_IND_CD SAS ALIAS: CONDIND STANDARD ALIAS: NCH_COND_TRLR_IND_CD

CODES:
C = Condition code trailer present

SOURCE:
NCH

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
138.	Claim Related Condition Code	CHAR	2			The code that indicates a condition relating to an institutional claim that may affect payer processing.

DB2 ALIAS: CLM_RLT_COND_CD
SAS ALIAS: RLT_COND
STANDARD ALIAS: CLM_RLT_COND_CD
SYSTEM ALIAS: LTCOND
TITLE ALIAS: RELATED_CONDITION_CD

CODES:
01 THRU 16 = Insurance related
17 THRU 30 = Special condition
31 THRU 35 = Student status codes which are required
when a patient is a dependent child
over 18 years old
36 THRU 45 = Accommodation
46 THRU 54 = CHAMPUS information
55 THRU 59 = Skilled nursing facility
60 THRU 70 = Prospective payment
71 THRU 99 = Renal dialysis setting
A0 THRU B9 = Special program codes
C0 THRU C9 = PRO approval services
D0 THRU W0 = Change conditions

CODES:
REFER TO: CLM_RLT_COND_TB
IN THE CODES APPENDIX

SOURCE:
CWF

****	Claim Related Occurrence Group	GROUP	11		The number of claim related occurrence trailers is determined by the claim related occurrence code count. Effective 10/93, up to 30 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported. OCCURS: UP TO 30 TIMES DEPENDING ON HHA_CLM_RLT_OCRNC_CD_CNT STANDARD ALIAS: CLM_RLT_OCRNC_GRP
139.	NCH Occurrence Trailer Indicator Code	CHAR	1		Effective with Version H, the code indicating the presence of a occurrence code trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). DB2 ALIAS: OCRNC_TRLR_IND_CD SAS ALIAS: OCRNCIND STANDARD ALIAS: NCH_OCRNC_TRLR_IND_CD CODES: O = Occurrence code trailer present SOURCE: NCH

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
140.	Claim Related Occurrence Code	CHAR	2			The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date. DB2 ALIAS: CLM_RLT_OCRNC_CD SAS ALIAS: OCRNC_CD STANDARD ALIAS: CLM_RLT_OCRNC_CD

				SYSTEM ALIAS: LTOCRNC TITLE ALIAS: OCCURRENCE_CD CODES: 01 THRU 09 = Accident 10 THRU 19 = Medical condition 20 THRU 39 = Insurance related 40 THRU 69 = Service related A1-A3 = Miscellaneous CODES: REFER TO: CLM_RLT_OCRNC_TB IN THE CODES APPENDIX SOURCE: CWF
141.	Claim Related Occurrence Date	NUM	8	The date associated with a significant event related to an institutional claim that may affect payer processing. 8 DIGITS UNSIGNED DB2 ALIAS: CLM_RLT_OCRNC_DT SAS ALIAS: OCRNCDT STANDARD ALIAS: CLM_RLT_OCRNC_DT TITLE ALIAS: RLT_OCRNC_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
****	Claim Occurrence Span Group	GROUP	19	The number of claim occurrence span trailers is determined by the claim occurrence span code count. Up to 10 occurrences may be reported on an institutional claim. OCCURS: UP TO 10 TIMES DEPENDING ON HHA_CLM_OCRNC_SPAN_CD_CNT STANDARD ALIAS: CLM_OCRNC_SPAN_GRP

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
142.	NCH Span Trailer Indicator Code	CHAR	1			Effective with Version H, the code indicating the presence of a span code trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). DB2 ALIAS: SPAN_TRLR_IND_CD SAS ALIAS: SPANIND STANDARD ALIAS: NCH_SPAN_TRLR_IND_CD CODES: S = Span code trailer present SOURCE: NCH
143.	Claim Occurrence Span Code	CHAR	2			The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a time period (span of dates). DB2 ALIAS: CLM_OCRNC_SPAN_CD SAS ALIAS: SPAN_CD STANDARD ALIAS: CLM_OCRNC_SPAN_CD SYSTEM ALIAS: LTSPAN TITLE ALIAS: SPAN_CD CODES: REFER TO: CLM_OCRNC_SPAN_TB IN THE CODES APPENDIX SOURCE: CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
144.	Claim Occurrence Span From Date	NUM	8			The from date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing. 8 DIGITS UNSIGNED DB2 ALIAS: OCRNC_SPAN_FROM_DT SAS ALIAS: SPANFROM STANDARD ALIAS: CLM_OCRNC_SPAN_FROM_DT TITLE ALIAS: SPAN_FROM_DT EDIT-RULES: YYYYMMDD SOURCE: CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
145.	Claim Occurrence Span Through Date	NUM	8			The thru date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing. 8 DIGITS UNSIGNED DB2 ALIAS: OCRNC_SPAN_THRU_DT SAS ALIAS: SPANTHRU STANDARD ALIAS: CLM_OCRNC_SPAN_THRU_DT TITLE ALIAS: SPAN_THRU_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
****	Claim Value Group	GROUP	9			The number of claim value data trailers present is

determined by the claim value code count. Effective 10/93, up to 36 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

OCCURS: UP TO 36 TIMES
DEPENDING ON HHA_CLM_VAL_CD_CNT

STANDARD ALIAS: CLM_VAL_GRP

146. NCH Value Trailer Indicator Code — CHAR, 1

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

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

DB2 ALIAS: VAL_TRLR_IND_CD
SAS ALIAS: VALIND
STANDARD ALIAS: NCH_VAL_TRLR_IND_CD

CODES:
V = Value code trailer present

SOURCE:
NCH

147. Claim Value Code — CHAR, 2

The code indicating the value of a monetary condition which was used by the intermediary to process an institutional claim.

DB2 ALIAS: CLM_VAL_CD
SAS ALIAS: VAL_CD
STANDARD ALIAS: CLM_VAL_CD
SYSTEM ALIAS: LTVALUE
TITLE ALIAS: VALUE_CD

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

CODES:

				REFER TO: CLM_VAL_TB IN THE CODES APPENDIX SOURCE: CWF
148.	Claim Value Amount	PACK	6	The amount related to the condition identified in the CLM_VAL_CD which was used by the intermediary to process the institutional claim. 9.2 DIGITS SIGNED DB2 ALIAS: CLM_VAL_AMT SAS ALIAS: VAL_AMT STANDARD ALIAS: CLM_VAL_AMT TITLE ALIAS: VALUE_AMOUNT EDIT-RULES: $$$$$$$$$CC SOURCE: CWF
****	Claim Revenue Center Group	GROUP	224	The number of claim revenue center data trailers is determined by the claim revenue center code count. Effective 7/7/00, up to 450 occurrences may be reported for an institutional claim. The increase in the number of revenue center lines causes each claim to be broken out into records/segments (up to 10). Each record can have up to 45 occurrences of revenue center lines. Prior to 7/7/00, up to 58 occurrences may be reported on an institutional claim. Claims submitted prior to 10/93, contained up to 28 occurrences. OCCURS: UP TO 45 TIMES DEPENDING ON HHA_REV_CNTR_CD_I_CNT STANDARD ALIAS: CLM_REV_CNTR_GRP COMMENT: ****************** FOR SNF PPS **********************

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					The Balanced Budget Act modified how payment will be made for skilled nursing facility (SNF) services. Effective with cost reporting periods beginning on or after 7/1/98 (with all providers transitioning by 6/30/99, SNFs will be paid on a prospective payment system (PPS).
					SNFs will classify beneficiaries on the basis of residents' characteristics and resource needs, using the 44-group patient classification system known as Resource Utilization Groups (RUGS), Version III. Facilities will use information from the Minimum Data Set (MDS), Version 2.0, Resident Assessment Instrument (RAI) to classify residents into the RUG-III groups.
					********** FOR OUTPATIENT PPS ********** The Balanced Budget Act modified how payment will be made for hospital outpatient services, certain PTB services furnished to inpatients who have no PTA coverage, CMHCs, and limited services provided by CORFs, Home Health Agencies or to hospice patients for the treatment of a non-terminal illness. Implementation for Outpatient PPS (OPPS) will be effective for claims with dates of service on or after July 1, 2000.
					Payment for services under the OPPS system is calculated based on grouping outpatient services into ambulatory payment classifications (APC) groups.
					********** FOR HOME HEALTH PPS ********** The Balanced Budget Act of 1997 mandated changes in payment and other provider requirements for home health. All home health agencies will be paid through a prospective payment system beginning October 1, 2000.

					Under Home Health PPS (HH PPS) the unit of payment will be a 60-day episode. Home Health Resources Groups (HHRGs), also called HRGs represented by HCFA HIPPS coding, will be the basis of payment for each episode; HHRGs will be produced through pubicly available Grouper software that will determine the appropriate HHRG when results of comprehensive assessments of the beneficiary (made incorporating the OASIS data set) are input or grouped in this software.
149.	NCH Revenue Center Trailer Indicator Code	CHAR	1		Effective with Version H, the code identifying the revenue center trailer. During the Version H conversion this field was populated with data throughout history (back to service year 1991). DB2 ALIAS: REV_CNTR_TRLR_CD SAS ALIAS: REVIND STANDARD ALIAS: NCH_REV_CNTR_TRLR_IND_CD CODES: R = Revenue code trailer present

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					SOURCE: NCH
150. Revenue Center Code	CHAR	4			The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim. COBOL ALIAS: REV_CD DB2 ALIAS: REV_CNTR_CD SAS ALIAS: REV_CNTR

STANDARD ALIAS: REV_CNTR_CD
SYSTEM ALIAS: LTRC
TITLE ALIAS: REVENUE_CENTER_CD

CODES:
REFER TO: REV_CNTR_TB
IN THE CODES APPENDIX

SOURCE:
CWF

151. Revenue Center Date	NUM	8	Effective with Version H, the date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS. NOTE1: 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. NOTE2: When revenue center code equals '0022' (SNF PPS) and revenue center HCPCS code not equal to 'AAA00' (default for no assessment), date represents the MDS RAI assessment reference date. NOTE3: When revenue center code equals '0023' (HHPPS), the date on the initial claim (RAP) must represent the first date of service in the episode. The final claim will match the '0023' information submitted on the initial claim. The SCIC (significant change in condition) claims may show additional '0023' revenue lines in which the date represents the date of the first service under the revised plan of treatment. 8 DIGITS UNSIGNED

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						DB2 ALIAS: REV_CNTR_DT SAS ALIAS: REV_DT STANDARD ALIAS: REV_CNTR_DT TITLE ALIAS: REV_CNTR_DATE EDIT-RULES: YYYYMMDD SOURCE: CWF
152.	Revenue Center 1st ANSI Code	CHAR	5			The first code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment). NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. DB2 ALIAS: REV_CNTR_ANSI1_CD SAS ALIAS: REVANSI1 STANDARD ALIAS: REV_CNTR_ANSI_1_CD SYSTEM ALIAS: LTANSI TITLE ALIAS: ANSI_CD CODES: REFER TO: REV_CNTR_ANSI_TB IN THE CODES APPENDIX SOURCE: CWF
153.	Revenue Center 2nd ANSI Code	CHAR	5			The second code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment). NOTE: Beginning with NCH weekly process date

					7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. DB2 ALIAS: REV_CNTR_ANSI2_CD SAS ALIAS: REVANSI2 STANDARD ALIAS: REV_CNTR_ANSI_2_CD TITLE ALIAS: ANSI_CD SOURCE: CWF
154.	Revenue Center 3rd ANSI Code	CHAR	5		The third code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. DB2 ALIAS: REV_CNTR_ANSI3_CD SAS ALIAS: REVANSI3 STANDARD ALIAS: REV_CNTR_ANSI_3_CD TITLE ALIAS: ANSI_CD SOURCE: CWF
155.	Revenue Center 4th ANSI Code	CHAR	5			The fourth code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment). NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS: REV_CNTR_ANSI4_CD
SAS ALIAS: REVANSI4
STANDARD ALIAS: REV_CNTR_ANSI_4_CD
TITLE ALIAS: ANSI_CD

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
156.	Revenue Center APC/HIPPS Code	CHAR	5			Effective with Outpatient PPS (OPPS), the Ambulatory Payment Classification (APC) code used to identify groupings of outpatient services. APC codes are used to calculate payment for services under OPPS. Effective with Home Health PPS (HHPPS), this field will only be populated with a HIPPS code if the HIPPS code that is stored in the HCPCS field has been downcoded and the new code will be placed in this field. NOTE1: Under SNF PPS and HHPPS, HIPPS codes are stored in the HCPCS field. **EXCEPTION: if a HHPPS HIPPS code is downcoded the downcoded HIPPS will be stored in this field. NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV_APC_HIPPS_CD
SAS ALIAS: APCHIPPS
STANDARD ALIAS: REV_CNTR_APC_HIPPS_CD
SYSTEM ALIAS: LTAPC
TITLE ALIAS: APC_HIPPS

CODES:
REFER TO: REV_CNTR_APC_TB
IN THE CODES APPENDIX

SOURCE:
CWF

157. Revenue Center HCFA Common Procedure Coding System Code — CHAR — 5

HCFA's 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: REV_CNTR_HCPCS_CD
SAS ALIAS: HCPCS_CD
STANDARD ALIAS: REV_CNTR_HCPCS_CD
SYSTEM ALIAS: LTHIPPS
TITLE ALIAS: HCPCS_CD

CODES:
REFER TO: CLM_HIPPS_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this 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 non-institutional: LINE).

NOTE: When revenue center code = '0022' (SNF PPS) or '0023' (HH PPS), this field contains the Health Insurance PPS (HIPPS) code. The HIPPS code for SNF PPS contains the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.

The HIPPS code for Home Health PPS identifies

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					(1) the three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived.
					The HHRGs, represented by the HIPPS coding, will be the basis of payment for each episode. For both SNF PPS & HH PPS HIPPS values see CLM_HIPPS_TB. Level I Codes and descriptors copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4). These are 5 position numeric codes representing physician and nonphysician services. **** Note: **** CPT-4 codes including both long and short descriptions shall be used in accordance with the HCFA/AMA agreement. Any other use violates the AMA copyright. Level II Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

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

158. Revenue Center HCPCS Initial Modifier Code — CHAR — 2

A first modifier to the procedure code to enable a more specific procedure identification for the claim.

DB2 ALIAS: REV_HCPCS_MDFR_CD
SAS ALIAS: MDFR_CD1
STANDARD ALIAS: REV_CNTR_HCPCS_INITL_MDFR_CD
TITLE ALIAS: INITIAL_MODIFIER

EDIT-RULES:
Carrier Information File

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

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

SOURCE:
CWF

159. Revenue Center HCPCS Second Modifier Code — CHAR — 2

A second modifier to the procedure code to make it more specific than the first modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS: REV_HCPCS_2ND_CD
SAS ALIAS: MDFR_CD2
STANDARD ALIAS: REV_CNTR_HCPCS_2ND_MDFR_CD

TITLE ALIAS: SECOND_MODIFIER

EDIT-RULES:
CARRIER INFORMATION FILE

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

SOURCE:
CWF

160. Revenue Center HCPCS Third Modifier Code — CHAR — 2

Effective with Version I, a third modifier to the procedure code to make it more specific than the second modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS: REV_HCPCS_3RD_CD
SAS ALIAS: MDFR_CD3
STANDARD ALIAS: REV_CNTR_HCPCS_3RD_MDFR_CD
TITLE ALIAS: THIRD_MODIFIER

EDIT-RULES:
CARRIER INFORMATION FILE

COMMENT:
NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE:
CWF

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

161. Revenue Center HCPCS Fourth Modifier Code	CHAR	2	Effective with Version I, a fourth modifier to the procedure code to make it more specific than the third modifier code to identify the procedures performed on the beneficiary for the claim. DB2 ALIAS: REV_HCPCS_4TH_CD SAS ALIAS: MDFR_CD4 STANDARD ALIAS: REV_CNTR_HCPCS_4TH_MDFR_CD TITLE ALIAS: FOURTH_MODIFIER EDIT-RULES: CARRIER INFORMATION FILE COMMENT: NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field. SOURCE: CWF
162. Revenue Center HCPCS Fifth Modifier Code	CHAR	2	Effective with Version I, a fifth modifier to the procedure code to make it more specific than the fourth modifier code to identify the procedures performed on the beneficiary for the claim. DB2 ALIAS: REV_HCPCS_5TH_CD SAS ALIAS: MDFR_CD5 STANDARD ALIAS: REV_CNTR_HCPCS_5TH_MDFR_CD TITLE ALIAS: FIFTH_MODIFIER EDIT-RULES: CARRIER INFORMATION FILE COMMENT: NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field. SOURCE: CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
163.	Revenue Center Payment Method Indicator Code	CHAR	2			Effective with Version 'I', the code used to identify how the service is priced for payment. This field is made up of two pieces of data, 1st position being the service indicator and the 2nd position being the payment indicator. NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV_PMT_MTHD_CD
SAS ALIAS: PMTMTHD
STANDARD ALIAS: REV_CNTR_PMT_MTHD_IND_CD
SYSTEM ALIAS: LTPMTHD
TITLE ALIAS: PMT_MTHD

CODES:
REFER TO: REV_CNTR_PMT_MTHD_IND_TB
IN THE CODES APPENDIX

SOURCE:
CWF

164.	Revenue Center Discount Indicator Code	CHAR	1			Effective with Version 'I', for all services subject to Outpatient PPS, this code represents a factor that specifies the amount of any APC discount. The discounting factor is applied to a line item with a service indicator (part of the REV_CNTR_PMT_MTHD_IND_CD) of 'T'. The flag is applicable when more than one significant procedure is performed. **If there is no discounting the factor will be 1.0.** NOTE1: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain

					spaces in this field. DB2 ALIAS: REV_DSCNT_IND_CD SAS ALIAS: DSCNTIND STANDARD ALIAS: REV_CNTR_DSCNT_IND_CD SYSTEM ALIAS: LTDSCNT TITLE ALIAS: REV_CNTR_DSCNT_IND_CD CODES: *DISCOUNTING FORMULAS* 1 = 1.0 2 = (1.0+D(U-1))/U 3 = T/U 4 = (1+D)/U 5 = D 6 = TD/U 7 = D(1+D)/U 8 = 2.0/U SOURCE: CWF
165.	Revenue Center Packaging Indicator Code	CHAR	1		Effective with Version 'I', for all services subject to Outpatient PPS, the code used to identify those services that are packaged/ bundled with another service.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field. DB2 ALIAS: REV_PACKG_IND_CD SAS ALIAS: PACKGIND STANDARD ALIAS: REV_CNTR_PACKG_IND_CD SYSTEM ALIAS: LTPACKG TITLE ALIAS: REV_CNTR_PACKG_IND

CODES:
0 = Not packaged
1 = Packaged service (service indicator N)
2 = Packaged as part of partial hospitalization
    per diem or daily mental health service
    per diem

SOURCE:
CWF

166.	Revenue Center Pricing Indicator Code	CHAR	2	Effective with Version 'I', the code used to identify if there was a deviation from the standard method of calculating payment amount. NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field. DB2 ALIAS: REV_PRICNG_IND_CD SAS ALIAS: PRICNG STANDARD ALIAS: REV_CNTR_PRICNG_IND_CD SYSTEM ALIAS: LTPRICNG TITLE ALIAS: REV_CNTR_PRICNG_IND CODES: REFER TO: REV_CNTR_PRICNG_IND_TB IN THE CODES APPENDIX SOURCE: CWF
167.	Revenue Center Obligation to Accept As Full (OTAF) Payment Code	CHAR	1	Effective with Version 'I' the code used to indicate that the provider was obligated to accept as full payment the amount received from the primary (or secondary) payer. NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						DB2 ALIAS: REV_OTAF1_IND_CD SAS ALIAS: OTAF_1 STANDARD ALIAS: REV_CNTR_OTAF_1_IND_CD TITLE ALIAS: REV_CNTR_OTAF_1_IND_CD EDIT-RULES: Y = provider is obligated to accept the payment as payment in full for the service. N or blank = provider is not obligated to accept the payment, or there is no payment by a prior payer. SOURCE: CWF
168.	Revenue Center Obligation to Accept As Full (OTAF) Payment Code	CHAR	1			**********FIELD NOT POPULATED********** This field was intended to collect information for two payers if Medicare was tertiary. It was discovered that MSP system only deals with one payer so there is no need to have 2 OTAF fields. DB2 ALIAS: REV_OTAF2_IND_CD SAS ALIAS: OTAF_2 STANDARD ALIAS: REV_CNTR_OTAF_2_IND_CD TITLE ALIAS: REV_CNTR_OTAF_2_IND_CD SOURCE: CWF
169.	Revenue Center IDE, NDC, UPC Number	CHAR	24			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. IDE's are always associated with revenue center code '0624'.

NOTE1: Prior to Version H a 'dummy' revenue center code '0624' trailer was created to store IDE's. The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'. There can be up to 7 distinct IDE numbers associated with an '0624' dummy trailer. During the Version H conversion IDE's were moved from the dummy '0624' trailer to this dedicated field.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

NOTE2: Effective with Version 'I', this field was renamed to eventually accommodate the National Drug Code (NDC) and the Universal Product Code (UPC). This field could contain either of these 3 fields (there would never be an instance where more than one would come in on a claim). The size of this field was expanded to X(24) to accommodate either of the new fields (under Version 'H' it was X(7). DATA ANAMOLY/LIMITATION: During an CWFMQA review an edit revealed the IDE was missing. The problem occurs in claim with an NCH weekly process dates of 6/9/00 through 9/8/00. During processing of the new format the program receives the IDE but then blanked out the data.

DB2 ALIAS: IDE_NDC_UPC_NUM
SAS ALIAS: IDENDC
STANDARD ALIAS: REV_CNTR_IDE_NDC_UPC_NUM
TITLE ALIAS: IDE_NDC_UPC

SOURCE:
CWF

170. Revenue Center Unit Count	PACK	4		A quantitative measure (unit) of the number of times the service or procedure being reported was performed according to the revenue center/HCPCS code definition as described on an institutional claim. Depending on type of service, units are measured by number of covered days in a particular accommodation, pints of blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests. NOTE1: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code. 7 DIGITS SIGNED DB2 ALIAS: REV_CNTR_UNIT_CNT SAS ALIAS: REV_UNIT STANDARD ALIAS: REV_CNTR_UNIT_CNT TITLE ALIAS: UNITS SOURCE: CWF
171. Revenue Center Rate Amount	PACK	6		Charges relating to unit cost associated with the revenue center code. Exception (encounter data only): If plan (e.g. MCO) does not know the actual rate for the accommodations, $1 will be reported in the field.

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					NOTE1: For SNF PPS claims (when revenue center code equals '0022'), HCFA has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue

				center HCPCS code field). NOTE2: For OP PPS claims, HCFA has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index. NOTE3: Under HH PPS (when revenue center code equals '0023'), HCFA has developed a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode. On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment. In cases of SCICs, there will be more than one '0023' revenue center line, each representing the payment made at each case-mix level. 9.2 DIGITS SIGNED DB2 ALIAS: REV_CNTR_RATE_AMT SAS ALIAS: REV_RATE STANDARD ALIAS: REV_CNTR_RATE_AMT TITLE ALIAS: CHARGE_PER_UNIT EFFECTIVE-DATE: 10/01/1993 COMMENT: Prior to Version H the size of this field was: S9(7)V99. SOURCE: CWF
172.	Revenue Center Blood Deductible Amount	PACK	6	Effective with Version 'I', the amount of money for which the intermediary determined the beneficiary is liable for the blood deductible

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						for the line item service. NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.
						9.2 DIGITS SIGNED DB2 ALIAS: REV_BLOOD_DDCTBL SAS ALIAS: REVBLOOD STANDARD ALIAS: REV_CNTR_BLOOD_DDCTBL_AMT TITLE ALIAS: BLOOD_DDCTBL_AMT SOURCE: CWF
173.	Revenue Center Cash Deductible Amount	PACK	6			Effective with Version 'I' the amount of cash deductible the beneficiary paid for the line item service. NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_CASH_DDCTBL SAS ALIAS: REVDCTBL STANDARD ALIAS: REV_CNTR_CASH_DDCTBL_AMT TITLE ALIAS: CASH_DDCTBL SOURCE: CWF
174.	Revenue Center	PACK	6			Effective with Version 'I', the amount of

	Coinsurance/Wage Adjusted Coinsurance Amount				coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted. NOTE1: This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification. NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field. 9.2 DIGITS SIGNED

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						DB2 ALIAS: ADJSTD_COINSRNC SAS ALIAS: WAGEADJ STANDARD ALIAS: REV_CNTR_WAGE_ADJSTD_COINS_AMT TITLE ALIAS: WAGE_ADJSTD_COINS SOURCE: CWF
175.	Revenue Center Reduced Coinsurance Amount	PACK	6			Effective with Version 'I', for all services subject to Outpatient PPS, the amount of coinsurance applicable to the line for a particular service (HCPCS) for which the provider has elected to reduce the coinsurance amount.

NOTE1: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.

NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: RDCD_COINSRNC
SAS ALIAS: RDCDCOIN
STANDARD ALIAS: REV_CNTR_RDCD_COINS_AMT
TITLE ALIAS: REDUCED_COINS

SOURCE:
CWF

176. Revenue Center 1st Medicare Secondary Payer Paid Amount — PACK, 6

Effective with Version 'I', the amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary or tertiary).

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_MSP1_PD_AMT
SAS ALIAS: REV_MSP1
STANDARD ALIAS: REV_CNTR_MSP1_PD_AMT
TITLE ALIAS: MSP PAID AMOUNT

SOURCE:
CWF

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

177.	Revenue Center 2nd Medicare Secondary Payer Paid Amount	PACK	6		Effective with Version 'I', the amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer). NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_MSP2_PD_AMT SAS ALIAS: REV_MSP2 STANDARD ALIAS: REV_CNTR_MSP2_PD_AMT TITLE ALIAS: MSP PAID AMOUNT SOURCE: CWF
178.	Revenue Center Professional Component Amount	PACK	6		**********FIELD NOT POPULATED********** Intended to be populated for line item services subject to PPS, as the amount associated with Value Code '05'. However, with line item date of service reporting, there is no way to correctly allocate professional component charges reported in value code '05' to specific line items on the claim. 9.2 DIGITS SIGNED DB2 ALIAS: REV_PROFNL_CMPNT SAS ALIAS: REVPCCHG STANDARD ALIAS: REV_CNTR_PROFNL_CMPNT_AMT TITLE ALIAS: PROFNL_CMPNT_CHARGES SOURCE: CWF
179.	Revenue Center Provider Payment Amount	PACK	6		Effective with Version 'I', the amount paid to the provider for the services reported on the line item.

						NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_PRVDR_PMT_AMT SAS ALIAS: RPRVDPMT STANDARD ALIAS: REV_CNTR_PRVDR_PMT_AMT TITLE ALIAS: REV_PRVDR_PMT

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						SOURCE: CWF
180.	Revenue Center Beneficiary Payment Amount	PACK	6			Effective with Version I, the amount paid to the beneficiary for the services reported on the line item. NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_BENE_PMT_AMT SAS ALIAS: RBENEPMT STANDARD ALIAS: REV_CNTR_BENE_PMT_AMT TITLE ALIAS: REV_BENE_PMT SOURCE: CWF
181.	Revenue Center Patient Responsibility Payment	PACK	6			Effective with Version I, the amount paid by the beneficiary to the provider for the

	Amount				line item service. NOTE: Beginning with NCH weekly process date 7/7/00 this field was populated with data. Claims processed prior to 7/7/00 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_PTNT_RESP_AMT SAS ALIAS: PTNTRESP STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT TITLE ALIAS: REV_PTNT_RESP SOURCE: CWF
182.	Revenue Center Payment Amount	PACK	6		Effective with Version 'I', the line item Medicare payment amount for the specific revenue center. Under OP PPS, PRICER will compute the standard OPPS payment for a line item based on the payment APC. Under HH PPS, PRICER will compute/return a line item payment amount for the case-mixed, wage-index adjusted HIPPS code assigned to the '0023' revenue center line. The HIPPS code will be stored in the Revenue Center HCPCS code field.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						9.2 DIGITS SIGNED COMMON ALIAS: REIMBURSEMENT DB2 ALIAS: REV_CNTR_PMT_AMT SAS ALIAS: REVPMT STANDARD ALIAS: REV_CNTR_PMT_AMT

183. Revenue Center Total Charge Amount	PACK	6	TITLE ALIAS: REIMBURSEMENT EDIT-RULES: $$$$$$$$$CC SOURCE: CWF The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided. NOTE: For accommodation revenue center total charges must equal the rate times units (days). EXCEPTIONS: (1) For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo). (2) For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero. (3) For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line. (4) For Home Health PPS (final claim), when revenue center code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023'). (5) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be $1 (rate) times units (days). 9.2 DIGITS SIGNED DB2 ALIAS: REV_TOT_CHRG_AMT SAS ALIAS: REV_CHRG STANDARD ALIAS: REV_CNTR_TOT_CHRG_AMT

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						TITLE ALIAS: REVENUE_CENTER_CHARGES EDIT-RULES: $$$$$$$$$CC
						COMMENT: Prior to Version H the size of this field was: S9(7)V99. SOURCE: CWF
184.	Revenue Center Non-Covered Charge Amount	PACK	6			The charge amount related to a revenue center code for services that are not covered by Medicare. NOTE: Prior to Version H the field size was S9(7)V99 and the element was only present on the Inpatient/SNF format. As of NCH weekly process date 10/3/97 this field was added to all institutional claim types. 9.2 DIGITS SIGNED DB2 ALIAS: REV_NCVR_CHRG_AMT SAS ALIAS: REV_NCVR STANDARD ALIAS: REV_CNTR_NCVR_CHRG_AMT TITLE ALIAS: REV_CENTER_NONCOVERED_CHARGES EDIT-RULES: $$$$$$$$$CC SOURCE: CWF
185.	Revenue Center Deductible Coinsurance Code	CHAR	1			Code indicating whether the revenue center charges are subject to deductible and/or coinsurance. DB2 ALIAS: DDCTBL_COINSRNC_CD

SAS ALIAS: REVDEDCD
STANDARD ALIAS: REV_CNTR_DDCTBL_COINSRNC_CD
TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD

CODES:
REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB
IN THE CODES APPENDIX

SOURCE:
CWF

186.	FILLER	CHAR	50		
187.	End of Record Code	CHAR	3		Effective with Version 'I', the code used to identify the end of a record/segment or the end of the claim.

DB2 ALIAS: END_REC_CD
SAS ALIAS: EOR
STANDARD ALIAS: END_REC_CD
TITLE ALIAS: END_OF_REC

1 FI HHA Claim Record -- 08/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

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

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

SOURCE:
NCH

1 BENE_IDENT_TB — Beneficiary Identification Code (BIC) Table

Social Security Administration:

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

D7 = Surviving divorced wife (2nd claimant)
D8 = Aged widow (3rd claimant)
D9 = Remarried widow (2nd claimant)
DA = Remarried widow (3rd claimant)
DC = Surviving divorced husband (1st claimant)
DD = Aged widow (4th claimant)
DG = Aged widow (5th claimant)
DH = Aged widower (3rd claimant)
DJ = Aged widower (4th claimant)
DK = Aged widower (5th claimant)
DL = Remarried widow (4th claimant)
DM = Surviving divorced husband (2nd claimant)
DN = Remarried widow (5th claimant)

1 BENE_IDENT_TB — Beneficiary Identification Code (BIC) Table

DP = Remarried widower (2nd claimant)
DQ = Remarried widower (3rd claimant)
DR = Remarried widower (4th claimant)
DS = Surviving divorced husband (3rd claimant)
DT = Remarried widower (5th claimant)
DV = Surviving divorced wife (3rd claimant)
DW = Surviving divorced wife (4th claimant)
DX = Surviving divorced husband (4th claimant)
DY = Surviving divorced wife (5th claimant)
DZ = Surviving divorced husband (5th claimant)
E = Mother (widow) (1st claimant)
E1 = Surviving divorced mother (1st claimant)
E2 = Mother (widow) (2nd claimant)
E3 = Surviving divorced mother (2nd claimant)
E4 = Father (widower) (1st claimant)
E5 = Surviving divorced father (widower) (1st claimant)
E6 = Father (widower) (2nd claimant)
E7 = Mother (widow) (3rd claimant)
E8 = Mother (widow) (4th claimant)
E9 = Surviving divorced father (widower)

(2nd claimant)
EA = Mother (widow) (5th claimant)
EB = Surviving divorced mother (3rd claimant)
EC = Surviving divorced mother (4th claimant)
ED = Surviving divorced mother (5th claimant
EF = Father (widower) (3rd claimant)
EG = Father (widower) (4th claimant)
EH = Father (widower) (5th claimant)
EJ = Surviving divorced father (3rd claimant)
EK = Surviving divorced father (4th claimant)
EM = Surviving divorced father (5th claimant)
F1 = Father
F2 = Mother
F3 = Stepfather
F4 = Stepmother
F5 = Adopting father
F6 = Adopting mother
F7 = Second alleged father
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

1 BENE_IDENT_TB — Beneficiary Identification Code (BIC) Table

(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)

1 BENE_IDENT_TB — Beneficiary Identification Code (BIC) Table

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

W9 = Disabled widow (4th claimant)
WB = Disabled widower (4th claimant)
WC = Disabled surviving divorced wife (4th claimant)
WF = Disabled widow (5th claimant)
WG = Disabled widower (5th claimant)
WJ = Disabled surviving divorced wife (5th claimant)
WR = Disabled surviving divorced husband (1st claimant)
WT = Disabled surviving divorced husband (2nd claimant)

Railroad Retirement Board:

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

1 BENE_IDENT_TB — Beneficiary Identification Code (BIC) Table

10 = Retirement - employee or annuitant
80 = RR pensioner (age or disability)
14 = Spouse of RR employee or annuitant (husband or wife)
84 = Spouse of RR pensioner
43 = Child of RR employee
13 = Child of RR annuitant
17 = Disabled adult child of RR annuitant
46 = Widow/widower of RR employee
16 = Widow/widower of RR annuitant
86 = Widow/widower of RR pensioner
43 = Widow of employee with a child in her care
13 = Widow of annuitant with a child in her care
83 = Widow of pensioner with a child in her care

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

1 BENE_PRMRY_PYR_TB — Beneficiary Primary Payer Table

A = Working aged bene/spouse with employer
group health plan (EGHP)
B = End stage renal disease (ESRD) beneficiary
in the 18 month coordination period with
an employer group health plan
C = Conditional payment by Medicare; future
reimbursement expected
D = Automobile no-fault (eff. 4/97; Prior
to 3/94, also included any liability
insurance)
E = Workers' compensation
F = Public Health Service or other federal
agency (other than Dept. of Veterans
Affairs)
G = Working disabled bene (under age 65
with LGHP)
H = Black Lung
I = Dept. of Veterans Affairs
J = Any liability insurance
(eff. 3/94 - 3/97)
L = Any liability insurance (eff. 4/97)
(eff. 12/90 for carrier claims and 10/93
for FI claims; obsoleted for all claim
types 7/1/96)

M = Override code: EGHP services involved
(eff. 12/90 for carrier claims and 10/93
for FI claims; obsoleted for all claim
types 7/1/96)

N = Override code: non-EGHP services involved
(eff. 12/90 for carrier claims and 10/93

for FI claims; obsoleted for all claim types 7/1/96)

BLANK = Medicare is primary payer (not sure of effective date: in use 1/91, if not earlier)

T = MSP cost avoided - IEQ contractor (eff. 7/96 carrier claims only)
U = MSP cost avoided - HMO rate cell adjustment contractor (eff. 7/96 carrier claims only)
V = MSP cost avoided - litigation settlement contractor (eff. 7/96 carrier claims only)

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

Prior to 12/90

Y = Other secondary payer investigation shows Medicare as primary payer

1 BENE_PRMRY_PYR_TB — Beneficiary Primary Payer Table

Z = Medicare is primary payer

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

1 BETOS_TB — BETOS Table

M1A = Office visits - new
M1B = Office visits - established

M2A = Hospital visit - initial
M2B = Hospital visit - subsequent
M2C = Hospital visit - critical care
M3 = Emergency room visit
M4A = Home visit
M4B = Nursing home visit
M5A = Specialist - pathology
M5B = Specialist - psychiatry
M5C = Specialist - opthamology
M5D = Specialist - other
M6 = Consultations
P0 = Anesthesia
P1A = Major procedure - breast
P1B = Major procedure - colectomy
P1C = Major procedure - cholecystectomy
P1D = Major procedure - turp
P1E = Major procedure - hysterctomy
P1F = Major procedure - explor/decompr/excisdisc
P1G = Major procedure - Other
P2A = Major procedure, cardiovascular-CABG
P2B = Major procedure, cardiovascular-Aneurysm repair
P2C = Major Procedure, cardiovascular-Thromboendarterectomy
P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA)
P2E = Major procedure, cardiovascular-Pacemaker insertion
P2F = Major procedure, cardiovascular-Other
P3A = Major procedure, orthopedic - Hip fracture repair
P3B = Major procedure, orthopedic - Hip replacement
P3C = Major procedure, orthopedic - Knee replacement
P3D = Major procedure, orthopedic - other
P4A = Eye procedure - corneal transplant
P4B = Eye procedure - cataract removal/lens insertion
P4C = Eye procedure - retinal detachment
P4D = Eye procedure - treatment
P4E = Eye procedure - other
P5A = Ambulatory procedures - skin
P5B = Ambulatory procedures - musculoskeletal
P5C = Ambulatory procedures - inguinal hernia repair
P5D = Ambulatory procedures - lithotripsy
P5E = Ambulatory procedures - other
P6A = Minor procedures - skin
P6B = Minor procedures - musculoskeletal
P6C = Minor procedures - other (Medicare fee schedule)
P6D = Minor procedures - other (non-Medicare fee schedule)

P7A = Oncology - radiation therapy
P7B = Oncology - other
P8A = Endoscopy - arthroscopy
P8B = Endoscopy - upper gastrointestinal
P8C = Endoscopy - sigmoidoscopy
P8D = Endoscopy - colonoscopy
P8E = Endoscopy - cystoscopy
P8F = Endoscopy - bronchoscopy
P8G = Endoscopy - laparoscopic cholecystectomy
P8H = Endoscopy - laryngoscopy
P8I = Endoscopy - other
P9A = Dialysis services

1 BETOS_TB BETOS Table

I1A = Standard imaging - chest
I1B = Standard imaging - musculoskeletal
I1C = Standard imaging - breast
I1D = Standard imaging - contrast gastrointestinal
I1E = Standard imaging - nuclear medicine
I1F = Standard imaging - other
I2A = Advanced imaging - CAT: head
I2B = Advanced imaging - CAT: other
I2C = Advanced imaging - MRI: brain
I2D = Advanced imaging - MRI: other
I3A = Echography - eye
I3B = Echography - abdomen/pelvis
I3C = Echography - heart
I3D = Echography - carotid arteries
I3E = Echography - prostate, transrectal
I3F = Echography - other
I4A = Imaging/procedure - heart including cardiac catheter
I4B = Imaging/procedure - other
T1A = Lab tests - routine venipuncture (non Medicare fee schedule)
T1B = Lab tests - automated general profiles
T1C = Lab tests - urinalysis
T1D = Lab tests - blood counts
T1E = Lab tests - glucose
T1F = Lab tests - bacterial cultures
T1G = Lab tests - other (Medicare fee schedule)
T1H = Lab tests - other (non-Medicare fee schedule)

T2A = Other tests - electrocardiograms
T2B = Other tests - cardiovascular stress tests
T2C = Other tests - EKG monitoring
T2D = Other tests - other
D1A = Medical/surgical supplies
D1B = Hospital beds
D1C = Oxygen and supplies
D1D = Wheelchairs
D1E = Other DME
D1F = Orthotic devices
O1A = Ambulance
O1B = Chiropractic
O1C = Enteral and parenteral
O1D = Chemotherapy
O1E = Other drugs
O1F = Vision, hearing and speech services
O1G = Influenza immunization
Y1 = Other - Medicare fee schedule
Y2 = Other - non-Medicare fee schedule
Z1 = Local codes
Z2 = Undefined codes

1 CARR_CLM_PMT_DNL_TB Carrier Claim Payment Denial Table

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

Match (eff. 7/3/00)
F = MSP cost avoided HMO Rate Cell (eff. 7/3/00)
G = MSP cost avoided Litigation Settlement (eff. 7/3/00)
H = MSP cost avoided Employer Voluntary Reporting (eff. 7/3/00)
J = MSP cost avoided Insurer Voluntary Reporting (eff. 7/3/00)
K = MSP cost avoided Initial Enrollment Questionnaire (eff. 7/3/00)
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided - (Contractor #88888) voluntary agreement (eff. 1/98)
T = MSP cost avoided - IEQ contractor (eff. 7/96) (obsolete 6/30/00)
U = MSP cost avoided - HMO rate cell adjustment (eff. 7/96) (obsolete 6/30/00)
V = MSP cost avoided - litigation settlement (eff. 7/96) (obsolete 6/30/00)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data match project (obsolete 6/30/00)

1 CARR_LINE_PRVDR_TYPE_TB — Carrier Line Provider Type Table

For Physician/Supplier (RIC O) Claims:

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

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

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

1CARR_LINE_RDCD_PHYSN_ASTNT_TB

Carrier Line Part B Reduced Physician Assistant Table

BLANK = Adjustment situation (where
CLM_DISP_CD equal 3)
0 = N/A
1 = 65%
A) Physician assistants assisting in
surgery
B) Nurse midwives
2 = 75%
A) Physician assistants performing

services in a hospital (other than assisting surgery)
B) Nurse practitioners and clinical nurse specialists performing services in rural areas
C) Clinical social worker services

3 = 85%
A) Physician assistant services for other than assisting surgery
B) Nurse practitioners services

1 CARR_NUM_TB — Carrier Number Table

00510 = Alabama BS (eff. 1983)
00511 = Georgia - Alabama BS (eff. 1998)
00512 = Mississippi - Alabama BS (eff. 2000)
00520 = Arkansas BS (eff. 1983)
00521 = New Mexico - Arkansas BS (eff. 1998)
00522 = Oklahoma - Arkansas BS (eff. 1998)
00523 = Missouri - Arkansas BS (eff. 1999)
00528 = Louisianna - Arkansas BS (eff. 1984)
00542 = California BS (eff. 1983; term. 1996)
00550 = Colorado BS (eff. 1983; term. 1994)
00570 = Delaware - Pennsylvania BS (eff. 1983; term. 1997)
00580 = District of Columbia - Pennsylvania BS (eff. 1983; term. 1997)
00590 = Florida BS (eff. 1983)
00591 = Connecticut - Florida BS (eff. 2000)
00621 = Illinois BS - HCSC (eff. 1983; term. 1998)
00623 = Michigan - Illinois Blue Shield (eff. 1995) (term. 1998)
00630 = Indiana - Administar (eff. 1983)
00635 = DMERC-B (Administar Federal, Inc.) (eff. 1993)
00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)
00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)
00650 = Kansas BS (eff. 1983)
00655 = Nebraska - Kansas BS (eff. 1988)
00660 = Kentucky - Administar (eff. 1983)
00690 = Maryland BS (eff. 1983; term. 1994)

00700 = Massachusetts BS (eff. 1983; term. 1997)
00710 = Michigan BS (eff. 1983; term. 1994)
00720 = Minnesota BS (eff. 1983; term. 1995)
00740 = Missouri - BS Kansas City (eff. 1983)
00751 = Montana BS (eff. 1983)
00770 = New Hampshire/Vermont Physician Services
(eff. 1983; term. 1984)
00780 = New Hampshire/Vermont - Massachusetts BS
(eff. 1985; term. 1997)
00801 = New York - Western BS (eff. 1983)
00803 = New York - Empire BS (eff. 1983)
00805 = New Jersey - Empire BS (eff. 3/99)
00811 = DMERC (A) - Western New York BS (eff. 2000)
00820 = North Dakota - North Dakota BS (eff. 1983)
00824 = Colorado - North Dakota BS (eff. 1995)
00825 = Wyoming - North Dakota BS (eff. 1990)
00826 = Iowa - North Dakota BS (eff. 1999)
00831 = Alaska - North Dakota BS (eff. 1998)
00832 = Arizona - North Dakota BS (eff. 1998)
00833 = Hawaii - North Dakota BS (eff. 1998)
00834 = Nevada - North Dakota BS (eff. 1998)
00835 = Oregon - North Dakota BS (eff. 1998)
00836 = Washington - North Dakota BS (eff. 1998)
00860 = New Jersey - Pennsylvania BS (eff. 1988;
term. 1999)
00865 = Pennsylvania BS (eff. 1983)
00870 = Rhode Island BS (eff. 1983)
00880 = South Carolina BS (eff. 1983)
00882 = RRB - South Carolina PGBA (eff. 2000)

1 CARR_NUM_TB Carrier Number Table
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00885 = DMERC C - Palmetto (eff. 1993)
00900 = Texas BS (eff. 1983)
00901 = Maryland - Texas BS (eff. 1995)
00902 = Delaware - Texas BS (eff. 1998)
00903 = District of Columbia - Texas BS (eff. 1998)
00904 = Virginia - Texas BS (eff. 2000)
00910 = Utah BS (eff. 1983)
00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)
00952 = Illinois - Wisconsin Phy Svc (eff. 1999)
00953 = Michigan - Wisconsin Phy Svc (eff. 1999)
00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)

00973 = Triple-S, Inc. - Puerto Rico (eff. 1983)
00974 = Triple-S, Inc. - Virgin Islands
01020 = Alaska - AETNA (eff. 1983; term. 1997)
01030 = Arizona - AETNA (eff. 1983; term. 1997)
01040 = Georgia - AETNA (eff. 1988; term. 1997)
01120 = Hawaii - AETNA (eff. 1983; term. 1997)
01290 = Nevada - AETNA (eff. 1983; term. 1997)
01360 = New Mexico - AETNA (eff. 1986; term. 1997)
01370 = Oklahoma - AETNA (eff. 1983; term. 1997)
01380 = Oregon - AETNA (eff. 1983; term. 1997
01390 = Washington - AETNA (eff. 1994; term. 1997)
02050 = California - TOLIC (eff. 1983)
(term. 2000)
03070 = Connecticut General Life Insurance Co.
(eff. 1983; term. 1985)
05130 = Idaho - Connecticut General (eff. 1983)
05320 = New Mexico - Equitable Insurance
(eff. 1983; term. 1985)
05440 = Tennessee - Connecticut General (eff. 1983)
05530 = Wyoming - Equitable Insurance (eff. 1983)
(term. 1989)
05535 = North Carolina - Connecticut General
(eff. 1988)
05655 = DMERC-D - Connecticut General (eff. 1993)
10071 = Railroad Board Travelers (eff. 1983)
(term. 2000)
10230 = Connecticut - Metra Health (eff. 1986)
(term. 2000)
10240 = Minnesota - Metra Health (eff. 1983)
(term. 2000)
10250 = Mississippi - Metra Health (eff. 1983)
(term. 2000)
10490 = Virginia - Metra Health (eff. 1983)
(term. 2000)
10555 = Travelers Insurance Co. (eff. 1993)
(term. 2000)
11260 = Missouri - General American Life
(eff. 1983; term. 1998)
14330 = New York - GHI (eff. 1983)
16360 = Ohio - Nationwide Insurance Co.
16510 = West Virginia - Nationwide Insurance Co.
21200 = Maine - BS of Massachusetts
31140 = California - National Heritage Ins.

31142 = Maine - National Heritage Ins.
31143 = Massachusetts - National Heritage Ins.
31144 = New Hampshire - National Heritage Ins.
31145 = Vermont - National Heritage Ins.

1 CARR_NUM_TB — Carrier Number Table

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

1 CLM_BILL_TYPE_TB — Claim Bill Type Table

11 = Hospital-inpatient (including Part A)
12 = Hospital-inpatient or home health visits (Part B only)
13 = Hospital-outpatient (HHA-A also) (under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00)
14 = Hospital-other (Part B)
15 = Hospital-intermediate care - level I
16 = Hospital-intermediate care - level II
17 = Hospital-intermediate care - level III
18 = Hospital-swing beds
19 = Hospital-reserved for national assignment
21 = SNF-inpatient (including Part A)
22 = SNF-inpatient or home health visits (Part B only)
23 = SNF-outpatient (HHA-A also)
24 = SNF-other (Part B)
25 = SNF-intermediate care - level I
26 = SNF-intermediate care - level II
27 = SNF-intermediate care - level III
28 = SNF-swing beds
29 = SNF-reserved for national assignment
31 = HHA-inpatient (including Part A)
32 = HHA-inpatient or home health visits (Part B only)
33 = HHA-outpatient (HHA-A also)
34 = HHA-other (Part B)
35 = HHA-intermediate care - level I
36 = HHA-intermediate care - level II
37 = HHA-intermediate care - level III
38 = HHA-swing beds
39 = HHA-reserved for national assignment
41 = Religious Nonmedical Health Care Institution (RNHCI)

hospital-inpatient (including Part A) (all references
to Christian Science (CS) is obsolete eff. 8/00 and
replaced with RNHCI)
42 = RNHCI hospital-inpatient or home health visits (Part B only)
43 = RNHCI hospital-outpatient (HHA-A also)
44 = RNHCI hospital-other (Part B)
45 = RNHCI hospital-intermediate care - level I
46 = RNHCI hospital-intermediate care - level II
47 = RNHCI hospital-intermediate care - level III
48 = RNHCI hospital-swing beds
49 = RNHCI hospital-reserved for national assignment
51 = CS extended care-inpatient (including Part A) OBSOLETE
eff. 7/00 - implementation of Religious Nonmedical
Health Care Institutions (RNHCI)
52 = RNHCI extended care-inpatient or home health visits
(Part B only) (eff. 7/00); prior to 7/00 Christian Science (CS)
53 = RNHCI extended care-outpatient (HHA-A also) (eff. 7/00);
prior to 7/00 referenced CS
54 = RNHCI extended care-other (Part B)(eff. 7/00); prior
to 7/00 referenced CS
55 = RNHCI extended care-intermediate care - level I (eff. 7/00)
prior to 7/00 referenced CS
56 = RNHCI extended care-intermediate care - level II (eff. 7/00)
prior to 7/00 referenced CS
57 = RNHCI extended care-intermediate care - level III (eff. 7/00)
prior to 7/00 referenced CS
58 = RNHCI extended care-swing beds (eff. 7/00)

1 CLM_BILL_TYPE_TB Claim Bill Type Table

prior to 7/00 referenced CS
59 = RNHCI extended care-reserved for national assignment
(eff. 7/00); prior to 7/00 referenced CS
61 = Intermediate care-inpatient (including Part A)
62 = Intermediate care-inpatient or home health visits (Part B only)
63 = Intermediate care-outpatient (HHA-A also)
64 = Intermediate care-other (Part B)
65 = Intermediate care-intermediate care - level I
66 = Intermediate care-intermediate care - level II
67 = Intermediate care-intermediate care - level III
68 = Intermediate care-swing beds
69 = Intermediate care-reserved for national assignment
71 = Clinic-rural health

72 = Clinic-hospital based or independent renal dialysis facility
73 = Clinic-independent provider based FQHC (eff 10/91)
74 = Clinic-ORF only (eff 4/97);
ORF and CMHC (10/91 - 3/97)
75 = Clinic-CORF
76 = Clinic-CMHC (eff 4/97)
77 = Clinic-reserved for national assignment
78 = Clinic-reserved for national assignment
79 = Clinic-other
81 = Special facility or ASC surgery-hospice (non-hospital based)
82 = Special facility or ASC surgery-hospice (hospital based)
83 = Special facility or ASC surgery-ambulatory surgical center
(Discontinued for Hospitals Subject to Outpatient PPS;
hospitals must use 13X for ASC claims submitted for OPPS
payment -- eff. 7/00)
84 = Special facility or ASC surgery-freestanding birthing center
85 = Special facility or ASC surgery-rural primary care hospital (eff
86 = Special facility or ASC surgery-reserved for national use
87 = Special facility or ASC surgery-reserved for national use
88 = Special facility or ASC surgery-reserved for national use
89 = Special facility or ASC surgery-other
91 = Reserved-inpatient (including Part A)
92 = Reserved-inpatient or home health visits (Part B only)
93 = Reserved-outpatient (HHA-A also)
94 = Reserved-other (Part B)
95 = Reserved-intermediate care - level I
96 = Reserved-intermediate care - level II
97 = Reserved-intermediate care - level III
98 = Reserved-swing beds
99 = Reserved-reserved for national assignment

1 CLM_DISP_TB Claim Disposition Table

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

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

1 CLM_FAC_TYPE_TB — Claim Facility Type Table

1 = Hospital
2 = Skilled nursing facility (SNF)
3 = Home health agency (HHA)
4 = Religious Nonmedical (Hospital)
(eff. 8/1/00); prior to 8/00 referenced Christian Science (CS)
5 = Religious Nonmedical (Extended Care)
(eff. 8/1/00); prior to 8/00 referenced CS
6 = Intermediate care
7 = Clinic or hospital-based renal dialysis facility
8 = Special facility or ASC surgery
9 = Reserved

1 CLM_FREQ_TB — Claim Frequency Table

0 = Non-payment/zero claims
1 = Admit thru discharge claim
2 = Interim - first claim
3 = Interim - continuing claim
4 = Interim - last claim
5 = Late charge(s) only claim
6 = Adjustment of prior claim
7 = Replacement of prior claim;
eff 10/93, provider debit
8 = Void/cancel prior claim.
eff 10/93, provider cancel
9 = Final claim -- used in an HH PPS episode to indicate the claim should be processed like debit/ credit adjustment to RAP (initial claim) (eff. 10/00)
A = Admission notice - used when hospice is submitting the HCFA-1450 as an

admission notice - hospice NOE only
B = Hospice termination/revocation notice - hospice NOE only (eff 9/93)
C = Hospice change of provider notice - hospice NOE only (eff 9/93)
D = Hospice election void/cancel - hospice NOE only (eff 9/93)
E = Hospice change of ownership - hospice NOE only (eff 1/97)
F = Beneficiary initiated adjustment (eff 10/93)
G = CWF generated adjustment (eff 10/93)
H = HCFA generated adjustment (eff 10/93)
I = Misc adjustment claim (other than PRO or provider) - used to identify a debit adjustment initiated by HCFA or an intermediary - eff 10/93, used to identify intermediary initiated adjustment only
J = Other adjustment request (eff 10/93)
K = OIG initiated adjustment (eff 10/93)
M = MSP adjustment (eff 10/93)
P = Adjustment required by peer review organization (PRO)
X = Special adjustment processing - used for QA editing (eff 8/92)
Z = Hospital Encounter Data alternate submission (TOB '11Z') used for MCO enrollee hospital discharges 7/1/97-12/31/98; not stored in NCH. Exception: Problem in startup months may have resulted in this abbreviated UB-92 being erroneously stored in NCH.

1 CLM_HHA_RFRL_TB — Claim Home Health Referral Table

1 = Physician referral - The patient was admitted upon the recommendation of a personal physician.
2 = Clinic referral - The patient was admitted upon the recommendation of

this facility's clinic physician.

3 = HMO referral - The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician.

4 = Transfer from hospital - The patient was admitted as an inpatient transfer from an acute care facility.

5 = Transfer from a skilled nursing facility (SNF) - The patient was admitted as an inpatient transfer from a SNF.

6 = Transfer from another health care facility - The patient was admitted as a transfer from a health care facility other than an acute care facility or SNF.

7 = Emergency room - The patient was admitted upon the recommendation of this facility's emergency room physician.

8 = Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative.

9 = Information not available - The means by which the patient was admitted is not known.

A = Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.

B = Transfer from another HHA - Beneficiaries are permitted to transfer from one HHA to another unrelated HHA under HH PPS. (eff. 10/00)

C = Readmission to same HHA - If a beneficiary is discharged from an HHA and then re-admitted within the original 60-day episode, the original episode must be closed early and a new once created. NOTE: the use of this code will permit

the agency to send a new RAP allowing
all claims to be accepted by Medicare.
(eff. 10/00)

1 CLM_HIPPS_TB — Claim SNF & HHA Health Insurance — PPS Table

********** SNF PPS HIPPS **********
**********1st 3 positions (RUGS-III group)**********
AAA = Default: No assessment

BA1,BA2,BB1,BB2 = Behavior only problems (e.g., physical/verbal abuse)

CA1,CA2,CB1,CB2 = Clinically-complex conditions
CC1,CC2 (e.g., chemo, dialysis)

IA1,IA2,IB1,IB2 = Impaired cognition (e.g., im-
paired cognition (e.g., short-
term memory)

PA1,PA2,PB1,PB2 = Reduced physical functions
PC1,PC2,PD1,PD2
PE1,PE2

RHA,RHB,RHC,RLA = Low/medium/high rehabilitation
RLB,RMA,RMB,RMC

RUA,RUB,RUC,RVA = Very high/ultra high rehabilita-
RVB,RVC tion: highest level

SE1,SE2,SE3 = Extensive services; e.g.; IV feed
trach care

SSA,SSB,SSC = Special care; e.g.; coma, burns

**********Positions 4 & 5 represent HIPPS modifier/********
********** assessment type indicator **********

00 = No assessment completed
01 = Medicare 5-day full assessment/not an initial
admission assessment

02 = Medicare 30-day full assessment
03 = Medicare 60-day full assessment
04 = Medicare 90-day full assessment
05 = Medicare Readmission/Return required assessment
(eff. 10/2000)
07 = Medicare 14-day full or comprehensive assessment/
not an initial admission assessment
08 = Off-cycle Other Medicare Required Assessment (OMRA)
11 = Admission assessment AND Medicare 5-day (or readmission/
return) assessment
17 = Medicare 14-day required assessment AND initial
admission assessment (eff. 10/2000)
18 = OMRA replacing Medicare 5-day required assessment
(eff. 10/2000)
28 = OMRA replacing Medicare 30-day required assessment
(eff. 10/2000)
30 = Off-cycle significant change assessment (outside
assessment window) (eff. 10/2000)
31 = Significant change assessment replaces Medicare
5-day assessment (eff. 10/2000)
32 = Significant change assessment replaces Medicare
30-day assessment

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table

33 = Significant change assessment replaces Medicare
6--day assessment
34 = Significant change assessment replaces Medicare
90-day assessment
35 = Significant change assessment replaces a Medicare
readmission/return assessment
37 = Significant change assessment replaces Medicare
14-day assessment
38 = OMRA replacing Medicare 60-day required
assessment
40 = Off-cycle significant correction assessment of a
prior assessment (outside assessment window)
(eff. 10/2000)
41 = Significant correction of prior full assessment
replaces a Medicare 5-day assessment
42 = Significant correction of prior full assessment
replaces a Medicare 30-day assessment
43 = Significant correction of prior full assessment

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     replaces a Medicare 60-day assessment
44 = Significant correction of prior full assessment
     replaces a Medicare 90-day assessment
45 = Significant correction of a prior assessment
     replaces a readmission/return assessment
     (eff. 10/2000)
47 = Significant correction of prior full assessment
     replaces a Medicare 14-day required assessment
48 = OMRA replacing Medicare 90-day required assessment
54 = Quarterly review assessment - Medicare 90-day
     full assessment
78 = OMRA replacing a Medicare 14-day assessment
     (eff. 10/2000)

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*************Claim Home Health PPS HIPPS Table***************
************************* KEY ******************************
Position 1 = 'H'
Position 2 = Clinical (A, B, C, D)
Position 3 = Functional (E, F, G, H, I)
Position 4 = Service (J, K, K, M)
Position 5 = identifies which elements of the code were
             computed or derived:
             1 = 2nd, 3rd, 4th positions computed
             2 = 2nd position derived
             3 = 3rd position derived
             4 = 4th position derived
             5 = 2nd & 3rd positions derived
             6 = 3rd & 4th positions derived
             7 = 2nd & 4th positions derived
             8 = 2nd, 3rd, 4th positions derived
*************************************************************

**HHRG = C0F0S0/Clinical = Min, Functional = Min, Service = Min**
HAEJ1
HAEJ2
HAEJ3
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1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table
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HAEJ4
HAEJ5
HAEJ6
HAEJ7
HAEJ8
HHRG = C0F0S1/Clinical = Min, Functional = Min, Service = Low
HAEK1
HAEK2
HAEK3
HAEK4
HAEK5
HAEK6
HAEK7
HAEK8
HHRG = C0F0S2/Clinical = Min, Functional = Min, Service = Mod
HAEL1
HAEL2
HAEL3
HAEL4
HAEL5
HAEL6
HAEL7
HAEL8
HHRG = C0F0S3/Clinical = Min, Functional = Min, Service = High
HAEM1
HAEM2
HAEM3
HAEM4
HAEM5
HAEM6
HAEM7
HAEM8
HHRG = C0F1S0/Clinical = Min, Functional = Low, Service = Min
HAFJ1
HAFJ2
HAFJ3
HAFJ4
HAFJ5
HAFJ6
HAFJ7
HAFJ8
HHRG = C0F1S1/Clinical = Min, Functional = Low, Service = Low
HAFK1

HAFK2
HAFK3
HAFK4
HAFK5
HAFK6
HAFK7
HAFK8
HHRG = C0F1S2/Clinical = Min, Functional = Low, Service = Mod
HAFL1
HAFL2
HAFL3
HAFL4
HAFL5
HAFL6
HAFL7

1 CLM_HIPPS_TB Claim SNF & HHA Health Insurance PPS Table

HAFL8
HHRG = C0F1S3/Clinical = Min, Functional = Low, Service = High
HAFM1
HAFM2
HAFM3
HAFM4
HAFM5
HAFM6
HAFM7
HAFM8
HHRG = C0F2S0/Clinical = Min, Functional = Mod, Service = Min
HAGJ1
HAGJ2
HAGJ3
HAGJ4
HAGJ5
HAGJ6
HAGJ7
HAGJ8
HHRG = C0F2S1/Clinical = Min, Functional = Mod, Service = Low
HAGK1
HAGK2
HAGK3
HAGK4
HAGK5

HAGK6
HAGK7
HAGK8
HHRG = C0F2S2/Clinical = Min, Functional = Mod, Service = Mod
HAGL1
HAGL2
HAGL3
HAGL4
HAGL5
HAGL6
HAGL7
HAGL8
HHRG = C0F2S3/Clinical = Min, Functional = Mod, Service = High
HAGM1
HAGM2
HAGM3
HAGM4
HAGM5
HAGM6
HAGM7
HAGM8
HHRG = C0F3S0/Clinical = Min, Functional = High, Service = Min
HAHJ1
HAHJ2
HAHJ3
HAHJ4
HAHJ5
HAHJ6
HAHJ7
HAHJ8
HHRG = C0F3S1/Clinical = Min, Functional = High, Service = Low
HAHK1
HAHK2

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table

HAHK3
HAHK4
HAHK5
HAHK6
HAHK7
HAHK8
HHRG = C0F3S2/Clinical = Min, Functional = High, Service = Mod

HAHL1
HAHL2
HAHL3
HAHL4
HAHL5
HAHL6
HAHL7
HAHL8
HHRG = C0F3S3/Clinical = Min, Functional = High, Service = High
HAHM1
HAHM2
HAHM3
HAHM4
HAHM5
HAHM6
HAHM7
HAHM8
HHRG = C0F4S0/Clinical = Min, Functional = Max, Service = Min
HAIJ1
HAIJ2
HAIJ3
HAIJ4
HAIJ5
HAIJ6
HAIJ7
HAIJ8
HHRG = C0F4S1/Clinical = Min, Functional = Max, Service = Low
HAIK1
HAIK2
HAIK3
HAIK4
HAIK5
HAIK6
HAIK7
HAIK8
HHRG = C0F4S2/Clinical = Min, Functional = Max, Service = Mod
HAIL1
HAIL2
HAIL3
HAIL4
HAIL5
HAIL6
HAIL7

HAIL8
HHRG = C0F4S3/Clinical = Min, Functional = Max, Service = High
HAIM1
HAIM2
HAIM3
HAIM4
HAIM5
HAIM6

1 CLM_HIPPS_TB Claim SNF & HHA Health Insurance PPS Table

HAIM7
HAIM8
HHRG = C1F0S0/Clinical = Low, Functional = Min, Service = Min
HBEJ1
HBEJ2
HBEJ3
HBEJ4
HBEJ5
HBEJ6
HBEJ7
HBEJ8
HHRG = C1F0S1/Clinical = Low, Functional = Min, Service = Low
HBEK1
HBEK2
HBEK3
HBEK4
HBEK5
HBEK6
HBEK7
HBEK8
HHRG = C1F0S2/Clinical = Low, Functional = Min, Service = Mod
HBEL1
HBEL2
HBEL3
HBEL4
HBEL5
HBEL6
HBEL7
HBEL8
HHRG = C1F0S3/Clinical = Low, Functional = Min, Service = High
HBEM1
HBEM2

HBEM3
HBEM4
HBEM5
HBEM6
HBEM7
HBEM8
HHRG = C1F1S0/Clinical = Low, Functional = Low, Service = Min
HBFJ1
HBFJ2
HBFJ3
HBFJ4
HBFJ5
HBFJ6
HBFJ7
HBFJ8
HHRG = C1F1S1/Clinical = Low, Functional = Low, Service = Low
HBFK1
HBFK2
HBFK3
HBFK4
HBFK5
HBFK6
HBFK7
HBFK8
HHRG = C1F1S2/Clinical = Low, Functional = Low, Service = Mod
HBFL1

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table
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HBFL2
HBFL3
HBFL4
HBFL5
HBFL6
HBFL7
HBFL8
HHRG = C1F1S3/Clinical = Low, Functional = Low, Service = High
HBFM1
HBFM2
HBFM3
HBFM4
HBFM5
HBFM6

HBFM7
HBFM8
HHRG = C1F2S0/Clinical = Low, Functional = Mod, Service = Min
HBGJ1
HBGJ2
HBGJ3
HBGJ4
HBGJ5
HBGJ6
HBGJ7
HBGJ8
HHRG = C1F2S1/Clinical = Low, Functional = Mod, Service = Low
HBGK1
HBGK2
HBGK3
HBGK4
HBGK5
HBGK6
HBGK7
HBGK8
HHRG = C1F2S2/Clinical = Low, Functional = Mod, Service = Mod
HBGL1
HBGL2
HBGL3
HBGL4
HBGL5
HBGL6
HBGL7
HBGL8
HHRG = C1F2S3/Clinical = Low, Functional = Mod, Service = High
HBGM1
HBGM2
HBGM3
HBGM4
HBGM5
HBGM6
HBGM7
HBGM8
HHRG = C1F3S0/Clinical = Low, Functional = High, Service = Min
HBHJ1
HBHJ2
HBHJ3
HBHJ4

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                                HBHJ5
1         CLM_HIPPS_TB                  Claim SNF & HHA Health Insurance        PPS Table
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                                HBHJ6
                                HBHJ7
                                HBHJ8
                                **HHRG = C1F3S1/Clinical = Low, Functional = High, Service = Low**
                                HBHK1
                                HBHK2
                                HBHK3
                                HBHK4
                                HBHK5
                                HBHK6
                                HBHK7
                                HBHK8
                                **HHRG = C1F3S2/Clinical = Low, Functional = High, Service = Mod**
                                HBHL1
                                HBHL2
                                HBHL3
                                HBHL4
                                HBHL5
                                HBHL6
                                HBHL7
                                HBHL8
                                **HHRG = C1F3S3/Clinical = Low, Functional = High, Service = High**
                                HBHM1
                                HBHM2
                                HBHM3
                                HBHM4
                                HBHM5
                                HBHM6
                                HBHM7
                                HBHM8
                                **HHRG = C1F4S0/Clinical = Low, Functional = Max, Service = Min**
                                HBIJ1
                                HBIJ2
                                HBIJ3
                                HBIJ4
                                HBIJ5
                                HBIJ6
                                HBIJ7
                                HBIJ8
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                                **HHRG = C1F4S1/Clinical = Low, Functional = Max, Service = Low**
                                HBIK1
                                HBIK2
                                HBIK3
                                HBIK4
                                HBIK5
                                HBIK6
                                HBIK7
                                HBIK8
                                **HHRG = C1F4S2/Clinical = Low, Functional = Max, Service = Mod**
                                HBIL1
                                HBIL2
                                HBIL3
                                HBIL4
                                HBIL5
                                HBIL6
                                HBIL7
                                HBIL8
                                **HHRG = C1F4S3/Clinical = Low, Functional = Max, Service = High**
1         CLM_HIPPS_TB                 Claim SNF & HHA Health Insurance        PPS Table
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                                HBIM1
                                HBIM2
                                HBIM3
                                HBIM4
                                HBIM5
                                HBIM6
                                HBIM7
                                HBIM8
                                **HHRG = C2F0S0/Clinical = Mod, Functional = Min, Service = Min**
                                HCEJ1
                                HCEJ2
                                HCEJ3
                                HCEJ4
                                HCEJ5
                                HCEJ6
                                HCEJ7
                                HCEJ8
                                **HHRG = C2F0S1/Clinical = Mod, Functional = Min, Service = Low**
                                HCEK1
                                HCEK2
                                HCEK3
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HCEK4
HCEK5
HCEK6
HCEK7
HCEK8
HHRG = C2F0S2/Clinical = Mod, Functional = Min, Service = Mod
HCEL1
HCEL2
HCEL3
HCEL4
HCEL5
HCEL6
HCEL7
HCEL8
HHRG = C2F0S3/Clinical = Mod, Functional = Min, Service = High
HCEM1
HCEM2
HCEM3
HCEM4
HCEM5
HCEM6
HCEM7
HCEM8
HHRG = C2F1S0/Clinical = Mod, Functional = Low, Service = Min
HCFJ1
HCFJ2
HCFJ3
HCFJ4
HCFJ5
HCFJ6
HCFJ7
HCFJ8
HHRG = C2F1S2/Clinical = Mod, Functional = Low, Service = Mod
HCFL1
HCFL2
HCFL3
HCFL4

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table

HCFL5
HCFL6
HCFL7

HCFL8
HHRG = C2F1S3/Clinical = Mod, Functional = Low, Service = High
HCFM1
HCFM2
HCFM3
HCFM4
HCFM5
HCFM6
HCFM7
HCFM8
HHRG = C2F2S0/Clinical = Mod, Functional = Mod, Service = Min
HCGJ1
HCGJ2
HCGJ3
HCGJ4
HCGJ5
HCGJ6
HCGJ7
HCGJ8
HHRG = C2F2S1/Clinical = Mod, Functional = Mod, Service = Low
HCGK1
HCGK2
HCGK3
HCGK4
HCGK5
HCGK6
HCGK7
HCGK8
HHRG = C2F2S2/Clinical = Mod, Functional = Mod, Service = Mod
HCGL1
HCGL2
HCGL3
HCGL4
HCGL5
HCGL6
HCGL7
HCGL8
HHRG = C2F2S3/Clinical = Mod, Functional = Mod, Service = High
HCGM1
HCGM2
HCGM3
HCGM4
HCGM5

HCGM6
HCGM7
HCGM8
HHRG = C2F3S0/Clinical = Mod, Functional = High, Service = Min
HCHJ1
HCHJ2
HCHJ3
HCHJ4
HCHJ5
HCHJ6
HCHJ7
HCHJ8

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table
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HHRG = C2F3S1/Clinical = Mod, Functional = High, Service = Low
HCHK1
HCHK2
HCHK3
HCHK4
HCHK5
HCHK6
HCHK7
HCHK8
HHRG = C2F3S2/Clinical = Mod, Functional = High, Service = Mod
HCHL1
HCHL2
HCHL3
HCHL4
HCHL5
HCHL6
HCHL7
HCHL8
HHRG = C2F3S3/Clinical = Mod, Functional = High, Service = High
HCHM1
HCHM2
HCHM3
HCHM4
HCHM5
HCHM6
HCHM7
HCHM8
HHRG = C2F4S0/Clinical = Mod, Functional = Max, Service = Min

HCIJ1
HCIJ2
HCIJ3
HCIJ4
HCIJ5
HCIJ6
HCIJ7
HCIJ8
HHRG = C2F4S1/Clinical = Mod, Functional = Max, Service = Low
HCIK1
HCIK2
HCIK3
HCIK4
HCIK5
HCIK6
HCIK7
HCIK8
HHRG = C2F4S2/Clinical = Mod, Functional = Max, Service = Mod
HCIL1
HCIL2
HCIL3
HCIL4
HCIL5
HCIL6
HCIL7
HCIL8
HHRG = C2F4S3/Clinical = Mod, Functional = Max, Service = High
HCIM1
HCIM2
HCIM3

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table

HCIM4
HCIM5
HCIM6
HCIM7
HCIM8
HHRG = C3F0S0/Clinical = High, Functional = Min, Service = Min
HDEJ1
HDEJ2
HDEJ3
HDEJ4

HDEJ5
HDEJ6
HDEJ7
HDEJ8
HHRG = C3F0S1/Clinical = High, Functional = Min, Service = Low
HDEK1
HDEK2
HDEK3
HDEK4
HDEK5
HDEK6
HDEK7
HDEK8
HHRG = C3F0S2/Clinical = High, Functional = Min, Service = Mod
HDEL1
HDEL2
HDEL3
HDEL4
HDEL5
HDEL6
HDEL7
HDEL8
HHRG = C3F0S3/Clinical = High, Functional = Min, Service = High
HDEM1
HDEM2
HDEM3
HDEM4
HDEM5
HDEM6
HDEM7
HDEM8
HHRG = C3F1S0/Clinical = High, Functional = Low, Service = Min
HDFJ1
HDFJ2
HDFJ3
HDFJ4
HDFJ5
HDFJ6
HDFJ7
HDFJ8
HHRG = C3F1S1/Clinical = High, Functional = Low, Service = Low
HDFK1
HDFK2

HDFK3
HDFK4
HDFK5
HDFK6
HDFK7

1 CLM_HIPPS_TB Claim SNF & HHA Health Insurance PPS Table

HDFK8
HHRG = C3F1S2/Clinical = High, Functional = Low, Service = Mod
HDFL1
HDFL2
HDFL3
HDFL4
HDFL5
HDFL6
HDFL7
HDFL8
HHRG = C3F1S3/Clinical = High, Functional = Low, Service = High
HDFM1
HDFM2
HDFM3
HDFM4
HDFM5
HDFM6
HDFM7
HDFM8
HHRG = C3F2S0/Clinical = High, Functional = Mod, Service = Min
HDGJ1
HDGJ2
HDGJ3
HDGJ4
HDGJ5
HDGJ6
HDGJ7
HDGJ8
HHRG = C3F2S1/Clinical = High, Functional = Mod, Service = Low
HDGK1
HDGK2
HDGK3
HDGK4
HDGK5
HDGK6

HDGK7
HDGK8
HHRG = C3F2S2/Clinical = High, Functional = Mod, Service = Mod
HDGL1
HDGL2
HDGL3
HDGL4
HDGL5
HDGL6
HDGL7
HDGL8
HHRG = C3F2S3/Clinical = High, Functional = Mod, Service = High
HDGM1
HDGM2
HDGM3
HDGM4
HDGM5
HDGM6
HDGM7
HDGM8
HHRG = C3F3S0/Clinical = High, Functional = High, Service = Min
HDHJ1
HDHJ2

1 CLM_HIPPS_TB Claim SNF & HHA Health Insurance PPS Table

HDHJ3
HDHJ4
HDHJ5
HDHJ6
HDHJ7
HDHJ8
HHRG = C3F3S1/Clinical = High, Functional = High, Service = Low
HDHK1
HDHK2
HDHK3
HDHK4
HDHK5
HDHK6
HDHK7
HDHK8
HHRG = C3F3S2/Clinical = High, Functional = High, Service = Mod
HDHL1

HDHL2
HDHL3
HDHL4
HDHL5
HDHL6
HDHL7
HDHL8
HHRG = C3F3S3/Clinical = High, Functional = High, Service = High
HDHM1
HDHM2
HDHM3
HDHM4
HDHM5
HDHM6
HDHM7
HDHM8
HHRG = C3F4S0/Clinical = High, Functional = Max, Service = Min
HDIJ1
HDIJ2
HDIJ3
HDIJ4
HDIJ5
HDIJ6
HDIJ7
HDIJ8
HHRG = C3F4S1/Clinical = High, Functional = Max, Service = Low
HDIK1
HDIK2
HDIK3
HDIK4
HDIK5
HDIK6
HDIK7
HDIK8
HHRG = C3F4S2/Clinical = High, Functional = Max, Service = Mod
HDIL1
HDIL2
HDIL3
HDIL4
HDIL5
HDIL6

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table
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HDIL7
HDIL8
HHRG = C3F4S3/Clinical = High, Functional = Max, Service = High
HDIM1
HDIM2
HDIM3
HDIM4
HDIM5
HDIM6
HDIM7
HDIM8

1 CLM_MDCR_NPMT_RSN_TB — Claim Medicare Non-Payment Reason Table

A = Covered worker's compensation (Obsolete)
B = Benefit exhausted
C = Custodial care - noncovered care
(includes all 'beneficiary at fault'
waiver cases) (Obsolete)
E = HMO out-of-plan services not emergency
or urgently needed (Obsolete)
E = MSP cost avoided - IRS/SSA/HCFA Data
Match (eff. 7/00)
F = MSP cost avoid HMO Rate Cell (eff. 7/00)
G = MSP cost avoided Litigation Settlement
(eff. 7/00)
H = MSP cost avoided Employer Voluntary
Reporting (eff. 7/00)
J = MSP cost avoid Insurer Voluntary
Reporting (eff. 7/00)
K = MSP cost avoid Initial Enrollment
Questionnaire (eff. 7/00)
N = All other reasons for nonpayment
P = Payment requested
Q = MSP cost avoided Voluntary Agreement
(eff. 7/00)
R = Benefits refused, or evidence not
submitted
T = MSP cost avoided - IEQ contractor
(eff. 9/76) (obsolete 6/30/00)

U = MSP cost avoided - HMO rate cell
adjustment (eff. 9/76) (Obsolete 6/30/00)
V = MSP cost avoided - litigation
settlement (eff. 9/76) (Obsolete 6/30/00)
W = Worker's compensation (Obsolete)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data
match project (obsolete 6/30/00)
Z = Zero reimbursement RAPs -- zero reimbursement
made due to medical review intervention or
where provider specific zero payment has been
determined. (effective with HHPPS - 10/00)

1 CLM_OCRNC_SPAN_TB Claim Occurrence Span Table

70 = Eff 10/93, payer use only, the
nonutilization from/thru dates
for PPS-inlier stay where bene had
exhausted all full/coinsurance days, but
covered on cost report.
SNF qualifying hospital stay from/thru dates
71 = Hospital prior stay dates - the from/
thru dates of any hospital stay that
ended within 60 days of this hospital
or SNF admission.
72 = First/last visit - the dates of the
first and last visits occurring in this
billing period if the dates are different
from those in the statement covers period.
73 = Benefit eligibility period - the
inclusive dates during which CHAMPUS
medical benefits are available to a
sponsor's bene as shown on the
bene's ID card.
74 = Non-covered level of care - The from/
thru dates of a period at a noncovered
level of care in an otherwise
covered stay, excluding any period
reported with occurrence span code 76,
77, or 79.
75 = The from/thru dates of SNF level of care

during IP hospital stay. Shows PRO approval
of patient remaining in hospital
because SNF bed not available.
not applicable to swing bed
cases. PPS hospitals use in day
outlier cases only.

76 = Patient liability - From/thru
dates of period of noncovered care
for which hospital may charge
bene. The FI or PRO must have
approved such charges in advance.
patient must be notified in writing
3 days prior to noncovered period

77 = Provider liability - The from/thru
dates of period of noncovered care
for which the provider is liable.
Eff 3/92, applies to provider liability
where bene is charged with utilization
and is liable for deductible/coinsurance

78 = SNF prior stay dates - The from/
thru dates of any SNF stay that
ended within 60 days of this hospital
or SNF admission.

79 = (Payer code) -
Eff 3/92, from/thru dates of
period of noncovered care where
bene is not charged with utilization,
deductible, or coinsurance.
and provider is liable.
Eff 9/93, noncovered period of care
due to lack of medical necessity.

1 CLM_OCRNC_SPAN_TB — Claim Occurrence Span Table

80 - 99 = Reserved for state assignment

M0 = PRO/UR approved stay dates - Eff 10/93,
the first and last days that were
approved where not all of the stay was
approved.

1 CLM_PPS_IND_TB — Claim PPS Indicator Table

Effective NCH weekly process date 10/3/97 - 5/29/98

0 = not PPS bill (claim contains no PPS indicator)
2 = PPS bill (claim contains PPS indicator)

Effective NCH weekly process date 6/5/98

0 = not applicable (claim contains neither PPS
    nor deemed insured MQGE status indicators)
1 = Deemed insured MQGE (claim contains deemed
    insured MQGE indicator but not PPS indicator)
2 = PPS bill (claim contains PPS indicator but no
    deemed insured MQGE status indicator)
3 = Both PPS and deemed insured MQGE (contains both
    PPS and deemed insured MQGE indicators)

1 CLM_RLT_COND_TB — Claim Related Condition Table

01 = Military service related - Medical
     condition incurred during military
     service.
02 = Employment related - Patient alleged
     that the medical condition causing this
     episode of care was due to environment/
     events resulting from employment.
03 = Patient covered by insurance not
     reflected here - Indicates that patient
     or patient representative has stated
     that coverage may exist beyond that
     reflected on this bill.
04 = Health Maintenance Organization (HMO)
     enrollee - Medicare beneficiary is
     enrolled in an HMO. Eff 9/93, hospital
     must also expect to receive payment
     from HMO.
05 = Lien has been filed - Provider has
     filed legal claim for recovery of funds
     potentially due a patient as a result
     of legal action initiated by or on
     behalf of the patient.

06 = ESRD patient in 1st 18 months of entitlement covered by employer group health insurance - indicates Medicare may be secondary insurer. Eff 3/1/96, ESRD patient in 1st 30 months of entitlement covered by employer group health insurance.
07 = Treatment of nonterminal condition for hospice patient - The patient is a hospice enrollee, but the provider is not treating a terminal condition and is requesting Medicare reimbursement.
08 = Beneficiary would not provide information concerning other insurance coverage.
09 = Neither patient nor spouse is employed - Code indicates that in response to development questions, the patient and spouse have denied employment.
10 = Patient and/or spouse is employed but no EGHP coverage exists or (eff 9/93) other employer sponsored/provided health insurance covering patient.
11 = The disabled beneficiary and/or family member has no group coverage from a LGHP or (eff 9/93) other employer sponsored/provided health insurance covering patient.
12 = Payer code - Reserved for internal use only by third party payers. HCFA will assign as needed. Providers will not report them.
13 = Payer code - Reserved for internal use only by third party payers. HCFA will assign as needed. Providers will not report them.
14 = Payer code - Reserved for internal

1 CLM_RLT_COND_TB — Claim Related Condition Table

use only by third party payers. HCFA will assign as needed. Providers will not report them.
15 = Clean claim (eff 10/92)
16 = SNF transition exemption - An

exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date

17 = Patient is over 100 years old - Code indicates that the patient was over 100 years old at the date of admission.

18 = Maiden name retained - A dependent spouse entitled to benefits who does not use her husband's last name.

19 = Child retains mother's name - A patient who is a dependent child entitled to CHAMPVA benefits that does not have father's last name.

20 = Bene requested billing - Provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the bene has requested formal determination

21 = Billing for denial notice - The SNF or HHA realizes services are at a noncovered level of care or excluded, but requests a Medicare denial in order to bill medicaid or other insurer

22 = Patient on multiple drug regimen - A patient who is receiving multiple intravenous drugs while on home IV therapy

23 = Homecaregiver available - The patient has a caregiver available to assist him or her during self-administration of an intravenous drug

24 = Home IV patient also receiving HHA services - the patient is under care of HHA while receiving home IV drug therapy services

25 = Reserved for national assignment

26 = VA eligible patient chooses to receive services in Medicare certified facility rather than a VA facility (eff 3/92)

27 = Patient referred to a sole community hospital for a diagnostic laboratory test - (sole community hospital only).

(eff 9/93)
28 = Patient and/or spouse's EGHP is secondary to Medicare - Qualifying EGHP for employers who have fewer than 20 employees. (eff 9/93)
29 = Disabled beneficiary and/or family member's LGHP is secondary to Medicare - Qualifying LGHP for employer having fewer than 100 full and part-time employees

1 CLM_RLT_COND_TB Claim Related Condition Table

31 = Patient is student (full time - day) - Patient declares that he or she is enrolled as a full time day student.
32 = Patient is student (cooperative/work study program)
33 = Patient is student (full time - night) - Patient declares that he or she is enrolled as a full time night student.
34 = Patient is student (part time) - Patient declares that he or she is enrolled as a part time student.
36 = General care patient in a special unit - Patient is temporarily placed in special care unit bed because no general care beds were available.
37 = Ward accommodation is patient's request - Patient is assigned to ward accommodations at patient's request.
38 = Semi-private room not available - Indicates that either private or ward accommodations were assigned because semi-private accomodations were not available.
39 = Private room medically necessary - Patient needed a private room for medical reasons.
40 = Same day transfer - Patient transferred to another facility before midnight of the day of admission.
41 = Partial hospitalization - Eff 3/92,

indicates claim is for partial hospitalization services. For OP services, this includes a variety of psych programs.
42 = Reserved for national assignment.
43 = Reserved for national assignment.
44 = Reserved for national assignment.
45 = Reserved for national assignment.
46 = Nonavailability statement on file for CHAMPUS claim for nonemergency IP care for CHAMPUS bene residing within the catchment area (usually a 40 mile radius) of a uniform services hospital.
47 = Reserved for CHAMPUS.
48 = Reserved for national assignment.
49 = Reserved for national assignment.
50 = Reserved for national assignment.
51 = Reserved for national assignment.
52 = Reserved for national assignment.
53 = Reserved for national assignment.
54 = Reserved for national assignment.
55 = SNF bed not available - The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56 = Medical appropriateness - Patient's SNF admission was delayed more than 30 days after hospital discharge because

1 CLM_RLT_COND_TB — Claim Related Condition Table

physical condition made it inappropriate to begin active care within that period
57 = SNF readmission - Patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
58 = Payment of SNF claims for beneficiaries disenrolling from terminating M+C plans plans who have not met the 3-day hospital stay requirement (eff. 10/1/00)
59 = Reserved for national assignment.
60 = Operating cost day outlier - PRICER

indicates this bill is length of stay outlier (PPS)

61 = Operating cost cost outlier - PRICER indicates this bill is a cost outlier (PPS)

62 = PIP bill - This bill is a periodic interim payment bill.

63 = PRO denial received before batch clearance report - The HCSSACL receipt date is used on PRO adjustment if the PRO's notification is before orig bill's acceptance report. (Payer only code eff 9/93)

64 = Other than clean claim - The claim is not a 'clean claim'

65 = Non-PPS code - The bill is not a prospective payment system bill.

66 = Outlier not claimed - Bill may meet the criteria for cost outlier, but the hospital did not claim the cost outlier (PPS)

67 = Beneficiary elects not to use LTR days

68 = Beneficiary elects to use LTR days

69 = Operating IME Payment Only - providers request for IME payment for each discharge of MCO enrollee, beginning 1/1/98, from teaching hospitals (facilities with approved medical residency training program); not stored in NCH. Exception: problem in startup year may have resulted in this special IME payment request being erroneously stored in NCH. If present, disregard claim as condition code '69' is not valid NCH claim.

70 = Self-administered EPO - Billing is for a home dialysis patient who self administers EPO.

71 = Full care in unit - Billing is for a patient who received staff assisted dialysis services in a hospital or renal dialysis facility.

72 = Self care in unit - Billing is for a patient who managed his own dialysis services without staff assistance in a

hospital or renal dialysis facility.
73 = Self care training - Billing is for special dialysis services where the

1 CLM_RLT_COND_TB Claim Related Condition Table

patient and helper (if necessary) were learning to perform dialysis.
74 = Home - Billing is for a patient who received dialysis services at home.
75 = Home 100% reimbursement - (not to be used for services after 4/15/90) The billing is for home dialsis patient using a dialysis machine that was purchased under the 100% program.
76 = Back-up facility - Billing is for a patient who received dialysis services in a back-up facility.
77 = Provider accepts or is obligated/ required due to contractual agreement or law to accept payment by a primary payer as payment in full - Medicare pays nothing.
78 = New coverage not implemented by HMO - eff 3/92, indicates newly covered service under Medicare for which HMO does not pay.
79 = CORF services provided off site - Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.
80 - 99 = Reserved for state assignment.
A0 = CHAMPUS external partnership program special program indicator code. (eff 10/93)
A1 = EPSDT/CHAP - Early and periodic screening diagnosis and treatment special program indicator code. (eff 10/93)
A2 = Physically handicapped children's program - Services provided receive special funding through Title 8 of the Social Security Act or the CHAMPUS program for the handicapped. (eff 10/93)
A3 = Special federal funding - Designed for

uniform use by state uniform billing committees.
Special program indicator code (eff 10/93)

A4 = Family planning - Designed for uniform use by state uniform billing committees.
Special program indicator code (eff 10/93)

A5 = Disability - Designed for uniform use by state uniform billing committees.
Special program indicator code (eff 10/93)

A6 = PPV/Medicare - Identifies that pneumococcal pneumonia 100% payment vaccine (PPV) services should be reimbursed under a special Medicare program provision.
Special program indicator code (eff 10/93)

A7 = Induced abortion to avoid danger to woman's life.
Special program indicator code (eff 10/93)

A8 = Induced abortion - Victim of rape/

incest.
Special program indicator code (eff 10/93)

A9 = Second opinion surgery - Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.
Special program indicator code (eff 10/93)

B0 = Special program indicator
Reserved for national assignment.

B1 = Special program indicator
Reserved for national assignment.

B2 = Special program indicator
Reserved for national assignment.

B3 = Special program indicator
Reserved for national assignment.

B4 = Special program indicator
Reserved for national assignment.

B5 = Special program indicator
Reserved for national assignment.

B6 = Special program indicator
Reserved for national assignment.
B7 = Special program indicator
Reserved for national assignment.
B8 = Special program indicator
Reserved for national assignment.
B9 = Special program indicator
Reserved for national assignment.
C0 = Reserved for national assignment.
C1 = Approved as billed - The services
provided for this billing period have
been reviewed by the PRO/UR or
intermediary and are fully approved
including any day or cost outlier. (eff 10/93)
C2 = Automatic approval as billed based on
focused review. (No longer used for
Medicare)
PRO approval indicator services (eff 10/93)
C3 = Partial approval - The services
provided for this billing period have
been reviewed by the PRO/UR or
intermediary and some portion has been
denied (days or services). (eff 10/93)
C4 = Admission/services denied - Indicates
that all of the services were denied
by the PRO/UR.
PRO approval indicator services (eff 10/93)
C5 = Postpayment review applicable - PRO/UR
review to take place after payment.
PRO approval indicator services (eff 10/93)
C6 = Admission preauthorization - The
PRO/UR authorized this admission/
service but has not reviewed the
services provided.
PRO approval indicator services (eff 10/93)
C7 = Extended authorization - the PRO has
authorized these services for an
extended length of time but has not
reviewed the services provided.

1 CLM_RLT_COND_TB Claim Related Condition Table

PRO approval indicator services (eff 10/93)

C8 = Reserved for national assignment.
PRO approval indicator services (eff 10/93)
C9 = Reserved for national assignment.
PRO approval indicator services (eff 10/93)
D0 = Changes to service dates.
Change condition (eff 10/93)
D1 = Changes in charges.
Change condition (eff 10/93)
D2 = Changes in revenue codes/HCPCS.
Change condition (eff 10/93)
D3 = Second or subsequent interim
PPS bill.
Change condition (eff 10/93)
D4 = Change in grouper input (diagnosis
and/or procedures are changed resulting
in a different DRG).
Change condition (eff 10/93)
D5 = Cancel only to correct a beneficiary
claim account number or provider
identification number.
change condition (eff 10/93)
D6 = Cancel only to repay a duplicate
payment or OIG overpayment (includes
cancellation of an OP bill containing
services required to be included on the
IP bill). Change condition eff 10/93.
D7 = Change to make Medicare the secondary
payer.
Change condition (eff 10/93)
D8 = Change to make Medicare the primary
payer.
Change condition (eff 10/93)
D9 = Any other change.
Change condition (eff 10/93)
E0 = Change in patient status.
Change condition (eff 10/93)
EY = National Emphysema Treatment Trial (NETT)
or Lung Volume Reduction Surgery (LVRS)
clinical study (eff. 11/97)
G0 = Multiple medical visits occur on the same
day in the same revenue center but visits
are distinct and constitute independent
visits (allows for payment under outpatient

PPS -- eff. 7/3/00).
M0 = All inclusive rate for outpatient services. (payer only code)
M1 = Roster billed influenza virus vaccine. (payer only code) Eff 10/96, also includes pneumoccocal pneumonia vaccine (PPV)
M2 = HH override code - home health total reimbursement exceeds the $150,000 cap or the number of total visits exceeds the 150 limitation. (eff 4/3/95) (payer only code)
W0 = United Mine Workers of America (UMWA) SNF demonstration indicator (eff 1/97);

1 CLM_RLT_COND_TB — Claim Related Condition Table

but no claims transmitted until 2/98)

1 CLM_RLT_OCRNC_TB — Claim Related Occurrence Table

01 = Auto accident - The date of an auto accident.
02 = No-fault insurance involved, including auto accident/other - The date of an accident where the state has applicable no-fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt).
03 = Accident/tort liability - The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04 = Accident/employment related - The date of an accident relating to the patient's employment.
05 = Other accident - The date of an accident not described by the codes 01 thru 04.
06 = Crime victim - Code indicating the

date on which a medical condition resulted from alleged criminal action committed by one or more parties.

07 = Reserved for national assignment.

08 = Reserved for national assignment.

11 = Onset of symptoms/illness - The date the patient first became aware of symptoms/illness.

12 = Date of onset for a chronically dependent individual - Code indicates the date the patient/bene became a chronically dependent individual.

13 = Reserved for national assignment.

14 = Reserved for national assignment.

15 = Reserved for national assignment.

16 = Reserved for national assignment.

17 = Date outpatient occupational therapy plan established or last reviewed - Code indicating the date an occupational therapy plan was established or last reviewed (eff 3/93)

18 = Date of retirement (patient/bene) - Code indicates the date of retirement for the patient/bene.

19 = Date of retirement spouse - Code indicates the date of retirement for the patient's spouse.

20 = Guarantee of payment began - The date on which the provider began claiming Medicare payment under the guarantee of payment provision.

21 = UR notice received - Code indicating the date of receipt by the hospital of the UR committee's finding that the admission or future stay was not medically necessary.

22 = Active care ended - The date on which a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis

1 CLM_RLT_OCRNC_TB — Claim Related Occurrence Table

hospital. (For use by intermediary only)

23 = Reserved for national assignment (eff 10/93).
Benefits exhausted - The last date for which benefits can be paid. (term 9/30/93; replaced by code A3)

24 = Date insurance denied - The date the insurer's denial of coverage was received by a higher priority payer.

25 = Date benefits terminated by primary payer - The date on which coverage (including worker's compensation benefits or no-fault coverage) is no longer available to the patient.

26 = Date skilled nursing facility (SNF) bed available - The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.

27 = Date home health plan established or last reviewed - Code indicating the date a home health plan of treatment was established or last reviewed.
not used by hospital unless owner of facility

28 = Date comprehensive outpatient rehabilitation plan established or last reviewed - Code indicating the date a comprehensive outpatient rehabilitation plan was established or last reviewed.
not used by hospital unless owner of facility

29 = Date OPT plan established or last reviewed - the date a plan of treatment was established for outpatient physical therapy.
Not used by hospital unless owner of facility

30 = Date speech pathology plan treatment established or last reviewed - The date a speech pathology plan of treatment was established or last reviewed.
Not used by hospital unless owner of facility

31 = Date bene notified of intent to bill (accommodations) - The date of the notice provided to the patient by

the hospital stating that he no longer required a covered level of IP care.

32 = Date bene notified of intent to bill (procedures or treatment) - The date of the notice provided to the patient by the hospital stating requested care (diagnostic procedures or treatments) is not considered reasonable or necessary.

33 = First day of the Medicare coordination period for ESRD bene - During which Medicare benefits are secondary to benefits payable under an EGHP.

1 CLM_RLT_OCRNC_TB — Claim Related Occurrence Table

Required only for ESRD beneficiaries.

34 = Date of election of extended care facilities - The date the guest elected to receive extended care services (used by Christian Science Sanatoria only).

35 = Date treatment started for physical therapy - Code indicates the date services were initiated by the billing provider for physical therapy.

36 = Date of discharge for the IP hospital stay when patient received a transplant procedure - Hospital is billing for immunosuppressive drugs.

37 = The date of discharge for the IP hospital stay when patient received a noncovered transplant procedure - Hospital is billing for immunosuppresive drugs.

38 = Date treatment started for home IV therapy - Date the patient was first treated in his home for IV therapy.

39 = Date discharged on a continuous course of IV therapy - Date the patient was discharged from the hospital on a continuous course of IV therapy.

40 = Scheduled date of admission - The date on which a patient will be admitted

as an inpatient to the hospital. (This code may only be used on an outpatient claim.)

41 = The date on which the first outpatient diagnostic test was performed as part of a pre-admission testing (PAT) program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s).

42 = Date of discharge/termination of hospice care - for the final bill for hospice care. Eff 5/93, definition revised to apply only to date patient revoked hospice election.

43 = Reserved for national assignment.

44 = Date treatment started for occupational therapy - Code indicates the date services were initiated by the billing provider for occupational therapy.

45 = Date treatment started for speech therapy - Code indicates the date services were initiated by the billing provider for speech therapy.

46 = Date treatment started for cardiac rehabilitation - Code indicates the date services were initiated by the billing provider for cardiac rehabilitation.

47 = Noncovered Outlier Stay Began- code

1 CLM_RLT_OCRNC_TB — Claim Related Occurrence Table

indicates the date that cost outlier status began and no Medicare payment will be made because all benefits have been exhausted during the inlier stay or the beneficiary does not elect to use life time reserve days (to be implemented in 1999).

48 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for

your use. Providers will not report it.
49 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.
50 - 69 = Reserved for state assignment
A1 = Birthdate, Insured A - The birthdate of the individual in whose name the insurance is carried. (Eff 10/93)
A2 = Effective date, Insured A policy - A code indicating the first date insurance is in force. (eff 10/93)
A3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer A. (eff 10/93)
B1 = Birthdate, Insured B - The birthdate of the individual in whose name the insurance is carried. (eff 10/93)
B2 = Effective date, Insured B policy - A code indicating the first date insurance is in force. (eff 10/93)
B3 = Benefits exhausted - code indicating the last date for which benefits are available and after which no payment can be made to payer B. (eff 10/93)
C1 = Birthdate, Insured C - The birthdate of the individual in whose name the insurance is carried. (eff 10/93)
C2 = Effective date, Insured C policy - A code indicating the first date insurance is in force. (eff 10/93)
C3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer C. (eff 10/93)

1 CLM_SRVC_CLSFCTN_TYPE_TB — Claim Service Classification Type Table

For facility type code 1 thru 6, and 9

1 = Inpatient (including Part A)
2 = Hospital based or Inpatient (Part B only)
    or home health visits under Part B
3 = Outpatient (HHA-A also)
4 = Other (Part B)
5 = Intermediate care - level I
6 = Intermediate care - level II
7 = Subacute Inpatient
    (formerly Intermediate care - level III)
8 = Swing beds (used to indicate billing for
    SNF level of care in a hospital with an
    approved swing bed agreement)
9 = Reserved for national assignment

  For facility type code 7

1 = Rural health
2 = Hospital based or independent renal
    dialysis facility
3 = Free-standing provider based federally
    qualified health center (eff 10/91)
4 = Other Rehabilitation Facility (ORF) and
    Community Mental Health Center (CMHC)
    (eff 10/91 - 3/97); ORF only (eff. 4/97)
5 = Comprehensive Rehabilitation Center
      (CORF)
6 = Community Mental Health Center (CMHC) (eff 4/97)
7-8 = Reserved for national assignment
9 = Other

  For facility type code 8

1 = Hospice (non-hospital based)
2 = Hospice (hospital based)
3 = Ambulatory surgical center in hospital
    outpatient department
4 = Freestanding birthing center
5 = Critical Access Hospital (eff. 10/99)
    formerly Rural primary care hospital
    (eff. 10/94)
6-8 = Reserved for national use
9 = Other

1 CLM_TRANS_TB — Claim Transaction Table

0 = Religious NonMedical Health Care Institutions (RNHCI) bill (prior to 8/00, Christian Science bill), SNF bill, or state buy-in
1 = Psychiatric hospital facility bill or dummy psychiatric
2 = Tuberculosis hospital facility bill
3 = General care hospital facility bill or dummy LRD
4 = Regular SNF bill
5 = Home health agency bill (HHA)
6 = Outpatient hospital bill
C = CORF bill - type of OP bill in the HHA bill format (obsoleted 7/98)
H = Hospice bill

1 CLM_VAL_TB — Claim Value Table

04 = Inpatient professional component charges which are combined billed - For use only by some all inclusive rate hospitals. (Eff 9/93)
05 = Professional component included in charges and also billed separately to carrier - For use on Medicare and Medicaid bills if the state requests this information.
06 = Medicare blood deductible - Total cash blood deductible (Part A blood deductible).
07 = Medicare cash deductible (term 9/30/93) reserved for national assignment. (eff 10/93)
08 = Medicare Part A lifetime reserve amount in first calendar year - Lifetime reserve amount charged in the year of admission. (not stored in NCH until 2/93)
09 = Medicare Part A coinsurance amount in the first calendar year - Coinsurance amount charged in the year of admission.

(not stored in NCH until 2/93)
10 = Medicare Part A lifetime reserve amount in the second calendar year - Lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.
(not stored in NCH until 2/93)
11 = Medicare Part A coinsurance amount in the second calendar year - Coinsurance amount charged in the year of discharge where the bill spans two calendar years
(not stored in NCH until 2/93)
12 = Amount is that portion of higher priority EGHP insurance payment made on behalf of aged bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.
13 = Amount is that portion of higher priority EGHP insurance payment made on behalf of ESRD bene provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
14 = That portion of payment from higher priority no fault auto/other liability insurance made on behalf of bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional payment
15 = That portion of a payment from a higher priority WC plan made on behalf of a bene that the provider applied to

1 CLM_VAL_TB Claim Value Table

Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
16 = That portion of a payment from higher priority PHS or other federal

agency made on behalf of a
bene the provider applied
to Medicare covered services on this
bill. Six zeroes indicate
provider claimed conditional Medicare
payment.

17 = Operating Outlier amount - Providers do
not report this. For payer internal use
only. Indicates the amount of day or
cost outlier payment to be made.
(Do not include any PPS capital outlier
payment in this entry).

18 = Operating Disproportionate share amount -
Providers do not report this. For
payer internal use only. Indicates the
disproportionate share amount applicable
to the bill. Use the amount provided by
the disproportionate share field in PRICER.
(Do not include any PPS capital DSH adjust-
ment in this entry).

19 = Operating Indirect medical education amount -
Providers do not report this. For
payer internal use only. Indicates the
indirect medical education amount applicable
to the bill. (Do not include PPS capital
IME adjustment in this entry).

20 = Total payment sent provider for capital
under PPS, including HSP, FSP, outlier,
old capital, DSH adjustment, IME
adjustment, and any exception amount.
(used 10/1/91 - 3/1/92 for provider
reporting. Payer only code eff 9/93.)

21 = Catastrophic - Medicaid - Eligibility
requirements to be determined at state
level. (Medicaid specific/deleted 9/93)

22 = Surplus - Medicaid - Eligibility
requirements to be determined at state
level. (Medicaid specific/deleted 9/93)

23 = Recurring monthly income - Medicaid -
Eligibility requirements to be
determined at state level. (Medicaid
specific/deleted 9/93)

24 = Medicaid rate code - Medicaid -

Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)

31 = Patient liability amount - Amount shown is that which you or the PRO approved to charge the bene for noncovered accommodations, diagnostic procedures or treatments.

37 = Pints of blood furnished - Total number of pints of whole blood or units of packed red cells furnished to the patient. (eff 10/93)

38 = Blood deductible pints - The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. (eff 10/93)

39 = Pints of blood replaced - The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient. (eff 10/93)

40 = New coverage not implemented by HMO - amount shown is for inpatient charges covered by HMO (eff 3/92). (use this code when the bill includes inpatient charges for newly covered services which are not paid by HMO.)

41 = Amount is that portion of a payment from higher priority BL program made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.

42 = Amount is that portion of a payment from higher priority VA made on behalf of bene the provider applied to Medicare covered services on this

bill. Six zeroes indicate the
provider claimed conditional Medicare
payment.
43 = Disabled bene under age 65 with
LGHP - Amount is that portion of
a payment from a higher priority LGHP
made on behalf of a disabled Medicare
bene the provider applied to
Medicare covered services on this bill.
44 = Amount provider agreed to accept from
primary payer when amount less than charges
but more than payment received -
When a lesser amount is received and the
received amount is less than charges, a
Medicare secondary payment is due.
46 = Number of grace days - Following the
date of the PRO/UR determination, this
is the number of days determined by the
PRO/UR to be necessary to arrange for
the patient's post-discharge care.
(eff 10/93)
47 = Any liability insurance - Amount
is that portion from a higher priority
liability insurance made on behalf of
Medicare bene the provider
is applying to Medicare covered
services on this bill. (Eff 9/93)
48 = Hemoglobin reading - The latest

hemoglobin reading taken during this
billing cycle.
49 = Latest hematocrit reading taken
during billing cycle - Usually
reported in two pos. (a percentage) to
left of the dollar/cent delimiter.
if provided with a
a decimal, use the 3rd pos. to right
of the delimiter for the third digit.
50 = Physical therapy visits - Indicates
the number of physical therapy
visits from onset (at billing provider)

through this billing period.

51 = Occupational therapy visits - Indicates the number of occupational therapy visits from onset (at the billing provider) through this billing period.

52 = Speech therapy visits - Indicates the number of speech therapy visits from onset (at billing provider) through this billing period.

53 = Cardiac rehabilitation - Indicates the number of cardiac rehabilitation visits from onset (at billing provider) through this billing period.

54 = Reserved for national assignment.

55 = Reserved for national assignment.

56 = Hours skilled nursing provided - The number of hours skilled nursing provided during the billing period. Count only hours spent in the home.

57 = Home health visit hours - The number of home health aide services provided during the billing period. Count only the hours spent in the home.

58 = Arterial blood gas - Arterial blood gas value at beginning of each reporting period for oxygen therapy. This value or value 59 will be required on the initial bill for oxygen therapy and on the fourth month's bill.

59 = Oxygen saturation - Oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 will be required on the initial bill for oxygen therapy and on the fourth month's bill.

60 = HHA branch MSA - MSA in which HHA branch is located.

61 = Location of HHA service or hospice service - the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of the provider.

(eff. 10/1/97)
62 = Number of Part A home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
63 = Number of Part B home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
64 = Amount of home health payments attributed to the Part A trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
65 = Amount of home health payments attributed to the Part B trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
66 = Reserved for national assignment.
67 = Peritoneal dialysis - The number of hours of peritoneal dialysis provided during the billing period (only the hours spent in the home). (eff. 10/97)
68 = EPO drug - Number of units of EPO administered relating to the billing period.
69 = Reserved for national assignment
70 = Interest amount - (Providers do not report this.) Report the amount applied to this bill.
71 = Funding of ESRD networks - (Providers do not report this.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.
72 = Flat rate surgery charge - Code indicates the amount of the charge for outpatient surgery where the hospital has such a charging structure.

73 = Drug deductible - (For internal use by third party payers only). Report the amount of the drug deductible to be applied to the claim.
74 = Drug coinsurance - (For internal use by third party payers only). Report the amount of drug coinsurance to be applied to the claim.
75 = Gramm/Rudman/Hollings - (Providers do not report this.) Report the amount of the sequestration applied to this bill.
76 = Report provider's percentage of billed charges interim rate during billing period. Applies to OP hospital, SNF and HHA claims where interim rate is applicable. Report to left of dollar/cents delimiter. (TP payers internal use only)
77 = Payer code - This codes is set aside for payer use only. Providers do not report these codes.

1 CLM_VAL_TB — Claim Value Table

78 = Payer code - This codes is set aside for payer use only. Providers do not report these codes.
79 = Payer code - This code is set aside for payer use only. Providers do not report these codes.
80 - 99 = Reserved for state assignment.
A1 = Deductible Payer A - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93) - Prior value 07
A2 = Coinsurance Payer A - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)
A4 = Self-administered drugs administered in an emergency situation - Ordinarily the only noncovered self-administered drug

paid for under Medicare in an emergency situation is insulin administered to a patient in a diabetic coma. (eff 7/97)

B1 = Deductible Payer B - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93) - Prior value 07

B2 = Coinsurance Payer B - the amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)

C1 = Deductible Payer C - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93) - Prior value 07

C2 = Coinsurance Payer C - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)

Y1 = Part A demo payment - Portion of the payment designated as reimbursement for Part A services per the ORD contract. No deductible or coinsurance has been applied. (eff. 5/97)

Y2 = Part B demo payment - Portion of the payment designated as reimbursement for Part B services for the ORD contract. No deductible or coinsurance has been applied. (eff. 5/97)

Y3 = Part B coinsurance - Amount of Part B coinsurance applied by the intermediary to this demo claim. (eff. 5/97)

Y4 = Conventional provider Part A payment - Amount Medicare would have reimbursed the provider for Part A services if there had been no demo. (eff. 5/97)

1	CTGRY_EQTBL_BENE_IDENT_TB	Category Equatable Beneficiary Identification Code (BIC) Table

NCH BIC	SSA Categories

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

RRB Categories

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

1 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

1 DMERC_LINE_SUPLR_TYPE_TB — DMERC Line Supplier Type Table

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

for whom the carrier's own code has been shown.
5 = Institutional providers and independent laboratories for whom EI numbers are used in coding the ID field.
6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.
7 = Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field.
8 = Other entities for whom EI numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.

1 FI_CLM_ACTN_TB — Fiscal Intermediary Claim Action Table

1 = Original debit action (includes non-adjustment RTI correction items) - it will always be a 1 in regular bills.
2 = Cancel by credit adjustment - used only in credit/debit pairs (under HHPPS, updates the RAP).
3 = Secondary debit adjustment - used only in credit/debit pairs (under HHPPS, would be the final claim or an adjustment on a LUPA).
4 = Cancel only adjustment (under HHPPS, RAP/final claim/LUPA).
5 = Force action code 3
6 = Force action code 2
8 = Benefits refused (for inpatient bills, an 'R' nonpayment code must also be present
9 = Payment requested (used on bills that replace previously-submitted benefits-refused bills, action code 8. In such cases a debit/credit pair is not required. For inpatient bills, a 'P' should be entered in the nonpayment

code.)

1 FI_NUM_TB — Fiscal Intermediary Number Table

00010 = Alabama BC
00020 = Arkansas BC
00030 = Arizona BC
00040 = California BC (term. 12/00)
00050 = New Mexico BC/CO
00060 = Connecticut BC
00070 = Delaware BC - terminated 2/98
00080 = Florida BC
00090 = Florida BC
00101 = Georgia BC
00121 = Illinois - HCSC
00123 = Michigan - HCSC
00130 = Indiana BC/Administar Federal
00131 = Illinois - Administar
00140 = Iowa - Wellmark (term. 6/2000)
00150 = Kansas BC
00160 = Kentucky/Administar
00180 = Maine BC
00181 = Maine BC - Massachusetts
00190 = Maryland BC
00200 = Massachusetts BC - terminated 7/97
00210 = Michigan BC - terminated 9/94
00220 = Minnesota BC
00230 = Mississippi BC
00231 = Mississippi BC/LA
00232 = Mississippi BC
00241 = Missouri BC - terminated 9/92
00250 = Montana BC
00260 = Nebraska BC
00270 = New Hampshire/VT BC
00280 = New Jersey BC (term. 8/2000)
00290 = New Mexico BC - terminated 11/95
00308 = Empire BC
00310 = North Carolina BC
00320 = North Dakota BC
00332 = Community Mutual Ins Co; Ohio-Administar
00340 = Oklahoma BC

00350 = Oregon BC
00351 = Oregon BC/ID.
00355 = Oregon-CWF
00362 = Independence BC - terminated 8/97
00363 = Veritus, Inc (PITTS)
00370 = Rhode Island BC
00380 = South Carolina BC
00390 = Tennessee BC
00400 = Texas BC
00410 = Utah BC
00423 = Virginia BC; Trigon
00430 = Washington/Alaska BC
00450 = Wisconsin BC
00452 = Michigan - Wisconsin BC
00454 = United Government Services -
Wisconsin BC (eff. 12/00)
00460 = Wyoming BC
00468 = N Carolina BC/CPRTIVA
00993 = BC/BS Assoc.
17120 = Hawaii Medical Service

1 FI_NUM_TB — Fiscal Intermediary Number Table

50333 = Travelers; Connecticut United Healthcare
(terminated - date unknown)
51051 = Aetna California - terminated 6/97
51070 = Aetna Connecticut - terminated 6/97
51100 = Aetna Florida - terminated 6/97
51140 = Aetna Illinois - terminated 6/97
51390 = Aetna Pennsylvania - terminated 6/97
52280 = Mutual of Omaha
57400 = Cooperative, San Juan, PR
61000 = Aetna

1 FI_RQST_CLM_CNCL_RSN_TB — Claim Cancel Reason Code Table

C = Coverage Transfer
D = Duplicate Billing
H = Other or blank
L = Combining two beneficiary master records
P = Plan Transfer

S = Scramble
************For Action Code 4 ******************
*********Effective with HHPPS - 10/00************
A = RAP/Final claim/LUPA is cancelled by Interme-
diary. Does not delete episode. Do not set
cancellation indicator.
B = RAP/Final claim/LUPA is cancelled by Interme-
diary. Does not delete episode. Set
cancellation indicator to 1.
E = RAP/Final claim/LUPA is cancelled by Interme-
diary. Remove episode.
F = RAP/Final claim/LUPA is cancelled by Provider.
Remove episode.

1 GEO_SSA_STATE_TB State Table
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01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi

26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = Asia
56 = Canada & Islands
57 = Central America and West Indies

1	GEO_SSA_STATE_TB	State Table

58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = U.S. Possessions
64 = American Samoa
65 = Guam

66 = Saipan
97 = Northern Marianas
98 = Guam
99 = With 000 county code is American Samoa;
otherwise unknown

1 HCFA_PRVDR_SPCLTY_TB — HCFA Provider Specialty Table

Prior to 5/92

01 = General practice
02 = General surgery
03 = Allergy (revised 10/91 to mean allergy/
immunology)
04 = Otology, laryngology, rhinology
revised 10/91 to mean otolaryngology)
05 = Anesthesiology
06 = Cardiovascular disease (revised 10/91
to mean cardiology)
07 = Dermatology
08 = Family practice
09 = Gynecology--osteopaths only (deleted
10/91; changed to '16')
10 = Gastroenterology
11 = Internal medicine
12 = Manipulative therapy (osteopaths only)
(revised 10/91 to mean osteopathic
manipulative therapy)
13 = Neurology
14 = Neurological surgery (revised 10/91 to
mean neurosurgery)
15 = Obstetrics--osteopaths only (deleted
10/91; changed to '16')
16 = OB-gynecology
17 = Ophthalmology, otology, laryngology
rhinology--osteopaths only (deleted
10/91; changed to '18' if physicians
practice is more than 50% ophthalmology
or to '04' if physician's practice is
more than 50% otolaryngology. If
practice is 50/50, choose specialty

with greater allowed charges.
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Pathologic anatomy, clinical pathology-
osteopaths only (deleted 10/91;
changed to '22')
22 = Pathology
23 = Peripheral vascular disease or surgery
(deleted 10/91; changed to '76')
24 = Plastic surgery (revised to mean
plastic and reconstructive surgery).
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Psychiatry, neurology (osteopaths only)
(deleted 10/91; changed to '86')
28 = Proctology (revised 10/91 to mean
colorectal surgery).
29 = Pulmonary disease
30 = Radiology (revised 10/91 to mean
diagnostic radiology)
31 = Roentgenology, radiology (osteopaths)
(deleted 10/91; changed to '30')
32 = Radiation therapy--osteopaths (deleted

1 HCFA_PRVDR_SPCLTY_TB HCFA Provider Specialty Table

10/91; changed to '92')
33 = Thoracic surgery
34 = Urology
35 = Chiropractor, licensed (revised 10/91
to mean chiropractic)
36 = Nuclear medicine
37 = Pediatrics (revised 10/91 to mean
pediatric medicine)
38 = Geriatrics (revised 10/91 to mean
geriatric medicine)
39 = Nephrology
40 = Hand surgery
41 = Optometrist - services related to
condition of aphakia (revised 10/91 to
mean optometrist)
42 = Certified nurse midwife (added 7/88)

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

1 HCFA_PRVDR_SPCLTY_TB HCFA Provider Specialty Table

65 = Physical therapist (independent practice)
66 = Rheumatology (added 10/91)
67 = Occupational therapist--independent practice
68 = Clinical psychologist
69 = Independent laboratory--billing independently (revised 10/91 to mean independent clinical laboratory -- billing independently)
70 = Clinic or other group practice, except Group Practice Prepayment Plan (GPPP)
71 = Group Practice Prepayment Plan - diagnostic X-ray (do not use after 1/92)
72 = Group Practice Prepayment Plan - diagnostic laboratory (do not use after 1/92)
73 = Group Practice Prepayment Plan - physiotherapy (do not use after 1/92)
74 = Group Practice Prepayment Plan - occupational therapy (do not use after 1/92)
75 = Group Practice Prepayment Plan - other medical care (do not use after 1/92)
76 = Peripheral vascular disease (added 10/91)
77 = Vascular surgery (added 10/91)
78 = Cardiac surgery (added 10/91)
79 = Addiction medicine (added 10/91)
8O = Clinical social worker (1991)
81 = Critical care-intensivists (added 10/91)
82 = Ophthalmology, cataracts specialty (added 10/91; used only until 5/92)
83 = Hematology/oncology (added 10/91)
84 = Preventive medicine (added 10/91)
85 = Maxillofacial surgery (added 10/91)
86 = Neuropsychiatry (added 10/91)
87 = All other (e.g. drug and department stores) (revised 10/91 to mean all other suppliers)
88 = Unknown (revised 10/91 to mean physician assistant)
90 = Medical oncology (added 10/91)
91 = Surgical oncology (added 10/91)

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

Effective 5/92

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

1 HCFA_PRVDR_SPCLTY_TB HCFA Provider Specialty Table

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

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

1	HCFA_PRVDR_SPCLTY_TB	HCFA Provider Specialty Table

47 = Independent Diagnostic Testing Facility
(IDTF) (eff. 6/98)
48 = Podiatry
49 = Ambulatory surgical center
(formerly miscellaneous)

50 = Nurse practitioner
51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics)
52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics)
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
54 = Medical supply company not included in 51, 52, or 53. (Revised 10/93 to mean medical supply company for DMERC)
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-orthotist
58 = Individuals not included in 55, 56, or 57 (revised 10/93 to mean medical supply company with registered pharmacist)
59 = Ambulance service supplier, e.G., private ambulance companies, funeral homes, etc.
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.G., National Cancer Society, National Heart Associiation, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier
64 = Audiologist (billing independently)
65 = Physical therapist (independently practicing)
66 = Rheumatology (eff 5/92)
Note: during 93/94 DMERC also used this to mean medical supply company with

respiratory therapist
67 = Occupational therapist (independently practicing)
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Multispecialty clinic or group practice
71 = Diagnostic X-ray (GPPP) (not to be assigned after 5/92)

1 HCFA_PRVDR_SPCLTY_TB HCFA Provider Specialty Table

72 = Diagnostic laboratory (GPPP) (not to be assigned after 5/92)
73 = Physiotherapy (GPPP) (not to be assigned after 5/92)
74 = Occupational therapy (GPPP) (not to be assigned after 5/92)
75 = Other medical care (GPPP) (not to assigned after 5/92)
76 = Peripheral vascular disease (eff 5/92)
77 = Vascular surgery (eff 5/92)
78 = Cardiac surgery (eff 5/92)
79 = Addiction medicine (eff 5/92)
80 = Licensed clinical social worker
81 = Critical care (intensivists) (eff 5/92)
82 = Hematology (eff 5/92)
83 = Hematology/oncology (eff 5/92)
84 = Preventive medicine (eff 5/92)
85 = Maxillofacial surgery (eff 5/92)
86 = Neuropsychiatry (eff 5/92)
87 = All other suppliers (e.g. drug and department stores) (note: DMERC used 87 to mean department store from 10/93 through 9/94; recoded eff 10/94 to A7; NCH cross-walked DMERC reported 87 to A7.
88 = Unknown supplier/provider specialty (note: DMERC used 87 to mean grocery store from 10/93 - 9/94; recoded eff 10/94 to A8; NCH cross-walked DMERC

reported 88 to A8.
89 = Certified clinical nurse specialist
90 = Medical oncology (eff 5/92)
91 = Surgical oncology (eff 5/92)
92 = Radiation oncology (eff 5/92)
93 = Emergency medicine (eff 5/92)
94 = Interventional radiology (eff 5/92)
95 = Independent physiological
laboratory (eff 5/92)
96 = Optician (eff 10/93)
97 = Physician assistant (eff 5/92)
98 = Gynecologist/oncologist (eff 10/94)
99 = Unknown physician specialty
A0 = Hospital (eff 10/93) (DMERCs only)
A1 = SNF (eff 10/93) (DMERCs only)
A2 = Intermediate care nursing facility
(eff 10/93) (DMERCs only)
A3 = Nursing facility, other (eff 10/93)
(DMERCs only)
A4 = HHA (eff 10/93) (DMERCs only)
A5 = Pharmacy (eff 10/93) (DMERCs only)
A6 = Medical supply company with respiratory
therapist (eff 10/93) (DMERCs only)
A7 = Department store (for DMERC use:
eff 10/94, but cross-walked from
code 87 eff 10/93)
A8 = Grocery store (for DMERC use:
eff 10/94, but cross-walked from
code 88 eff 10/93)

1 HCFA_PRVDR_SPCLTY_TB — HCFA Provider Specialty Table

1 HCFA_TYPE_SRVC_TB — HCFA Type of Service Table

1 = Medical care
2 = Surgery
3 = Consultation
4 = Diagnostic radiology
5 = Diagnostic laboratory
6 = Therapeutic radiology

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

1 LINE_ADDTNL_CLM_DCMTN_IND_TB — Line Additional Claim Documentation Indicator Table

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

1 LINE_PLC_SRVC_TB — Line Place Of Service Table

Prior To 1/92

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

Effective 1/92

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

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

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

1 LINE_PRCSG_IND_TB — Line Processing Indicator Table

A = Allowed
B = Benefits exhausted
C = Noncovered care
D = Denied (existed prior to 1991; from BMAD)
I = Invalid data
L = CLIA (eff 9/92)
M = Multiple submittal--duplicate line item
N = Medically unnecessary
O = Other
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided (contractor #88888) - voluntary agreement (eff. 1/98)
R = Reprocessed--adjustments based on subsequent reprocessing of claim
S = Secondary payer
T = MSP cost avoided - IEQ contractor (eff. 7/76)
U = MSP cost avoided - HMO rate cell adjustment (eff. 7/96)
V = MSP cost avoided - litigation settlement (eff. 7/96)

X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data
match project
Z = Bundled test, no payment
(eff. 1/1/98)

1 LINE_PRVDR_PRTCPTG_IND_TB — Line Provider Participating Indicator Table

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

1 NCH_CLM_TYPE_TB — NCH Claim Type Table

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

73 = Physician 'Full-Encounter' claim
(available in NMUD)
81 = RIC M DMERC non-DMEPOS claim
82 = RIC M DMERC DMEPOS claim

1 NCH_EDIT_TB NCH EDIT TABLE

A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
A000 = (C) REIMB > $100,000 OR UNITS > 150
A002 = (C) CLAIM IDENTIFIER (CAN)
A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
A004 = (C) PATIENT SURNAME BLANK
A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
A006 = (C) DATE OF BIRTH IS NOT NUMERIC
A007 = (C) INVALID GENDER (0, 1, 2)
A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
A1X1 = (C) PERCENT ALLOWED INDICATOR
A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589
A1X3 = (C) DT>96365,DIAG=V725
A1X4 = (C) INVALID DIAGNOSTIC CODES
C050 = (U) HOSPICE - SPELL VALUE INVALID
D102 = (C) DME DATE OF BIRTH INVALID
D2X2 = (C) DME SCREEN SAVINGS INVALID
D2X3 = (C) DME SCREEN RESULT INVALID
D2X4 = (C) DME DECISION IND INVALID
D2X5 = (C) DME WAIVER OF PROV LIAB INVALID
D3X1 = (C) DME NATIONAL DRUG CODE INVALID
D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID
D4X2 = (C) DME OUT OF DMERC SERVICE AREA
D4X3 = (C) DME STATE CODE INVALID
D5X1 = (C) TOS INVALID FOR DME HCPCS
D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING
D5X3 = (C) DME INVALID USE OF MS MODIFIER
D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED
D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS
D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID
D6X1 = (C) DME SUPPLIER NUMBER MISSING
D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1
D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6

XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1
Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
Y003 = (C) HCPCS R0075/UNITS=SERVICES
Y010 = (C) TOB=13X/14X AND T.C.>$7,500
Y011 = (C) INP CLAIM/REIM > $75,000
Z001 = (C) RVNU 820-859 REQ COND CODE 71-76
Z002 = (C) CC M2 PRESENT/REIMB > $150,000
Z003 = (C) CC M2 PRESENT/UNITS > 150
Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX
Z005 = (C) REIMB>99999 AND REIMB<150000
Z006 = (C) UNITS>99 AND UNITS<150
Z237 = (E) HOSPICE OVERLAP - DATE ZERO
0011 = (C) ACTION CODE INVALID
0013 = (C) CABG/PCOE AND INVALID ADMIT DATE
0014 = (C) DEMO NUM NOT=01-06,08,15,31
0015 = (C) ESRD PLAN BUT DEMO ID NOT = 15
0016 = (C) INVALID VA CLAIM
0017 = (C) DEMO=31,TOB<>11 OR SPEC<>08
0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
0020 = (C) CANCEL ONLY CODE INVALID
0021 = (C) DEMO COUNT > 1
0301 = (C) INVALID HI CLAIM NUMBER

1 NCH_EDIT_TB NCH EDIT TABLE

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

0601 = (C) GENDER INVALID
0701 = (C) CONTRACTOR INVALID CARRIER/ETC
0702 = (C) PROVIDER NUMBER INCONSISTANT
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
0704 = (C) INVALID CONT FOR CABG DEMO
0705 = (C) INVALID CONT FOR PCOE DEMO
0901 = (C) INVALID DISP CODE OF 02
0902 = (C) INVALID DISP CODE OF SPACES
0903 = (C) INVALID DISP CODE
1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE
13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
1301 = (C) LINE COUNT NOT NUMERIC OR > 13
1302 = (C) RECORD LENGTH INVALID
1401 = (C) INVALID MEDICARE STATUS CODE
1501 = (C) ADMIT DATE/ENTRY CODE INVALID
1502 = (C) ADMIT DATE > STAY FROM DATE
1503 = (C) ADMIT DATE INVALID WITH THRU DATE
1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
1505 = (C) HCPCS W SERVICE DATES > 09-30-94
1601 = (C) INVESTIGATION IND INVALID
1701 = (C) SPLIT IND INVALID
1801 = (C) PAY-DENY CODE INVALID
1802 = (C) HEADER AMT AND NOT DENIED CLAIM
1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME
1901 = (C) AB CROSSOVER IND INVALID
2001 = (C) HOSPICE OVERRIDE INVALID
2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
2102 = (C) FROM/THRU DATE OR KRON/PAT STAT
2201 = (C) FROM/THRU DATE OR HCPCS YR INVAL
2202 = (C) STAY-FROM DATE > THRU-DATE
2203 = (C) THRU DATE INVALID
2204 = (C) FROM DATE BEFORE EFFECTIVE DATE
2205 = (C) DATE YEARS DIFFERENT ON OUTPAT
2207 = (C) MAMMOGRAPHY BEFORE 1991
2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID
2302 = (C) COVERED DAYS INVALID OR INCONSIST
2303 = (C) COST REPORT DAYS > ACCOMIDATION
2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL
2305 = (C) UTIL DAYS = INCONSISTENCIES
2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT
2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09

1 NCH_EDIT_TB NCH EDIT TABLE

2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
2401 = (C) NON-UTIL DAYS INVALID
2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL
2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
2504 = (C) COINSURANCE AMOUNT EXCESSIVE
2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT
2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST
2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR
2508 = (C) COINSURANCE DAYS INVALID FOR TRAN
2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
2602 = (C) LR-DYS, NO VAL 08,10/PD/DEN>CUR+27
2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
2604 = (C) PPS BILL, NO DAY OUTLIER
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
28XA = (C) UTIL DAYS > FROM TO BENEF EXH
28XB = (C) BENEFITS EXH DATE > FROM DATE
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN = (C) INVALID OCC CODE
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

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4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
4201 = (C) BLOOD PINTS UNREPLACED INVALID
4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED
4203 = (C) INVALID CPO PROVIDER NUMBER
4301 = (C) BLOOD DEDUCTABLE INVALID
4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
4304 = (C) BLOOD DEDUCT > 3 - REPLACED
4501 = (C) PRIMARY DIAGNOSIS INVALID
46XA = (C) MSP VET AND VET AT MEDICARE
46XB = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
46XC = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
46XG = (C) VALU CODE 20 INVALID
46XN = (C) VALUE CODE 37,38,39 INVALID
46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSNG
46XP = (C) BLD UNREP VS REV CDS AND/OR UNITS
46XQ = (C) VALUE CDE 37=39 AND 38 IS PRESENT
46XR = (C) BLD FIELDS VS REV CDE 380,381,382
46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT
46XT = (C) CABG/PCOE,VC<>Y1,Y2,Y3,Y4,VA NOT>0
46X1 = (C) VALUE AMOUNT INVALID
46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT

46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61
46X7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
4601 = (C) CABG/PCOE, MSP CODE PRESENT
4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
4901 = (C) PCOE/CABG,DEN CD NOT D
4902 = (C) PCOE/CABG BUT DME
50X1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
50X2 = (C) REV CD=054X,MOD NOT = QM,QN
5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
51XA = (C) HCPCS EYEWARE & REV CODE NOT 274
51XC = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51XD = (C) HCPCS REQUIRES UNITS > ZERO
51XE = (C) HCPCS REQUIRES REVENUE CODE 636
51XF = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51XG = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
51XH = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044
51XI = (C) TOB 21X/P82<>2/3/4:REV CD>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

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5320 = (U) BILL > DOEBA AND IND-1 = 2
5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
5355 = (U) HOSPICE DAYS USED SECONDARY
5378 = (C) SERVICE DATE < AGE 50
5399 = (U) HOSPICE PERIOD NUM MATCH
5410 = (U) INPAT DEDUCTABLE
5425 = (U) PART B DEDUCTABLE CHECK
5430 = (U) PART B DEDUCTABLE CHECK
5450 = (U) PART B COMPARE MED EXPENSE
5460 = (U) PART B COMPARE MED EXPENSE
5499 = (U) MED EXPENSE TRAILER MISSING
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS
5510 = (U) COIN DAYS/SNF COIN DAYS
5515 = (U) FULL DAYS/COIN DAYS
5516 = (U) SNF FULL DAYS/SNF COIN DAYS
5520 = (U) LIFE RESERVE DAYS
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS
5540 = (U) HH VISITS NE AFT PT B TRLR
5550 = (E) SNF LESS THAN PT A EFF DATE
5600 = (D) LOGICAL DUPE, COVERED
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123
5602 = (D) LOGICAL DUPE, PANDE C, E OR I
5603 = (D) LOGICAL DUPE, COVERED
5605 = (D) POSS DUPE, OUTPAT REIMB
5606 = (D) POSS DUPE, HOME HEALTH COVERED U
5623 = (U) NON-PAY CODE IS P
57X1 = (C) PROVIDER SPECIALITY CODE INVALID
57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL
57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND
57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID
5700 = (U) LINKED TO THREE SPELLS

5701 = (C) DEMO ID=02,RIC NOT = 5
5702 = (C) DEMO ID=02,INVALID PROVIDER NUM
58X1 = (C) PROVIDER TYPE INVALID
58X9 = (C) TYPE OF SERVICE INVALID
5802 = (C) REIMB > $150,000
5803 = (C) UNITS/VISITS > 150
5804 = (C) UNITS/VISITS > 99
59XA = (C) PROST ORTH HCPCS/FROM DATE
59XB = (C) HCPCS/FROM DATE/TYPE P OR I
59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE
59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE
59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS
59XG = (C) CAPPED/FREQ-MAINT/PROST HCPCS
59XH = (C) HCPCS E0620/TYPE/DATE
59XI = (C) HCPCS E0627-9/ DATE < 1991
59XL = (C) HCPCS 00104 - TOS/POS
59X1 = (C) INVALID HCPCS/TOS COMBINATION
59X2 = (C) ASC IND/TYPE OF SERVICE INVALID
59X3 = (C) TOS INVALID TO MODIFIER
59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB
59X5 = (C) MAMMOGRAPHY FOR MALE
59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS
59X7 = (C) CAPPED-HCPCS/FROM DATE
59X8 = (C) FREQUENTLY MAINTAINED HCPCS
59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R
5901 = (U) ERROR CODE OF Q
60X1 = (C) ASSIGN IND INVALID

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6000 = (U) ADJUSTMENT BILL SPELL DATA
6020 = (U) CURRENT SPELL DOEBA < 1990
6030 = (U) ADJUSTMENT BILL SPELL DATA
6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA
61X1 = (C) PAY PROCESS IND INVALID
61X2 = (C) DENIED CLAIM/NO DENIED LINE
61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
61X4 = (C) RATE MISSING OR NON-NUMERIC
6100 = (C) REV 0001 NOT PRESENT ON CLAIM
6101 = (C) REV COMPUTED CHARGES NOT=TOTAL
6102 = (C) REV COMPUTED NON-COVERED/NON-COV
6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER
62XA = (C) PSYC OT PT/REIM/TYPE

62X1 = (C) DME/DATE/100% OR INVAL REIMB IND
62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED
62X8 = (C) KIDNEY DONO/TYPE/100%
62X9 = (C) PNEUM VACCINE/TYPE/100%
6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV
6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE
6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA
6260 = (U) HOSPICE ADJUSTMENT STAY DAYS
6261 = (U) HOSPICE ADJUSTMENT DAYS USED
6265 = (U) HOSPICE ADJUSTMENT DAYS USED
6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)
63X1 = (C) DEDUCT IND INVALID
63X2 = (C) DED/HCFA COINS IN PCOE/CABG
6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS
6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)
64X1 = (C) PROVIDER IND INVALID
6430 = (U) PART B DEDUCTABLE CHECK
65X1 = (C) PAYSCREEN IND INVALID
66?? = (D) POSS DUPE, CR/DB, DOC-ID
66XX = (D) POSS DUPE, CR/DB, DOC-ID
66X1 = (C) UNITS AMOUNT INVALID
66X2 = (C) UNITS IND > 0; AMT NOT VALID
66X3 = (C) UNITS IND = 0; AMT > 0
66X4 = (C) MT INDICATOR/AMOUNT
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

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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

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94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT

94G4 = (C) NO PAY CODE = R & REIMB PRESENT
94X1 = (C) BLOOD LIMIT INVALID
94X2 = (C) TYPE/BLOOD DEDUCTIBLE
94X3 = (C) TYPE/DATE/LIMIT AMOUNT
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
9401 = (C) BLOOD DEDUCTIBLE AMT > 3
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
9404 = (C) INVALID GENDER CODE ON PRO-PAY
9407 = (C) INVALID DRG NUMBER
9408 = (C) INVALID DRG NUMBER (GLOBAL)
9409 = (C) HCFA DRG<>DRG ON BILL
9410 = (C) CABG/PCOE,INVALID DRG
95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
95X2 = (C) MSP AMOUNT APPLIED INVALID
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
95X5 = (C) MSP CODE = G/DATE BEFORE 1987
95X6 = (C) MSP CODE = X AND NOT AVOIDED
95X7 = (C) MSP CODE VALID, CABG/PCOE
96X1 = (C) OTHER AMOUNTS INVALID
96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB
97X1 = (C) OTHER AMOUNTS INDICATOR INVALID
97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0
98X1 = (C) COINSURANCE INVALID
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
99XX = (D) POSS DUPE, PART B DOC-ID
9901 = (C) REV CODE INVALID OR TRAILER CNT=0
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
9903 = (C) NO CLINIC VISITS FOR RHC
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE
991X = (C) NO DATE OF SERVICE
9910 = (C) EDIT 9910 (NEW)
9911 = (C) BLOOD VERIFIED INVALID
9920 = (C) EDIT 9920 (NEW)
9930 = (C) EDIT 9930 (NEW)
9931 = (C) OUTPAT COINSURANCE VALUES
9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT
9940 = (C) EDIT 9940 (NEW)
9942 = (C) EDIT 9942 (NEW)

9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
9945 = (C) SERVICE DATE < 98001
9946 = (C) INVALID DIAGNOSIS CODE
9947 = (C) INVALID DIAGNOSIS CODE
9948 = (C) STAY FROM>96365,DIAG=V725
9960 = (C) MED CHOICE BUT HMO DATA MISSING
9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER

1 NCH_NEAR_LINE_RIC_TB — NCH Near-Line Record Identification Code Table

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

1 NCH_PATCH_TB — NCH Patch Table

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

'H' conversion, patch applied to claims with NCH weekly process date prior to 3/94. Prior to version 'H', patch indicator stored in redefined Claim Edit Group, 4th occurrence, position 1.

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

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

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

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

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

65, MSC = '20'.
08 = Invalid NCH primary payer code set to blanks (Instnl) -- applied during Version 'H' conversion to claims with NCH weekly process date 10/1/93-10/30/95, where MSP values =

1 NCH_PATCH_TB NCH Patch Table

invalid '0', '1', '2', '3' or '4' (caused by erroneous logic in HCFA program code, which was corrected on 11/1/95).
09 = Zero CWF claim accretion date replaced with NCH weekly process date (all claim types) -- applied during Version 'H' conversion to Instnl and DMERC claims; applied during Version 'G' conversion to non-institutional (non-DMERC) claims. Prior to Version 'H', patch indicator stored in redefined claim edit group, 3rd occurrence, position 1.
10 = Multiple Revenue Center 0001 (Outpatient, HHA and Hospice) -- patch applied to 1998 & 1999 Nearline and SAFs to delete any revenue codes that followed the first '0001' revenue center code. The edit was applied across all institutional claim types, including Inpatient/SNF (the problem was only found with OP/HHA/Hospice claims). The problem was corrected 6/25/99.
11 = Truncated claim total charge amount in the fixed portion replaced with the total charge amount in the revenue center 0001 amount field -- service years 1998 & 1999 patched during quarterly merge. The 1998 & 1999 SAFs were corrected when finalized in 7/99. The patch was done for records with NCH Daily Process Date 1/4/99 - 5/14/99.
12 = Missing claim-level HHA Total Visit Count -- service years 1998, 1999 & 2000 patch applied during Version 'I' conversion of both the Nearline and SAFs. Problem occurs in those claims recovered during the missing claims effort.
13 = Inconsistent Claim MCO Paid Switch made consistent

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

1 NCH_STATE_SGMT_TB — NCH State Segment Table

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

1	NCH_STATE_SGMT_TB	NCH State Segment Table
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58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = US Possessions
97 = Saipan - MP
98 = Guam
99 = American Samoa

1	PRVDR_NUM_TB	Provider Number Table
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- First two positions are the GEO SSA State Code.
  Exception: 55 = California
  67 = Texas
  68 = Florida

- Positions 3 and sometimes 4 are used as a category identifier. The remaining positions are serial numbers. The following blocks of numbers are reserved for the facilities indicated (NOTE: may have different meanings dependent on the Type of Bill (TOB):

0001-0879	Short-term (general and specialty) hospitals where TOB = 11X; ESRD clinic where TOB = 72X
0880-0899	Reserved for hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB = 72X
0900-0999	Multiple hospital component in a medical complex (numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1000-1199	Reserved for future use
1200-1224	Alcohol/drug hospitals (excluded from PPS-numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1225-1299	Medical assistance facilities (Montana project); ESRD clinic where TOB = 72X
1300-1399	Rural Primary Care Hospital (RCPH) - eff. 10/97 changed to Critical Access Hospitals (CAH)
1400-1499	Continuation of 4900-4999 series (CMHC)
1500-1799	Hospices
1800-1989	Federally Qualified Health Centers (FQHC) where TOB = 73X; SNF (IP PTB) where TOB = 22X; HHA where TOB = 32X, 33X, 34X
1990-1999	Christian Science Sanatoria (hospital services)
2000-2299	Long-term hospitals (excluded from PPS)

	2300-2499	Chronic renal disease facilities (hospital based)
	2500-2899	Non-hospital renal disease treatment centers
	2900-2999	Independent special purpose renal dialysis facility (1)
	3000-3024	Formerly tuberculosis hospitals (numbers retired)
	3025-3099	Rehabilitation hospitals (excluded from PPS)
	3100-3199	Continuation of Subunits of Nonprofit and Proprietary Home Health Agencies (7300-7399) Series (3) (eff. 4/96)
	3200-3299	Continuation of 4800-4899 series (CORF)

1 PRVDR_NUM_TB

Provider Number Table

3300-3399	Children's hospitals (excluded from PPS) where TOB = 11X; ESRD clinic where TOB = 72X
3400-3499	Continuation of rural health clinics (provider-based) (3975-3999)
3500-3699	Renal disease treatment centers (hospital satellites)
3700-3799	Hospital based special purpose renal dialysis facility (1)
3800-3974	Rural health clinics (free-standing)
3975-3999	Rural health clinics (provider-based)
4000-4499	Psychiatric hospitals (excluded from PPS)
4500-4599	Comprehensive Outpatient Rehabilitation Facilities (CORF)
4600-4799	Community Mental Health Centers (CMHC); 9/30/91 - 3/31/97 used for clinic OPT where TOB = 74X
4800-4899	Continuation of 4500-4599 series (CORF) (eff. 10/95)
4900-4999	Continuation of 4600-4799 series (CMHC) (eff. 10/95); 9/30/91 - 3/31/97 used for clinic OPT where TOB = 74X
5000-6499	Skilled Nursing Facilities
6500-6989	CMHC / Outpatient physical therapy services where TOB = 74X; CORF where TOB =

75X

6990-6999	Christian Science Sanatoria (skilled nursing services)
7000-7299	Home Health Agencies (HHA) (2)
7300-7399	Subunits of 'nonprofit' and 'proprietary' Home Health Agencies (3)
7400-7799	Continuation of 7000-7299 series
7800-7999	Subunits of state and local governmental Home Health Agencies (3)
8000-8499	Continuation of 7400-7799 series (HHA)
8500-8899	Continuation of rural health center (provider based) (3400-3499)
8900-8999	Continuation of rural health center (free-standing) (3800-3974)
9000-9499	Continuation of 8000-8499 series (HHA) (eff. 10/95)
9500-9999	Reserved for future use (eff. 8/1/98) NOTE: 10/95-7/98 this series was assigned to HHA's but rescinded - no HHA's were ever assigned a number from this series.

Exception:

P001-P999	Organ procurement organization

(1) These facilities (SPRDFS) will be assigned the same provider number whenever they are recertified.

(2) The 6400-6499 series of provider numbers in Iowa (16), South Dakota (43) and Texas (45) have been used in reducing acute care costs (RACC) experiments.

(3) In Virginia (49), the series 7100-7299 has been reserved for statewide subunit components of the Virginia state home health agencies.

(4) Parent agency must have a number in the

7000-7299, 7400-7799 or 8000-8499 series.

NOTE:
There is a special numbering system for units of hospitals that are excluded from prospective payment system (PPS) and hospitals with SNF swing-bed designation. An alpha character in the third position of the provider number identifies the type of unit or swing-bed designation as follows:

S = Psychiatric unit (excluded from PPS)
T = Rehabilitation unit (excluded from PPS)
U = Short term/acute care swing-bed hospital
V = Alcohol drug unit (prior to 10/87 only)
W = Long term SNF swing-bed hospital (eff 3/91)
Y = Rehab hospital swing-bed (eff 9/92)
Z = Rural primary care swing-bed hospital

There is also a special numbering system for assigning emergency hospital identification numbers (non participating hospitals). The sixth position of the provider number is as follows:

E = Non-federal emergency hospital
F = Federal emergency hospital

1 PTNT_DSCHRG_STUS_TB — Patient Discharge Status Table

01 = Discharged to home/self care (routine charge).
02 = Discharged/transferred to other short term general hospital for inpatient care.
03 = Discharged/transferred to skilled nursing facility (SNF) - (For hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF.

04 = Discharged/transferred to intermediate care facility (ICF).
05 = Discharged/transferred to another type of institution for inpatient care (including distinct parts).
06 = Discharged/transferred to home care of organized home health service organization.
07 = Left against medical advice or discontinued care.
08 = Discharged/transferred to home under care of a home IV drug therapy provider.
09 = Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
20 = Expired (did not recover - Christian Science patient).
30 = Still patient.
40 = Expired at home (hospice claims only)
41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
42 = Expired - place unknown (Hospice claims only)
50 = Hospice - home (eff. 10/96)
51 = Hospice - medical facility (eff. 10/96)
61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (to be implemented in 1999)
71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (to be implemented in 1999).
72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (to be implemented in 1999).

1 REV_CNTR_ANSI_TB — Revenue Center ANSI Code Table

*******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*******
**************POSITIONS 1 & 2 OF ANSI CODE***************

CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals -- this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

OA = Other Adjustments -- this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions -- this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility -- this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

***********Claim Adjustment Reason Codes**************
***********POSITIONS 3 through 5 of ANSI CODE**********

1 = Deductible Amount
2 = Coinsurance Amount
3 = Co-pay Amount
4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.
5 = The procedure code/bill type is inconsistent with the place of service.
6 = The procedure code is inconsistent with the patient's

age.
7 = The procedure code is inconsistent with the patient's gender.
8 = The procedure code is inconsistent with the provider type.
9 = The diagnosis is inconsistent with the patient's age.
10 = The diagnosis is inconsistent with the patient's gender.
11 = The diagnosis is inconsistent with the procedure.
12 = The diagnosis is inconsistent with the provider type.
13 = the date of death precedes the date of service.
14 = The date of birth follows the date of service.
15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
16 = Claim/service lacks information which is needed for

1 REV_CNTR_ANSI_TB — Revenue Center ANSI Code Table

adjudication.
17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.
18 = Duplicate claim/service.
19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20 = Claim denied because this injury/illness is covered by the liability carrier.
21 = Claim denied because this injury/illness is the liability of the no-fault carrier.
22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.
23 = Claim adjusted because charges have been paid by another payer.
24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
25 = Payment denied. Your Stop loss deductible has not been met.
26 = Expenses incurred prior to coverage.
27 = Expenses incurred after coverage terminated.
28 = Coverage not in effect at the time the service was provided.
29 = The time limit for filing has expired.

30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31 = Claim denied as patient cannot be identified as our insured.
32 = Our records indicate that this dependent is not an eligible dependent as defined.
33 = Claim denied. Insured has no dependent coverage.
34 = Claim denied. Insured has no coverage for newborns.
35 = Benefit maximum has been reached.
36 = Balance does not exceed copayment amount.
37 = Balance does not exceed deductible amount.
38 = Services not provided or authorized by designated (network) providers.
39 = Services denied at the time authorization/pre-certification was requested.
40 = Charges do not meet qualifications for emergency/urgent care.
41 = Discount agreed to in Preferred Provider contract.
42 = Charges exceed our fee schedule or maximum allowable amount.
43 = Gramm-Rudman reduction.
44 = Prompt-pay discount.
45 = Charges exceed your contracted/legislated fee arrangement.
46 = This (these) service(s) is(are) not covered.
47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid.
48 = This (these) procedure(s) is(are) not covered.
49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.

1 REV_CNTR_ANSI_TB — Revenue Center ANSI Code Table

51 = These are non-covered services because this a pre-existing condition.
52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
53 = Services by an immediate relative or a member of the

same household are not covered.
54 = Multiple physicians/assistants are not covered in this case.
55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.
57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
60 = Charges for outpatient services with the proximity to inpatient services are not covered.
61 = Charges adjusted as penalty for failure to obtain second surgical opinion.
62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.
63 = Correction to a prior claim. INACTIVE
64 = Denial reversed per Medical Review. INACTIVE
65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE
66 = Blood Deductible.
67 = Lifetime reserve days. INACTIVE
68 = DRG weight. INACTIVE
69 = Day outlier amount.
70 = Cost outlier amount.
71 = Primary Payer amount.
72 = Coinsurance day. INACTIVE
73 = Administrative days. INACTIVE
74 = Indirect Medical Education Adjustment.
75 = Direct Medical Education Adjustment.
76 = Disproportionate Share Adjustment.
77 = Covered days. INACTIVE
78 = Non-covered days/room charge adjustment.
79 = Cost report days. INACTIVE
80 = Outlier days. INACTIVE
81 = Discharges. INACTIVE
82 = PIP days. INACTIVE

83 = Total visits. INACTIVE
84 = Capital adjustments. INACTIVE
85 = Interest amount. INACTIVE
86 = Statutory adjustment. INACTIVE
87 = Transfer amounts.
88 = Adjustment amount represents collection against
receivable created in prior overpayment.
89 = Professional fees removed from charges.
90 = Ingredient cost adjustment.

1 REV_CNTR_ANSI_TB Revenue Center ANSI Code Table

91 = Dispensing fee adjustment.
92 = Claim paid in full. INACTIVE
93 = No claim level adjustment. INACTIVE
94 = Process in excess of charges.
95 = Benefits adjusted. Plan procedures not followed.
96 = Non-covered charges.
97 = Payment is included in allowance for another
service/procedure.
98 = The hospital must file the Medicare claim for this
inpatient non-physician service. INACTIVE
99 = Medicare Secondary Payer Adjustment Amount. INACTIVE
100 = Payment made to patient/insured/responsible party.
101 = Predetermination: anticipated payment upon comple-
tion of services or claim ajudication.
102 = Major medical adjustment.
103 = Provider promotional discount (i.e. Senior citizen
discount).
104 = Managed care withholding.
105 = Tax withholding.
106 = Patient payment option/election not in effect.
107 = Claim/service denied because the related or qualifying
claim/service was not paid or identified on the claim.
108 = Claim/service reduced because rent/purchase guidelines
were not met.
109 = Claim not covered by this payer/contractor. You must
send the claim to the correct payer/contractor.
110 = Billing date predates service date.
111 = Not covered unless the provider accepts assignment.
112 = Claim/service adjusted as not furnished directly
to the patient and/or not documented.
113 = Claim denied because service/procedure was provided

outside the United States or as a result of war.
114 = Procedure/product not approved by the Food and Drug Administration.
115 = Claim/service adjusted as procedure postponed or canceled.
116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.
117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.
118 = Charges reduced for ESRD network support.
119 = Benefit maximum for this time period has been reached.
120 = Patient is covered by a managed care plan. INACTIVE
121 = Indemnification adjustment.
122 = Psychiatric reduction.
123 = Payer refund due to overpayment. INACTIVE
124 = Payer refund amount - not our patient. INACTIVE
125 = Claim/service adjusted due to a submission/billing error(s).
126 = Deductible - Major Medical.
127 = Coinsurance - Major Medical.
128 = Newborn's services are covered in the mother's allowance.
129 = Claim denied - prior processing information appears incorrect.
130 = Paper claim submission fee.

1 REV_CNTR_ANSI_TB — Revenue Center ANSI Code Table

131 = Claim specific negotiated discount.
132 = Prearranged demonstration project adjustment.
133 = The disposition of this claim/service is pending further review.
134 = Technical fees removed from charges.
135 = Claim denied. Interim bills cannot be processed.
136 = Claim adjusted. Plan procedures of a prior payer were not followed.
137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
138 = Claim/service denied. Appeal procedures not followed or time limits not met.
139 = Contracted funding agreement - subscriber is employed

by the provider of services.
140 = Patient/Insured health identification number and name do not match.
141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.
142 = Claim adjusted by the monthly Medicaid patient liability amount.
A0 = Patient refund amount
A1 = Claim denied charges.
A2 = Contractual adjustment.
A3 = Medicare Secondary Payer liability met. INACTIVE
A4 = Medicare Claim PPS Capital Day Outlier Amount.
A5 = Medicare Claim PPS Capital Cost Outlier Amount.
A6 = Prior hospitalization or 30 day transfer requirement not met.
A7 = Presumptive Payment Adjustment.
A8 = Claim denied; ungroupable DRG.
B1 = Non-covered visits.
B2 = Covered visits. INACTIVE
B3 = Covered charges. INACTIVE
B4 = Late filing penalty.
B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.
B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.
B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.
B9 = Services not covered because the patient is enrolled in a Hospice.
B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B12 = Services not documented in patients' medical records.

B13 = Previously paid. Payment for this claim/service
may have been provided in a previous payment.

1 REV_CNTR_ANSI_TB Revenue Center ANSI Code Table

B14 = Claim/service denied because only one visit or
consultation per physician per day is covered.
B15 = Claim/service adjusted because this procedure/
service is not paid separately.
B16 = Claim/service adjusted because 'New Patient'
qualifications were not met.
B17 = Claim/service adjusted because this service was
not prescribed by a physician, not prescribed
prior to delivery, the prescription is incomplete,
or the prescription is not current.
B18 = Claim/service denied because this procedure code/
modifier was invalid on the date of service or
claim submission.
B19 = Claim/service adjusted because of the finding of a
Review Organization. INACTIVE
B20 = Charges adjusted because procedure/service was
partially or fully furnished by another provider.
B21 = The charges were reduced because the service/care
was partially furnished by another physician.
INACTIVE
B22 = This claim/service is adjusted based on the
diagnosis.
B23 = Claim/service denied because this provider has
failed an aspect of a proficiency testing program.
W1 = Workers Compensation State Fee Schedule Adjustment.

1 REV_CNTR_APC_TB Revenue Center Ambulatory Payment Classification (APC)

0001 = Photochemotherapy
0002 = Fine needle Biopsy/Aspiration
0003 = Bone Marrow Biopsy/Aspiration
0004 = Level I Needle Biopsy/ Aspiration Except
Bone Marrow
0005 = Level II Needle Biopsy /Aspiration Except
Bone Marrow
0006 = Level I Incision & Drainage

0007 = Level II Incision & Drainage
0008 = Level III Incision & Drainage
0009 = Nail Procedures
0010 = Level I Destruction of Lesion
0011 = Level II Destruction of Lesion
0012 = Level I Debridement & Destruction
0013 = Level II Debridement & Destruction
0014 = Level III Debridement & Destruction
0015 = Level IV Debridement & Destruction
0016 = Level V Debridement & Destruction
0017 = Level VI Debridement & Destruction
0018 = Biopsy Skin, Subcutaneous Tissue or Mucous Membrane
0019 = Level I Excision/ Biopsy
0020 = Level II Excision/ Biopsy
0021 = Level III Excision/ Biopsy
0022 = Level IV Excision/ Biopsy
0023 = Exploration Penetrating Wound
0024 = Level I Skin Repair
0025 = Level II Skin Repair
0026 = Level III Skin Repair
0027 = Level IV Skin Repair
0029 = Incision/Excision Breast
0030 = Breast Reconstruction/Mastectomy
0031 = Hyperbaric Oxygen
0032 = Placement Transvenous Catheters/Arterial Cutdown
0033 = Partial Hospitalization
0040 = Arthrocentesis & Ligament/Tendon Injection
0041 = Arthroscopy
0042 = Arthroscopically-Aided Procedures
0043 = Closed Treatment Fracture Finger/Toe/Trunk
0044 = Closed Treatment Fracture/Dislocation Except
Finger/Toe/Trunk
0045 = Bone/Joint Manipulation Under Anesthesia
0046 = Open/Percutaneous Treatment Fracture or Dislocation
0047 = Arthroplasty without Prosthesis
0048 = Arthroplasty with Prosthesis
0049 = Level I Musculoskeletal Procedures Except Hand
and Foot
0050 = Level II Musculoskeletal Procedures Except Hand
and Foot
0051 = Level III Musculoskeletal Procedures Except Hand
and Foot
0052 = Level IV Musculoskeletal Procedures Except Hand

			and Foot
			0053 = Level I Hand Musculoskeletal Procedures
			0054 = Level II Hand Musculoskeletal Procedures
			0055 = Level I Foot Musculoskeletal Procedures
			0056 = Level II Foot Musculoskeletal Procedures
			0057 = Bunion Procedures
1	REV_CNTR_APC_TB		Revenue Center Ambulatory Payment Classification (APC)
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			0058 = Level I Strapping and Cast Application
			0059 = Level II Strapping and Cast Application
			0060 = Manipulation Therapy
			0070 = Thoracentesis/Lavage Procedures
			0071 = Level I Endoscopy Upper Airway
			0072 = Level II Endoscopy Upper Airway
			0073 = Level III Endoscopy Upper Airway
			0074 = Level IV Endoscopy Upper Airway
			0075 = Level V Endoscopy Upper Airway
			0076 = Endoscopy Lower Airway
			0077 = Level I Pulmonary Treatment
			0078 = Level II Pulmonary Treatment
			0079 = Ventilation Initiation and Management
			0080 = Diagnostic Cardiac Catheterization
			0081 = Non-Coronary Angioplasty or Atherectomy
			0082 = Coronary Atherectomy
			0083 = Coronary Angiosplasty
			0084 = Level I Electrophysiologic Evaluation
			0085 = Level II Electrophysiologic Evaluation
			0086 = Ablate Heart Dysrhythm Focus
			0087 = Cardiac Electrophysiologic Recording/Mapping
			0088 = Thrombectomy
			0089 = Level I Implantation/Removal/Revision of Pacemaker, AICD Vascular Device
			0090 = Level II Implantation/Removal/Revision of Pacemaker, AICD Vascular Device
			0091 = Level I Vascular Ligation
			0092 = Level II Vascular Ligation
			0093 = Vascular Repair/Fistula Construction
			0094 = Resuscitation and Cardioversion
			0095 = Cardiac Rehabilitation
			0096 = Non-Invasive Vascular Studies
			0097 = Cardiovascular Stress Test
			0098 = Injection of Sclerosing Solution

0099 = Continuous Cardiac Monitoring
0100 = Continuous ECG
0101 = Tilt Table Evaluation
0102 = Electronic Analysis of Pacemakers/other Devices
0109 = Bone Marrow Harvesting and Bone Marrow/Stem Cell
Transplant
0110 = Transfusion
0111 = Blood Product Exchange
0112 = Extracorporeal Photopheresis
0113 = Excision Lymphatic System
0114 = Thyroid/Lymphadenectomy Procedures
0116 = Chemotherapy Administration by Other Technique
Except Infusion
0117 = Chemotherapy Administration by Infusion Only
0118 = Chemotherapy Administration by Both Infusion and
Other Technique
0120 = Infusion Therapy Except Chemotherapy
0121 = Level I Tube changes and Repositioning
0122 = Level II Tube changes and Repositioning
0123 = Level III Tube changes and Repositioning
0130 = Level I Laparoscopy
0131 = Level II Laparoscopy
0132 = Level III Laparoscopy
0140 = Esophageal Dilation without Endoscopy

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)

0141 = Upper GI Procedures
0142 = Small Intestine Endoscopy
0143 = Lower GI Endoscopy
0144 = Diagnostic Anoscopy
0145 = Therapeutic Anoscopy
0146 = Level I Sigmoidoscopy
0147 = Level II Sigmoidoscopy
0148 = Level I Anal/Rectal Procedure
0149 = Level II Anal/Rectal Procedure
0150 = Level III Anal/Rectal Procedure
0151 = Endoscopic Retrograde Cholangio-Pancreatography (ERCP)
0152 = Percutaneous Biliary Endoscopic Procedures
0153 = Peritoneal and Abdominal Procedures
0154 = Hernia/Hydrocele Procedures
0157 = Colorectal Cancer Screening: Barium Enema
(Not subject to National coinsurance)

0158 = Colorectal Cancer Screening: Colonoscopy
Not subject to National coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. Payment rate is lower of the HOPD payment rate or the Ambulatory Surgical Center payment.
0159 = Colorectal Cancer Screening: Flexible Sigmoidoscopy
Not subject to National coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. Payment rate is lower of the HOPD payment rate or the Ambulatory Surgical Center payment.
0160 = Level I Cystourethroscopy and other Genitourinary Procedures
0161 = Level II Cystourethroscopy and other Genitourinary Procedures
0162 = Level III Cystourethroscopy and other Genitourinary Procedures
0163 = Level IV Cystourethroscopy and other Genitourinary Procedures
0164 = Level I Urinary and Anal Procedures
0165 = Level II Urinary and Anal Procedures
0166 = Level I Urethral Procedures
0167 = Level II Urethral Procedures
0168 = Level III Urethral Procedures
0169 = Lithotripsy
0170 = Dialysis for Other Than ESRD Patients
0180 = Circumcision
0181 = Penile Procedures
0182 = Insertion of Penile Prosthesis
0183 = Testes/Epididymis Procedures
0184 = Prostate Biopsy
0190 = Surgical Hysteroscopy
0191 = Level I Female Reproductive Procedures
0192 = Level II Female Reproductive Procedures
0193 = Level III Female Reproductive Procedures
0194 = Level IV Female Reproductive Procedures
0195 = Level V Female Reproductive Procedures
0196 = Dilatation & Curettage
0197 = Infertility Procedures
0198 = Pregnancy and Neonatal Care Procedures
0199 = Vaginal Delivery
0200 = Therapeutic Abortion
0201 = Spontaneous Abortion

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)

0210 = Spinal Tap
0211 = Level I Nervous System Injections
0212 = Level II Nervous System Injections
0213 = Extended EEG Studies and Sleep Studies
0214 = Electroencephalogram
0215 = Level I Nerve and Muscle Tests
0216 = Level II Nerve and Muscle Tests
0217 = Level III Nerve and Muscle Tests
0220 = Level I Nerve Procedures
0221 = Level II Nerve Procedures
0222 = Implantation of Neurological Device
0223 = Level I Revision/Removal Neurological Device
0224 = Level II Revision/Removal Neurological Device
0225 = Implantation of Neurostimulator Electrodes
0230 = Level I Eye Tests
0231 = Level II Eye Tests
0232 = Level I Anterior Segment Eye
0233 = Level II Anterior Segment Eye
0234 = Level III Anterior Segment Eye Procedures
0235 = Level I Posterior Segment Eye Procedures
0236 = Level II Posterior Segment Eye Procedures
0237 = Level III Posterior Segment Eye Procedures
0238 = Level I Repair and Plastic Eye Procedures
0239 = Level II Repair and Plastic Eye Procedures
0240 = Level III Repair and Plastic Eye Procedures
0241 = Level IV Repair and Plastic Eye Procedures
0242 = Level V Repair and Plastic Eye Procedures
0243 = Strabismus/Muscle Procedures
0244 = Corneal Transplant
0245 = Cataract Procedures without IOL Insert
0246 = Cataract Procedures with IOL Insert
0247 = Laser Eye Procedures Except Retinal
0248 = Laser Retinal Procedures
0250 = Nasal Cauterization/Packing
0251 = Level I ENT Procedures
0252 = Level II ENT Procedures
0253 = Level III ENT Procedures
0254 = Level IV ENT Procedures
0256 = Level V ENT Procedures
0257 = Implantation of Cochlear Device
0258 = Tonsil and Adenoid Procedures

0260 = Level I Plain Film Except Teeth
0261 = Level II Plain Film Except Teeth Including Bone
Density Measurement
0262 = Plain Film of Teeth
0263 = Level I Miscellaneous Radiology Procedures
0264 = Level II Miscellaneous Radiology Procedures
0265 = Level I Diagnostic Ultrasound Except Vascular
0266 = Level II Diagnostic Ultrasound Except Vascular
0267 = Vascular Ultrasound
0268 = Guidance Under Ultrasound
0269 = Echocardiogram Except Transesophageal
0270 = Transesophageal Echocardiogram
0271 = Mammography
0272 = Level I Fluoroscopy
0273 = Level II Fluoroscopy
0274 = Myelography
0275 = Arthrography

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)
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0276 = Level I Digestive Radiology
0277 = Level II Digestive Radiology
0278 = Diagnostic Urography
0279 = Level I Diagnostic Angiography and Venography
Except Extremity
0280 = Level II Diagnostic Angiography and Venography
Except Extremity
0281 = Venography of Extremity
0282 = Level I Computerized Axial Tomography
0283 = Level II Computerized Axial Tomography
0284 = Magnetic Resonance Imaging
0285 = Positron Emission Tomography (PET)
0286 = Myocardial Scans
0290 = Standard Non-Imaging Nuclear Medicine
0291 = Level I Diagnostic Nuclear Medicine Excluding
Myocardial Scans
0292 = Level II Diagnostic Nuclear Medicine Excluding
Myocardial Scans
0294 = Level I Therapeutic Nuclear Medicine
0295 = Level II Therapeutic Nuclear Medicine
0296 = Level I Therapeutic Radiologic Procedures
0297 = Level II Therapeutic Radiologic Procedures
0300 = Level I Radiation Therapy

0301 = Level II Radiation Therapy
0302 = Level III Radiation Therapy
0303 = Treatment Device Construction
0304 = Level I Therapeutic Radiation Treatment Preparation
0305 = Level II Therapeutic Radiation Treatment Preparation
0310 = Level III Therapeutic Radiation Treatment Preparation
0311 = Radiation Physics Services
0312 = Radioelement Applications
0313 = Brachytherapy
0314 = Hyperthermic Therapies
0320 = Electroconvulsive Therapy
0321 = Biofeedback and Other Training
0322 = Brief Individual Psychotherapy
0323 = Extended Individual Psychotherapy
0324 = Family Psychotherapy
0325 = Group Psychotherapy
0330 = Dental Procedures
0340 = Minor Ancillary Procedures
0341 = Immunology Tests
0342 = Level I Pathology
0343 = Level II Pathology
0344 = Level III Pathology
0354 = Administration of Influenza Vaccine (Not subject to national coinsurance)
0355 = Level I Immunizations
0356 = Level II Immunizations
0357 = Level III Immunizations
0358 = Level IV Immunizations
0359 = Injections
0360 = Level I Alimentary Tests
0361 = Level II Alimentary Tests
0362 = Fitting of Vision Aids

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)

0363 = Otorhinolaryngologic Function Tests
0364 = Level I Audiometry
0365 = Level II Audiometry
0366 = Electrocardiogram (ECG)
0367 = Level I Pulmonary Test

0368 = Level II Pulmonary Test
0369 = Level III Pulmonary Test
0370 = Allergy Tests
0371 = Allergy Injections
0372 = Therapeutic Phlebotomy
0373 = Neuropsychological Testing
0374 = Monitoring Psychiatric Drugs
0600 = Low Level Clinic Visits
0601 = Mid Level Clinic Visits
0602 = High Level Clinic Visits
0603 = Interdisciplinary Team Conference
0610 = Low Level Emergency Visits
0611 = Mid Level Emergency Visits
0612 = High Level Emergency Visits
0620 = Critical Care
0701 = Strontium (eligible for pass-through payments)
0702 = Samariam (eligible for pass-through payments)
0704 = Satumomab Pendetide (eligible for pass-through payments)
0705 = Tc99 Tetrofosmin (eligible for pass-through payments)
0725 = Leucovorin Calcium (eligible for pass-through payments)
0726 = Dexrazoxane Hydrochloride (eligible for pass-) through payments)
0727 = Injection, Etidronate Disodium (eligible for pass-through payments)
0728 = Filgrastim (G-CSF) (eligible for pass-through payments)
0730 = Pamidronate Disodium (eligible for pass-through payments)
0731 = Sargramostim (GM-CSF) (eligible for pass-through payments)
0732 = Mesna (eligible for pass-through payments)
0733 = Epoetin Alpha (eligible for pass-through) payments)
0750 = Dolasetron Mesylate 10 mg (eligible for pass-through payments)
0754 = Metoclopramide HCL (eligible for pass-through payments)
0755 = Thiethylperazine Maleate (eligible for pass-through payments)
0761 = Oral Substitute for IV Antiemtic (eligible for pass-

through payments)
0762 = Dronabinol (elibible for pass-through payments)
0763 = Dolasetron Mesylate 100 mg Oral (eligible for pass-through payments)
0764 = Granisetron HCL, 100 mcg (eligible for pass-through payments)
0765 = Granisetron HCL, 1mg Oral (eligible for pass-through payments)
0768 = Ondansetron Hydrochloride per 1 mg Injection (eligible for pass-through payments)

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)
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0769 = Ondansetron Hydrochloride 8 mg oral (eligible for pass-through payments)
0800 = Leuprolide Acetate per 3.75 mg (eligible for pass-through payments)
0801 = Cyclophosphamide (eligible for pass-through payments)
0802 = Etoposide (eligible for pass-through payments)
0803 = Melphalan (eligible for pass-through payments)
0807 = Aldesleukin single use vial (eligible for pass-through payments)
0809 = BCG (Intravesical) one vial (eligible for pass-through payments)
0810 = Goserelin Acetate Implant, per 3.6 mg (eligible for pass-through payments)
0811 = Carboplatin 50 mg (eligible for pass-through payments)
0812 = Carmustine 100 mg (eligible for pass-through payments)
0813 = Cisplatin 10 mg (eligible for pass-through payments)
0814 = Asparaginase, 10,000 units (eligible for pass-through payments)
0815 = Cyclophosphamide 100 mg (eligible for pass-through payments)
0816 = Cyclophosphamide, Lyophilized 100 mg (eligible for pass-through payments)
0817 = Cytrabine 100 mg (eligible for pass-through payments)
0818 = Dactinomycin 0.5 mg (eligible for pass-through payments)

0819 = Dacarbazine 100 mg (eligible for pass-through payments)
0820 = Daunorubicin HCI 10 mg (eligible for pass-through payments)
0821 = Daunorubicin Citrate, Liposomal Formulation, 10 mg (eligible for pass-through payments)
0822 = Diethylstibestrol Diphosphate 250 mg (eligible for pass-through payments)
0823 = Docetaxel 20 mg (eligible for pass-through payments)
0824 = Etoposide 10 mg (eligible for pass-through payments)
0826 = Methotrexate Oral 2.5 mg (eligible for pass-through payments)
0827 = Floxuridine 500 mg (eligible for pass-through payments)
0828 = Gemcitabine HCL 200 mg (eligibile for pass-through payments)
0830 = Irinotecan 20 mg (eligible for pass-through payments)
0831 = Ifosfamide per 1 gram (eligible for pass-through payments)
0832 = Idarubicin Hydrochloride 5 mg (eligible for pass-through payments)
0833 = Interferon Alfacon-1, Recombinant, 1 mcg (eligible for pass-through payments)
0834 = Interferon, Alfa-2A, Recombinant 3 million units (eligible for pass-through payments)

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)

0836 = Interferon, Alfa-2B, Recombinant, 1 million units (eligible for pass-through payments)
0838 = Interferon, Gamma 1-B, 3 million units (eligible for pass-through payments)
0839 = Mechlorethamine HCI 10 mg (eligible for pass-through payments)
0840 = Melphalan HCI 50 mg (eligible for pass-through payments)
0841 = Methotrexate Sodium 5 mg (eligible for pass-through payments)
0842 = Fludarabine Phosphate 50 mg (eligible for pass-through payments)

0843 = Pegaspargase per single dose vial (eligible for pass-through payments)
0844 = Pentostatin 10 mg (eligible for pass-through payments)
0847 = Doxorubicin HCL 10 mg (eligible for pass-through payments)
0849 = Rituximab, 100 mg (eligible for pass-through payments)
0850 = Streptozocin 1 gm (eligible for pass-through payments)
0851 = Thiotepa 15 mg (eligible for pass-through payments)
0852 = Topotecan 4 mg (eligible for pass-through payments)
0853 = Vinblastine Sulfate 1 mg (eligible for pass-through payments)
0854 = Vincristine Sulfate 1 mg (eligible for pass-through payments)
0855 = Vinorelbine Tartrate per 10 mg (eligible for pass-through payments)
0856 = Porfimer Sodium 75 mg (eligible for pass-through payments)
0857 = Bleomycin Sulfate 15 units (eligible for pass-through payments)
0858 = Cladribine, 1mg (eligible for pass-through payments)
0859 = Fluorouracil (eligible for pass-through payments)
0860 = Plicamycin 2.5 mg (eligible for pass-through payments)
0861 = Leuprolide Acetate 1 mg (eligible for pass-through payments)
0862 = Mitomycin, 5mg (eligible for pass-through payments)
0863 = Paclitaxel, 30mg (eligible for pass-through payments)
0864 = Mitoxantrone HCl, per 5mg (eligible for pass-through payments)
0865 = Interferon alfa-N3, 250,000 IU (eligible for pass-through payments)
0884 = Rho (D) Immune Globulin, Human one dose pack (eligible for pass-through payments)
0886 = Azathioprine, 50 mg oral (Not subject to national coinsurance)
0887 = Azathioprine, Parenteral 100 mg, 20 ml each injection (Not subject to national coinsurance)
0888 = Cyclosporine, Oral 100 mg (Not subject to national coinsurance)
0889 = Cyclosporine, Parenteral

(Not subject to national coinsurance)
0890 = Lymphocyte Immune Globulin 50 mg/ ml, 5 ml each
(Not subject to national coinsurance)

1 REV_CNTR_APC_TB — Revenue Center Ambulatory Payment Classification (APC)

0891 = Tacrolimus per 1 mg oral
(Not subject to national coinsurance)
0892 = Daclizumab, Parenteral, 25 mg
(eligible for pass-through payments)
0900 = Injection, Alglucerase per 10 units
(eligible for pass-through payments)
0901 = Alpha I, Proteinase Inhibitor, Human per 10mg
(eligible for pass-through payments)
0902 = Botulinum Toxin, Type A per unit
(eligible for pass-through payments)
0903 = CMV Immune Globulin
(eligible for pass-through payments)
0905 = Immune Globulin per 500 mg
(eligible for pass-through payments)
0906 = RSV Immune Globulin
(eligible for pass-through payments)
0907 = Ganciclovir Sodium 500 mg injection
(Not subject to national coinsurance)
0908 = Tetanus Immune Globulin, Human, up to 250 units
(Not subject to national coinsurance)
0909 = Interferon Beta - 1a 33 mcg (eligible for pass-through payments)
0910 = Interferon Beta - 1b 0.25 mg (eligible for pass-through payments)
0911 = Streptokinase per 250,000 iu
(Not subject to national coinsurance)
0913 = Ganciclovir 4.5 mg, Implant (eligible for pass-through payments)
0914 = Reteplase, 37.6 mg (Two Single Use Vials)
(Not subject to national coinsurance)
0915 = Alteplase recombinant, 10mg
(Not subject to national coinsurance)
0916 = Imiglucerase per unit (eligible for pass-through payments)
0917 = Dipyridamole, 10mg / Adenosine 6MG
(Not subject to national coinsurance)
0918 = Brachytherapy Seeds, Any type, Each (eligible

for pass-through payments)
0925 = Factor VIII (Antihemophilic Factor, Human) per iu (eligible for pass-through payments)
0926 = Factor VIII (Antihemophilic Factor, Porcine) per iu (eligible for pass-through payments)
0927 = Factor VIII (Antihemophilic Factor, Recombinant) per iu (eligible for pass-through payments)
0928 = Factor IX, Complex (eligible for pass-through payments)
0929 = Other Hemophilia Clotting Factors per iu (eligible for pass-through payments)
0930 = Antithrombin III (Human) per iu (eligible for pass-through payments)
0931 = Factor IX (Antihemophilic Factor, Purified, Non-Recombinant) (eligible for pass-through payments)
0932 = Factor IX (Antihemophilic Factor, Recombinant) (eligible for pass-through payments)
0949 = Plasma, Pooled Multiple Donor, Solvent/Detergent Treated, Frozen (not subject to national coinsurance)
0950 = Blood (Whole) For Transfusion (not subject to national coinsurance)

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)

0952 = Cryoprecipitate (not subject to national coinsurance)
0953 = Fibrinogen Unit (not subject to national coinsurance)
0954 = Leukocyte Poor Blood (not subject to national coinsurance)
0955 = Plasma, Fresh Frozen (not subject to national coinsurance)
0956 = Plasma Protein Fraction (not subject to national coinsurance)
0957 = Platelet Concentrate (not subject to national coinsurance)
0958 = Platelet Rich Plasma (not subject to national coinsurance)
0959 = Red Blood Cells (not subject to national coinsurance)
0960 = Washed Red Blood Cells (not subject to national coinsurance)
0961 = Infusion, Albumin (Human) 5%, 500 ml (not subject to national coinsurance)
0962 = Infusion, Albumin (Human) 25%, 50 ml (not subject to national coinsurance)

0970 = New Technology - Level I ($0 - $50)
(not subject to national coinsurance)
0971 = New Technology - Level II ($50 - $100)
(not subject to national coinsurance)
0972 = New Technology - Level III ($100 - $200)
(not subject to national coinsurance)
0973 = New Technology - Level IV ($200 - $300)
(not subject to national coinsurance)
0974 = New Technology - Level V ($300 - $500)
(not subject to national coinsurance)
0975 = New Technology - Level VI ($500 - $750)
(not subject to national coinsurance)
0976 = New Technology - Level VII ($750 - $1000)
(not subject to national coinsurance)
0977 = New Technology - Level VIII ($1000 - $1250)
(not subject to national coinsurance)
0978 = New Technology - Level IX ($1250 - $1500)
(not subject to national coinsurance)
0979 = New Technology - Level X ($1500 - $1750)
(not subject to national coinsurance)
0980 = New Technology - Level XI ($1750 - $2000)
(not subject to national coinsurance)
0981 = New Technology - Level XII ($2000 - $2500)
(not subject to national coinsurance)
0982 = New Technology - Level XIII ($2500 - $3500)
(not subject to national coinsurance)
0983 = New Technology - Level XIV ($3500 - $5000)
(not subject to national coinsurance)
0984 = New Technology - Level XV ($5000 - $6000)
(not subject to national coinsurance)
7000 = Amifostine, 500 mg (eligible for pass-through payments)
7001 = Amphotericin B lipid complex, 50 mg, Inj (eligible for pass-through payments)
7002 = Clonidine, HCl, 1 MG (eligible for pass-through payments)
7003 = Epoprostenol, 0.5 MG, inj (eligible for pass-through payments)
7004 = Immune globulin intravenous human 5g, inj

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)

(eligible for pass-through payments)

7005 = Gonadorelin hcI, 100 mcg (eligible for pass-through payments)
7007 = Milrinone lacetate, per 5 ml, inj (not subject to national coinsurance)
7010 = Morphine sulfate concentrate (preservative free) per 10 mg (eligible for pass-through payments)
7011 = Oprelevekin, inj, 5 mg (eligible for pass-through payments)
7012 = Pentamidine isethionate, 300 mg (eligible for pass-through payments)
7014 = Fentanyl citrate, inj, up to 2 ml (eligible for pass-through payments)
7015 = Busulfan, oral 2 mg (eligible for pass-through payments)
7019 = Aprotinin, 10,000 kiu (eligible for pass-through payments)
7021 = Baclofen, intrathecal, 50 mcg (eligible for pass-through payments)
7022 = Elliotts B Solution, per ml (eligible for pass-through payments)
7023 = Treatment for bladder calculi, I.e. Renacidin per 500 ml (eligible for pass-through payments)
7024 = Corticorelin ovine triflutate, 0.1 mg (eligible for pass-through payments)
7025 = Digoxin immune FAB (Ovine), 10 mg (eligible for pass-through payments)
7026 = Ethanolamine oleate, 1000 ml (eligible for pass-through payments)
7027 = Fomepizole, 1.5 G (eligible for pass-through payments)
7028 = Fosphenytoin, 50 mg (eligible for pass-through payments)
7029 = Glatiramer acetate, 25 mg (eligible for pass-through payments)
7030 = Hemin, 1 mg (eligible for pass-through payments)
7031 = Octreotide Acetate, 500 mcg (eligible for pass-through payments)
7032 = Sermorelin acetate, 0.5 mg (eligible for pass-through payments)
7033 = Somatrem, 5 mg (eligible for pass-through payments)
7034 = Somatropin, 1 mg

(eligible for pass-through payments)
7035 = Teniposide, 50 mg
(eligible for pass-through payments)
7036 = Urokinase, inj, IV, 250,000 I.U.
(not subject to national coinsurance)
7037 = Urofollitropin, 75 I.U.
(eligible for pass-through payments)
7038 = Muromonab-CD3, 5 mg
(eligible for pass-through payments)
7039 = Pegademase bovine inj 25 I.U.
(eligible for pass-through payments)
7040 = Pentastarch 10% inj, 100 ml
(eligible for pass-through payments)
7041 = Tirofiban HCL, 0.5 mg

1 REV_CNTR_APC_TB — Revenue Center Ambulatory Payment Classification (APC)

(not subject to national coinsurance)
7042 = Capecitabine, oral 150 mg
(eligible for pass-through payments)
7043 = Infliximab, 10 MG (eligible for pass-through payments)
7045 = Trimetrexate Glucoronate (eligible for pass-through payments)
7046 = Doxorubicin Hcl Liposome (eligible for pass-through payments)

1 REV_CNTR_DDCTBL_COINSRNC_TB — Revenue Center Deductible Coinsurance Code

0 = Charges are subject to deductible and coinsurance
1 = Charges are not subject to deductible
2 = Charges are not subject to coinsurance
3 = Charges are not subject to deductible or coinsurance
4 = No charge or units associated with this revenue center code. (For multiple HCPCS per single revenue center code)

For revenue center code 0001, the following MSP override values may be present:

M = Override code; EGHP services involved
(eff 12/90 for non-institutional claims;
10/93 for institutional claims)
N = Override code; non-EGHP services involved
(eff 12/90 for non-institutional claims;
10/93 for institutional claims)
X = Override code: MSP cost avoided
(eff 12/90 for non-institutional claims;
10/93 for institutional claims)

1 REV_CNTR_PMT_MTHD_IND_TB — Revenue Center Payment Method Indicator Table

**********Service Indicator**********
********** 1st position **********
A = Services not paid under OPPS
C = Inpatient procedure
E = Noncovered items or services
F = Corneal issue acquistion
G = Current drug or biological pass-through
H = Device pass-through
J = New drug or new biological pass-through
N = Packaged incidental service
P = Partial hospitalization services
S = Significant procedure not subject to
multiple procedure discounting
T = Significant procedure subject to multiple
procedure discounting
V = Medical visit to clinic or emergency
department
X = Ancillary service

**********Payment Indicator**********
********** 2nd position **********
1 = Paid standard hospital OPPS amount
(service indicators S,T,V,X)
2 = Services not paid under OPPS (service
indicator A, or no HCPCS code and not
certain revenue center codes)
3 = Not paid (service indicators C & E)
4 = Acquisition cost paid (service indica-

tor F)
5 = Additional payment for current drug or biological (service indicator G)
6 = Additional payment for device (service indicator H)
7 = Additional payment for new drug or new biological (service indicator J)
8 = Paid partial hospitalization per diem (service indicator P)
9 = No additional payment, payment included in line items with APCs (service indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization training)

1 REV_CNTR_PRICNG_IND_TB — Revenue Center Pricing Indicator Table

A = A valid HCPCS code not subject to a fee schedule payment. Reimbursement is calculated on provider submitted charges.
B = A valid HCPCS code subject to the fee schedule payment. Reimbursement is the lesser of provider submitted charges or the fee schedule amount.
D = a valid radiology HCPCS code subject to the Radiology Pricer and the rate is reflected as zeroes on the HCPCS file and cost report. The Radiology Pricer treates this HCPCS as a non-covered service. Reimbursement is calculated on provider submitted charges.
E = A valid ASC HCPCS code subject to the ASC Pricer. The rate is reflected as zeroes on the HCPCS file. The ASC Pricer determines the ASC payment rate and is reported on the cost report.
F = A valid ESRD HCPCS code subject to the parameter rate. Reimbursement is the lesser of provider submitted charges or the fee schedule amount for non-dialysis HCPCS. Reimbursement is calculated on the provider file rates for dialysis HCPCS.

G = A valid HCPCS, code is subject to a fee schedule, but the rate is no longer present on the HCPCS file. Reimbursement is calculated on provider submitted charges.

H = A valid DME HCPCS, code is subject to a fee schedule. The rates are reflected under the DME segment. Reimbursement is calculated either on a fee schedule, provider submitted charges or the lesser of provider submitted, or the fee schedule depending o the category.

I = A valid DME category 5 HCPCS, HCPCS is not found on the DME history record, but a match was found on HIC, category and generic code. Claim must be reviewed by Medical Review before payment can be calculated.

J = A valid DME HCPCS, no DME history is present, and a prescription is required before delivery. Claim must be reviewed by Medical Review.

K = A valid DME HCPCS, prescribed has been reviewed, and fee schedule payment is approved as prescription was present before delivery.

L = A valid TENS HCPCS, rental period is six months or greater and must be reviewed by Medical Review.

M = A valid TENS HCPCS, Medical Review has approved the rental charge in excess of five months.

R = A valid radiology HCPCS code and is subject to the Radiology Pricer. The rate is reported on the cost report. Reimbursement is calculated on provider submitted charges.

S = Valid influenza/PPV HCPCS. A fee amount is not applicable. The amount payable is present in the covered charge field. This amount is not subject to the coinsurance and deductible. This charge is subject to the provider's reimbursement rate.

T = Valid HCPCS. A fee amount is present. The amount payable should be the lower of the billed charge or

1 REV_CNTR_PRICNG_IND_TB — Revenue Center Pricing Indicator Table

fee amount. The system should compute the fee amount by multiplying the covered units times the rate. The fee amount is not subject to coinsurance and deductible or provider's reimbursement rate.

1 REV_CNTR_TB — Revenue Center Table

0001 = Total charge
0022 = SNF claim paid under PPS submitted as TOB 21X, effective for cost reporting periods beginning on or after 7/1/98 (dates of service after 6/30/98). NOTE: This code may appear multiple times on a claim to identify different HIPPS Rate Code/assessment periods.
0023 = Home Health services paid under PPS submitted as TOB 32X and 33X, effective 10/00. This code may appear multiple times on a claim to identify different HIPPS/Home Health Resource Groups (HRG).
0100 = All inclusive rate-room and board plus ancillary
0101 = All inclusive rate-room and board
0110 = Private medical or general-general classification
0111 = Private medical or general-medical/surgical/GYN
0112 = Private medical or general-OB
0113 = Private medical or general-pediatric
0114 = Private medical or general-psychiatric
0115 = Private medical or general-hospice
0116 = Private medical or general-detoxification
0117 = Private medical or general-oncology
0118 = Private medical or general-rehabilitation
0119 = Private medical or general-other
0120 = Semi-private 2 bed (medical or general) general classification
0121 = Semi-private 2 bed (medical or general) medical/surgical/GYN
0122 = Semi-private 2 bed (medical or general)-OB
0123 = Semi-private 2 bed (medical or general)-pediatric
0124 = Semi-private 2 bed (medical or general)-psychiatric
0125 = Semi-private 2 bed (medical or general)-hospice
0126 = Semi-private 2 bed (medical or general) detoxification
0127 = Semi-private 2 bed (medical or general)-oncology
0128 = Semi-private 2 bed (medical or general) rehabilitation
0129 = Semi-private 2 bed (medical or general)-other
0130 = Semi-private 3 and 4 beds-general classification
0131 = Semi-private 3 and 4 beds-medical/surgical/GYN

0132 = Semi-private 3 and 4 beds-OB
0133 = Semi-private 3 and 4 beds-pediatric
0134 = Semi-private 3 and 4 beds-psychiatric
0135 = Semi-private 3 and 4 beds-hospice
0136 = Semi-private 3 and 4 beds-detoxification
0137 = Semi-private 3 and 4 beds-oncology
0138 = Semi_private 3 and 4 beds-rehabilitation
0139 = Semi-private 3 and 4 beds-other
0140 = Private (deluxe)-general classification
0141 = Private (deluxe)-medical/surgical/GYN
0142 = Private (deluxe)-OB
0143 = Private (deluxe)-pediatric
0144 = Private (deluxe)-psychiatric
0145 = Private (deluxe)-hospice
0146 = Private (deluxe)-detoxification
0147 = Private (deluxe)-oncology
0148 = Private (deluxe)-rehabilitation
0149 = Private (deluxe)-other

1 REV_CNTR_TB Revenue Center Table

0150 = Room&Board ward (medical or general)
general classification
0151 = Room&Board ward (medical or general)
medical/surgical/GYN
0152 = Room&Board ward (medical or general)-OB
0153 = Room&Board ward (medical or general)-pediatric
0154 = Room&Board ward (medical or general)-psychiatric
0155 = Room&Board ward (medical or general)-hospice
0156 = Room&Board ward (medical or general)-detoxification
0157 = Room&Board ward (medical or general)-oncology
0158 = Room&Board ward (medical or general)-rehabilitation
0159 = Room&Board ward (medical or general)-other
0160 = Other Room&Board-general classification
0164 = Other Room&Board-sterile environment
0167 = Other Room&Board-self care
0169 = Other Room&Board-other
0170 = Nursery-general classification
0171 = Nursery-newborn
level I (routine)
0172 = Nursery-premature
newborn-level II (continuing care)
0173 = Nursery-newborn-level III (intermediate care)

(eff 10/96)
0174 = Nursery-newborn-level IV (intensive care)
(eff 10/96)
0175 = Nursery-neonatal ICU (obsolete eff 10/96)
0179 = Nursery-other
0180 = Leave of absence-general classification
0182 = Leave of absence-patient convenience charges
billable
0183 = Leave of absence-therapeutic leave
0184 = Leave of absence-ICF mentally retarded-any reason
0185 = Leave of absence-nursing home (hospitalization)
0189 = Leave of absence-other leave of absence
0190 = Subacute care - general classification
(eff. 10/97)
0191 = Subacute care - level I (eff. 10/97)
0192 = Subacute care - level II (eff. 10/97)
0193 = Subacute care - level III (eff. 10/97)
0194 = Subacute care - level IV (eff. 10/97)
0199 = Subacute care - other (eff 10/97)
0200 = Intensive care-general classification
0201 = Intensive care-surgical
0202 = Intensive care-medical
0203 = Intensive care-pediatric
0204 = Intensive care-psychiatric
0206 = Intensive care-post ICU; redefined as
intermediate ICU (eff 10/96)
0207 = Intensive care-burn care
0208 = Intensive care-trauma
0209 = Intensive care-other intensive care
0210 = Coronary care-general classification
0211 = Coronary care-myocardial infraction
0212 = Coronary care-pulmonary care
0213 = Coronary care-heart transplant
0214 = Coronary care-post CCU; redefined as
intermediate CCU (eff 10/96)
0219 = Coronary care-other coronary care

1 REV_CNTR_TB Revenue Center Table
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0220 = Special charges-general classification
0221 = Special charges-admission charge
0222 = Special charges-technical support charge
0223 = Special charges-UR service charge

0224 = Special charges-late discharge, medically necessary
0229 = Special charges-other special charges
0230 = Incremental nursing charge rate-general classification
0231 = Incremental nursing charge rate-nursery
0232 = Incremental nursing charge rate-OB
0233 = Incremental nursing charge rate-ICU (include transitional care)
0234 = Incremental nursing charge rate-CCU (include transitional care)
0235 = Incremental nursing charge rate-hospice
0239 = Incremental nursing charge rate-other
0240 = All inclusive ancillary-general classification
0241 = All inclusive ancillary-basic
0242 = All inclusive ancillary-comprehensive
0243 = All inclusive ancillary-specialty
0249 = All inclusive ancillary-other inclusive ancillary
0250 = Pharmacy-general classification
0251 = Pharmacy-generic drugs
0252 = Pharmacy-nongeneric drugs
0253 = Pharmacy-take home drugs
0254 = Pharmacy-drugs incident to other diagnostic service-subject to payment limit
0255 = Pharmacy-drugs incident to radiology-subject to payment limit
0256 = Pharmacy-experimental drugs
0257 = Pharmacy-non-prescription
0258 = Pharmacy-IV solutions
0259 = Pharmacy-other pharmacy
0260 = IV therapy-general classification
0261 = IV therapy-infusion pump
0262 = IV therapy-pharmacy services (eff 10/94)
0263 = IV therapy-drug supply/delivery (eff 10/94)
0264 = IV therapy-supplies (eff 10/94)
0269 = IV therapy-other IV therapy
0270 = Medical/surgical supplies-general classification (also see 062X)
0271 = Medical/surgical supplies-nonsterile supply
0272 = Medical/surgical supplies-sterile supply
0273 = Medical/surgical supplies-take home supplies
0274 = Medical/surgical supplies-prosthetic/orthotic devices

0275 = Medical/surgical supplies-pace maker
0276 = Medical/surgical supplies-intraocular lens
0277 = Medical/surgical supplies-oxygen-take home
0278 = Medical/surgical supplies-other implants
0279 = Medical/surgical supplies-other devices
0280 = Oncology-general classification
0289 = Oncology-other oncology
0290 = DME (other than renal)-general classification
0291 = DME (other than renal)-rental
0292 = DME (other than renal)-purchase of new DME
0293 = DME (other than renal)-purchase of used DME

0294 = DME (other than renal)-related to and listed as DME
0299 = DME (other than renal)-other
0300 = Laboratory-general classification
0301 = Laboratory-chemistry
0302 = Laboratory-immunology
0303 = Laboratory-renal patient (home)
0304 = Laboratory-non-routine dialysis
0305 = Laboratory-hematology
0306 = Laboratory-bacteriology & microbiology
0307 = Laboratory-urology
0309 = Laboratory-other laboratory
0310 = Laboratory pathological-general classification
0311 = Laboratory pathological-cytology
0312 = Laboratory pathological-histology
0314 = Laboratory pathological-biopsy
0319 = Laboratory pathological-other
0320 = Radiology diagnostic-general classification
0321 = Radiology diagnostic-angiocardiography
0322 = Radiology diagnostic-arthrography
0323 = Radiology diagnostic-arteriography
0324 = Radiology diagnostic-chest X-ray
0329 = Radiology diagnostic-other
0330 = Radiology therapeutic-general classification
0331 = Radiology therapeutic-chemotherapy injected
0332 = Radiology therapeutic-chemotherapy oral
0333 = Radiology therapeutic-radiation therapy
0335 = Radiology therapeutic-chemotherapy IV
0339 = Radiology therapeutic-other
0340 = Nuclear medicine-general classification

0341 = Nuclear medicine-diagnostic
0342 = Nuclear medicine-therapeutic
0349 = Nuclear medicine-other
0350 = Computed tomographic (CT) scan-general classification
0351 = CT scan-head scan
0352 = CT scan-body scan
0359 = CT scan-other CT scans
0360 = Operating room services-general classification
0361 = Operating room services-minor surgery
0362 = Operating room services-organ transplant, other than kidney
0367 = Operating room services-kidney transplant
0369 = Operating room services-other operating room services
0370 = Anesthesia-general classification
0371 = Anesthesia-incident to RAD and subject to the payment limit
0372 = Anesthesia-incident to other diagnostic service and subject to the payment limit
0374 = Anesthesia-acupuncture
0379 = Anesthesia-other anesthesia
0380 = Blood-general classification
0381 = Blood-packed red cells
0382 = Blood-whole blood
0383 = Blood-plasma
0384 = Blood-platelets
0385 = Blood-leukocytes
0386 = Blood-other components

0387 = Blood-other derivatives (cryopricipatates)
0389 = Blood-other blood
0390 = Blood storage and processing-general classification
0391 = Blood storage and processing-blood administration
0399 = Blood storage and processing-other
0400 = Other imaging services-general classification
0401 = Other imaging services-diagnostic mammography
0402 = Other imaging services-ultrasound
0403 = Other imaging services-screening mammography

(eff 1/1/91)
0404 = Other imaging services-positron emission tomography (eff 10/94)
0409 = Other imaging services-other
0410 = Respiratory services-general classification
0412 = Respiratory services-inhalation services
0413 = Respiratory services-hyperbaric oxygen therapy
0419 = Respiratory services-other
0420 = Physical therapy-general classification
0421 = Physical therapy-visit charge
0422 = Physical therapy-hourly charge
0423 = Physical therapy-group rate
0424 = Physical therapy-evaluation or re-evaluation
0429 = Physical therapy-other
0430 = Occupational therapy-general classification
0431 = Occupational therapy-visit charge
0432 = Occupational therapy-hourly charge
0433 = Occupational therapy-group rate
0434 = Occupational therapy-evaluation or re-evaluation
0439 = Occupational therapy-other (may include restorative therapy)
0440 = Speech language pathology-general classification
0441 = Speech language pathology-visit charge
0442 = Speech language pathology-hourly charge
0443 = Speech language pathology-group rate
0444 = Speech language pathology-evaluation or re-evaluation
0449 = Speech language pathology-other
0450 = Emergency room-general classification
0451 = Emergency room-emtala emergency medical screening services (eff 10/96)
0452 = Emergency room-ER beyond emtala screening (eff 10/96)
0456 = Emergency room-urgent care (eff 10/96)
0459 = Emergency room-other
0460 = Pulmonary function-general classification
0469 = Pulmonary function-other
0470 = Audiology-general classification
0471 = Audiology-diagnostic
0472 = Audiology-treatment
0479 = Audiology-other
0480 = Cardiology-general classification
0481 = Cardiology-cardiac cath lab

0482 = Cardiology-stress test
0483 = Cardiology-Echocardiology
0489 = Cardiology-other
0490 = Ambulatory surgical care-general classification

1 REV_CNTR_TB Revenue Center Table

0499 = Ambulatory surgical care-other
0500 = Outpatient services-general classification
(deleted 9/93)
0509 = Outpatient services-other (deleted 9/93)
0510 = Clinic-general classification
0511 = Clinic-chronic pain center
0512 = Clinic-dental center
0513 = Clinic-psychiatric
0514 = Clinic-OB-GYN
0515 = Clinic-pediatric
0516 = Clinic-urgent care clinic (eff 10/96)
0517 = Clinic-family practice clinic (eff 10/96)
0519 = Clinic-other
0520 = Free-standing clinic-general classification
0521 = Free-standing clinic-rural health clinic
0522 = Free-standing clinic-rural health home
0523 = Free-standing clinic-family practice
0526 = Free-standing clinic-urgent care (eff 10/96)
0529 = Free-standing clinic-other
0530 = Osteopathic services-general classification
0531 = Osteopathic services-osteopathic therapy
0539 = Osteopathic services-other
0540 = Ambulance-general classification
0541 = Ambulance-supplies
0542 = Ambulance-medical transport
0543 = Ambulance-heart mobile
0544 = Ambulance-oxygen
0545 = Ambulance-air ambulance
0546 = Ambulance-neo-natal ambulance
0547 = Ambulance-pharmacy
0548 = Ambulance-telephone transmission EKG
0549 = Ambulance-other
0550 = Skilled nursing-general classification
0551 = Skilled nursing-visit charge
0552 = Skilled nursing-hourly charge
0559 = Skilled nursing-other

0560 = Medical social services-general classification
0561 = Medical social services-visit charge
0562 = Medical social services-hourly charges
0569 = Medical social services-other
0570 = Home health aid (home health)-general
classification
0571 = Home health aid (home health)-visit charge
0572 = Home health aid (home health)-hourly charge
0579 = Home health aid (home health)-other
0580 = Other visits (home health)-general
classification (under HHPPS, not allowed
as covered charges)
0581 = Other visits (home health)-visit charge
(under HHPPS, not allowed as covered charges)
0582 = Other visits (home health)-hourly charge
(under HHPPS, not allowed as covered charges)
0589 = Other visits (home health)-other
(under HHPPS, not allowed as covered charges)
0590 = Units of service (home health)-general
classification (under HHPPS, not allowed
as covered charges)
0599 = Units of service (home health)-other

1 REV_CNTR_TB Revenue Center Table

(under HHPPS, not allowed as covered charges)
0600 = Oxygen-general classification
0601 = Oxygen-stat or port equip/supply or count
0602 = Oxygen-stat/equip/under 1 LPM
0603 = Oxygen-stat/equip/over 4 LPM
0604 = Oxygen-stat/equip/portable add-on
0610 = Magnetic resonance technology (MRT)-general
classification
0611 = MRT/MRI-brain (including brainstem)
0612 = MRT/MRI-spinal cord (including spine)
0614 = MRT/MRI-other
0615 = MRT/MRA-Head and Neck
0616 = MRT/MRA-Lower Extremities
0618 = MRT/MRA-other
0619 = MRT/Other MRI
0621 = Medical/surgical supplies-incident to radiology-
subject to the payment limit - extension of 027X
0622 = Medical/surgical supplies-incident to other

diagnostic service-subject to the payment limit - extension of 027X
0623 = Medical/surgical supplies-surgical dressings (eff 1/95) - extension of 027X
0624 = Medical/surgical supplies-medical investigational devices and procedures with FDA approved IDE's (eff 10/96) - extension of 027X
0630 = Drugs requiring specific identification-general classification
0631 = Drugs requiring specific identification-single drug source (eff 9/93)
0632 = Drugs requiring specific identification-multiple drug source (eff 9/93)
0633 = Drugs requiring specific identification-restrictive prescription (eff 9/93)
0634 = Drugs requiring specific identification-EPO under 10,000 units
0635 = Drugs requiring specific identification-EPO 10,000 units or more
0636 = Drugs requiring specific identification-detailed coding (eff 3/92)
0637 = Self-administered drugs administered in an emergency situation - not requiring detailed coding
0640 = Home IV therapy-general classification (eff 10/94)
0641 = Home IV therapy-nonroutine nursing (eff 10/94)
0642 = Home IV therapy-IV site care, central line (eff 10/94)
0643 = Home IV therapy-IV start/change peripheral line (eff 10/94)
0644 = Home IV therapy-nonroutine nursing, peripheral line (eff 10/94)
0645 = Home IV therapy-train patient/caregiver, central line (eff 10/94)
0646 = Home IV therapy-train disabled patient, central line (eff 10/94)
0647 = Home IV therapy-train patient/caregiver, peripheral line (eff 10/94)

1 REV_CNTR_TB — Revenue Center Table

0648 = Home IV therapy-train disabled patient, peripheral line (eff 10/94)
0649 = Home IV therapy-other IV therapy services (eff 10/94)
0650 = Hospice services-general classification
0651 = Hospice services-routine home care
0652 = Hospice services-continuous home care-1/2
0655 = Hospice services-inpatient care
0656 = Hospice services-general inpatient care (non-respite)
0657 = Hospice services-physician services
0659 = Hospice services-other
0660 = Respite care (HHA)-general classification (eff 9/93)
0661 = Respite care (HHA)-hourly charge/skilled nursing (eff 9/93)
0662 = Respite care (HHA)-hourly charge/home health aide/ homemaker (eff 9/93)
0670 = OP special residence charges - general classification
0671 = OP special residence charges - hospital based
0672 = OP special residence charges - contracted
0679 = OP special residence charges - other special residence charges
0700 = Cast room-general classification
0709 = Cast room-other
0710 = Recovery room-general classification
0719 = Recovery room-other
0720 = Labor room/delivery-general classification
0721 = Labor room/delivery-labor
0722 = Labor room/delivery-delivery
0723 = Labor room/delivery-circumcision
0724 = Labor room/delivery-birthing center
0729 = Labor room/delivery-other
0730 = EKG/ECG-general classification
0731 = EKG/ECG-Holter moniter
0732 = EKG/ECG-telemetry (include fetal monitering until 9/93)
0739 = EKG/ECG-other
0740 = EEG-general classification
0749 = EEG (electroencephalogram)-other
0750 = Gastro-intestinal services-general classification
0759 = Gastro-intestinal services-other

0760 = Treatment or observation room-general classification
0761 = Treatment or observation room-treatment room (eff 9/93)
0762 = Treatment or observation room-observation room (eff 9/93)
0769 = Treatment or observation room-other
0770 = Preventative care services-general classification (eff 10/94)
0771 = Preventative care services-vaccine administration (eff 10/94)
0779 = Preventative care services-other (eff 10/94)
0780 = Telemedicine - general classification (eff 10/97)
0789 = Telemedicine - telemedicine (eff 10/97)

0790 = Lithotripsy-general classification
0799 = Lithotripsy-other
0800 = Inpatient renal dialysis-general classification
0801 = Inpatient renal dialysis-inpatient hemodialysis
0802 = Inpatient renal dialysis-inpatient peritoneal (non-CAPD)
0803 = Inpatient renal dialysis-inpatient CAPD
0804 = Inpatient renal dialysis-inpatient CCPD
0809 = Inpatient renal dialysis-other inpatient dialysis
0810 = Organ acquisition-general classification
0811 = Organ acquisition-living donor (eff 10/94); prior to 10/94, defined as living donor kidney
0812 = Organ acquisition-cadaver donor (eff 10/94); prior to 10/94, defined as cadaver donor kidney
0813 = Organ acquisition-unknown donor (eff 10/94) prior to 10/94, defined as unknown donor kidney
0814 = Organ acquisition - unsuccessful organ search-donor bank charges (eff 10/94); prior to 10/94, defined as other kidney acquisition
0815 = Organ acquisition-cadaver donor-heart (obsolete, eff 10/94)
0816 = Organ acquisition-other heart acquisition (obsolete, eff 10/94)
0817 = Organ acquisition-donor-liver (obsolete, eff 10/94)

0819 = Organ acquisition-other donor (eff 10/94);
prior to 10/94, defined as other
0820 = Hemodialysis OP or home dialysis-general
classification
0821 = Hemodialysis OP or home dialysis-hemodialysis-
composite or other rate
0822 = Hemodialysis OP or home dialysis-home supplies
0823 = Hemodialysis OP or home dialysis-home equipment
0824 = Hemodialysis OP or home dialysis-maintenance/100%
0825 = Hemodialysis OP or home dialysis-support services
0829 = Hemodialysis OP or home dialysis-other
0830 = Peritoneal dialysis OP or home-general
classification
0831 = Peritoneal dialysis OP or home-peritoneal-
composite or other rate
0832 = Peritoneal dialysis OP or home-home supplies
0833 = Peritoneal dialysis OP or home-home equipment
0834 = Peritoneal dialysis OP or home-maintenance/100%
0835 = Peritoneal dialysis OP or home-support services
0839 = Peritoneal dialysis OP or home-other
0840 = CAPD outpatient-general classification
0841 = CAPD outpatient-CAPD/composite or other rate
0842 = CAPD outpatient-home supplies
0843 = CAPD outpatient-home equipment
0844 = CAPD outpatient-maintenance/100%
0845 = CAPD outpatient-support services
0849 = CAPD outpatient-other
0850 = CCPD outpatient-general classification
0851 = CCPD outpatient-CCPD/composite or other rate
0852 = CCPD outpatient-home supplies
0853 = CCPD outpatient-home equipment
0854 = CCPD outpatient-maintenance/100%
0855 = CCPD outpatient-support services

0859 = CCPD outpatient-other
0880 = Miscellaneous dialysis-general classification
0881 = Miscellaneous dialysis-ultrafiltration
0882 = Miscellaneous dialysis-home dialysis aide visit
(eff 9/93)
0889 = Miscellaneous dialysis-other
0890 = Other donor bank-general classification; changed to

reserved for national assignment (eff 4/94)
0891 = Other donor bank-bone; changed to
reserved for national assignment (eff 4/94)
0892 = Other donor bank-organ (other than kidney); changed
to reserved for national assignment (eff 4/94)
0893 = Other donor bank-skin; changed to
reserved for national assignment (eff 4/94)
0899 = Other donor bank-other; changed to
reserved for national assignment (eff 4/94)
0900 = Psychiatric/psychological treatments-general
classification
0901 = Psychiatric/psychological treatments-electroshock
treatment
0902 = Psychiatric/psychological treatments-milieu
therapy
0903 = Psychiatric/psychological treatments-play
therapy
0904 = Psychiatric/psychological treatments-activity
therapy (eff 4/94)
0909 = Psychiatric/psychological treatments-other
0910 = Psychiatric/psychological services-general
classification
0911 = Psychiatric/psychological services-rehabilitation
0912 = Psychiatric/psychological services-day care-
redefined 10/97 to less Intensive
0913 = Psychiatric/psychological services-night care
redefined 10/97 to Intensive
0914 = Psychiatric/psychological services-individual
therapy
0915 = Psychiatric/psychological services-group therapy
0916 = Psychiatric/psychological services-family therapy
0917 = Psychiatric/psychological services-biofeedback
0918 = Psychiatric/psychological services-testing
0919 = Psychiatric/psychological services-other
0920 = Other diagnostic services-general classification
0921 = Other diagnostic services-peripheral vascular lab
0922 = Other diagnostic services-electromyelogram
0923 = Other diagnostic services-pap smear
0924 = Other diagnostic services-allergy test
0925 = Other diagnostic services-pregnancy test
0929 = Other diagnostic services-other
0940 = Other therapeutic services-general classification
0941 = Other therapeutic services-recreational therapy

0942 = Other therapeutic services-education/training
(include diabetes diet training)
0943 = Other therapeutic services-cardiac rehabilitation
0944 = Other therapeutic services-drug rehabilitation
0945 = Other therapeutic services-alcohol
rehabilitation
0946 = Other therapeutic services-routine complex
medical equipment

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0947 = Other therapeutic services-ancillary complex
medical equipment (eff 3/92)
0949 = Other therapeutic services-other
0951 = Professional Fees-athletic training
0952 = Professional Fees-kinesiotherapy
0960 = Professional fees-general classification
0961 = Professional fees-psychiatric
0962 = Professional fees-ophthalmology
0963 = Professional fees-anesthesiologist (MD)
0964 = Professional fees-anesthetist (CRNA)
0969 = Professional fees-other
0971 = Professional fees-laboratory
0972 = Professional fees-radiology diagnostic
0973 = Professional fees-radiology therapeutic
0974 = Professional fees-nuclear medicine
0975 = Professional fees-operating room
0976 = Professional fees-respiratory therapy
0977 = Professional fees-physical therapy
0978 = Professional fees-occupational therapy
0979 = Professional fees-speech pathology
0981 = Professional fees-emergency room
0982 = Professional fees-outpatient services
0983 = Professional fees-clinic
0984 = Professional fees-medical social services
0985 = Professional fees-EKG
0986 = Professional fees-EEG
0987 = Professional fees-hospital visit
0988 = Professional fees-consultation
0989 = Professional fees-private duty nurse
0990 = Patient convenience items-general classification
0991 = Patient convenience items-cafeteria/guest tray
0992 = Patient convenience items-private linen service

0993 = Patient convenience items-telephone/telegraph
0994 = Patient convenience items-tv/radio
0995 = Patient convenience items-nonpatient room rentals
0996 = Patient convenience items-late discharge charge
0997 = Patient convenience items-admission kits
0998 = Patient convenience items-beauty shop/barber
0999 = Patient convenience items-other

NOTE: Following Revenue Codes reported
for NHCMQ (RUGS) demo claims effective
2/96.

9000 = RUGS-no MDS assessment available
9001 = Reduced physical functions-
RUGS PA1/ADL index of 4-5
9002 = Reduced physical functions-
RUGS PA2/ADL index of 4-5
9003 = Reduced physical functions-
RUGS PB1/ADL index of 6-8
9004 = Reduced physical functions-
RUGS PB2/ADL index of 6-8
9005 = Reduced physical functions-
RUGS PC1/ADL index of 9-10
9006 = Reduced physical functions-
RUGS PC2/ADL index of 9-10
9007 = Reduced physical functions-

RUGS PD1/ADL index of 11-15
9008 = Reduced physical functions-
RUGS PD2/ADL index of 11-15
9009 = Reduced physical functions-
RUGS PE1/ADL index of 16-18
9010 = Reduced physical functions-
RUGS PE2/ADL index of 16-18
9011 = Behavior only problems-
RUGS BA1/ADL index of 4-5
9012 = Behavior only problems-
RUGS BA2/ADL index of 4-5
9013 = Behavior only problems-
RUGS BB1/ADL index of 6-10
9014 = Behavior only problems-

RUGS BB2/ADL index of 6-10
9015 = Impaired cognition-
RUGS IA1/ADL index of 4-5
9016 = Impaired cognition-
RUGS IA2/ADL index of 4-5
9017 = Impaired cognition-
RUGS IB1/ADL index of 6-10
9018 = Impaired cognition-
RUGS IB2/ADL index of 6-10
9019 = Clinically complex-
RUGS CA1/ADL index of 4-5
9020 = Clinically complex-
RUGS CA2/ADL index of 4-5d
9021 = Clinically complex-
RUGS CB1/ADL index of 6-10
9022 = Clinically complex-
RUGS CB2/ADL index of 6-10d
9023 = Clinically complex-
RUGS CC1/ADL index of 11-16
9024 = Clinically complex-
RUGS CC2/ADL index of 11-16d
9025 = Clinically complex-
RUGS CD1/ADL index of 17-18
9026 = Clinically complex-
RUGS CD2/ADL index of 17-18d
9027 = Special care-
RUGS SSA/ADL index of 7-13
9028 = Special care-
RUGS SSB/ADL index of 14-16
9029 = Special care-
RUGS SSC/ADL index of 17-18
9030 = Extensive services-
RUGS SE1/1 procedure
9031 = Extensive services-
RUGS SE2/2 procedures
9032 = Extensive services-
RUGS SE3/3 procedures
9033 = Low rehabilitation-
RUGS RLA/ADL index of 4-11
9034 = Low rehabilitation-
RUGS RLB/ADL index of 12-18
9035 = Medium rehabilitation-
RUGS RMA/ADL index of 4-7

9036 = Medium rehabilitation-
RUGS RMB/ADL index of 8-15
9037 = Medium rehabilitation-
RUGS RMC/ADL index of 16-18
9038 = High rehabilitation-
RUGS RHA/ADL index of 4-7
9039 = High rehabilitation-
RUGS RHB/ADL index of 8-11
9040 = High rehabilitation-
RUGS RHC/ADL index of 12-14
9041 = High rehabilitation-
RUGS RHD/ADL index of 15-18
9042 = Very high rehabilitation-
RUGS RVA/ADL index of 4-7
9043 = Very high rehabilitation-
RUGS RVB/ADL index of 8-13
9044 = Very high rehabilitation-
RUGS RVC/ADL index of 14-18

Changes effective for providers entering
RUGS Demo Phase III as of 1/1/97 or later

9019 = Clinically complex-
RUGS CA1/ADL index of 11
9020 = Clinically complex-
RUGS CA2/ADL index of 11D
9021 = Clinically complex-
RUGS CB1/ADL index of 12-16
9022 = Clinically complex-
RUGS CB2/ADL index of 12-16D
9023 = Clinically complex-
RUGS CC1/ADL index of 17-18
9024 = Clinically complex-
RUGS CC2/ADL index of 17-18D
9025 = Special care-
RUGS SSA/ADL index of 14
9026 = Special care-
RUGS SSB/ADL index of 15-16
9027 = Special care-
RUGS SSC/ADL index of 17-18

9028 = Extensive services-
RUGS SE1/ADL index 7-18/1 procedure
9029 = Extensive services-
RUGS SE2/ADL index 7-18/2 procedures
9030 = Extensive services-
RUGS SE3/ADL index 7-18/3 procedures
9031 = Low rehabilitation-
RUGS RLA/ADL index of 4-13
9032 = Low rehabilitation-
RUGS RLB/ADL index of 14-18
9033 = Medium rehabilitation-
RUGS RMA/ADL index of 4-7
9034 = Medium rehabilitation-
RUGS RMB/ADL index of 8-14
9035 = Medium rehabilitation-
RUGS RMC/ADL index of 15-18
9036 = High rehabilitation-
RUGS RHA/ADL index of 4-7
9037 = High rehabilitation-

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RUGS RHB/ADL index of 8-12
9038 = High rehabilitation-
RUGS RHC/ADL index of 13-18
9039 = Very High rehabilitation-
RUGS RVA/ADL index of 4-8
9040 = Very high rehabilitation-
RUGS RVB/ADL index of 9-15
9041 = Very high rehabilitation-
RUGS RVC/ADL index of 16
9042 = Very high rehabilitation-
RUGS RUA/ADL index of 4-8
9043 = Very high rehabilitation-
RUGS RUB/ADL index of 9-15
9044 = Ultra high rehabilitation-
RUGS RUC/ADL index of 16-18

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