CMS RIF REPORT FOR RECORD: FI_IP_SNF_CLM_REC, STATUS: PROD, VERSION: 19068
PRINTED: 07/10/2019, USER: A4KJ, DATA SOURCE: CA REPOSITORY ON DB2T

```
     NAME                      LENGTH  BEG  END                                        CONTENTS
-------------------------------------------------------------------------------------------------------------
*** FI Inpatient/SNF Claim Record (NCH)
                              VAR      1  31656    REC

                                                  STANDARD ALIAS : FI_IP_SNF_CLM_REC
                                                  SYSTEM   ALIAS : UTLIPSNK

                                                  LIMITATIONS :

                                                   REFER TO :
                                                    CHOICES_DEMO_LIM
                                                    CLM_POA_IND_CD_LIM
                                                    CLM_SNF_VRSN_I_REC_LIM
                                                    CLM_TRANS_CD_LIM
                                                    CNCL_CLM_LIM
                                                    HHA_HCPCS_LIM
                                                    IP_IME_GME_LIM
                                                    MCO_PD_SW_LIM
                                                    MLTPL_REV_CNTR_0001_CD_LIM
                                                    PMT_AMT_EXCEDG_CHRG_AMT_LIM
                                                    PPS_CPTL_DRG_WT_NUM_LIM
                                                    PPS_CPTL_DSCHRG_FRCTN_PCT_LIM
                                                    REV_CNTR_IDE_NDC_UPC_LIM
                                                    REV_CNTR_TOT_CHRG_AMT_LIM
                                                    REV_RNDRNG_PHYSN_NPI_NUM_LIM
                                                    TOT_CHRG_AMT_LIM

1.   FI Inpatient/SNF Claim Fixed Group
                              2058      1  2058     GRP


2.   Claim Record Identification Group
                                 8      1     8     GRP


                                                  Effective with Version 'I' the record
                                                  length, version code, record identification,
                                                  code and NCH derived claim type code were moved
                                                  to this group for internal NCH processing.

                                                  STANDARD ALIAS : CLM_REC_IDENT_GRP
```

3.   Record Length Count

                          3   1   3   PACK

                                        Effective with Version H, the count (in bytes)
                                        of the length of the claim record.

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

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

                                        LENGTH   : 5   SIGNED : Y

                                        SOURCE   : NCH

4.   NCH Near-Line Record Version Code

                          1   4   4   CHAR

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

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

                                        LENGTH   : 1

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

                                        SOURCE   : NCH

                                        CODE TABLE   : NCH_NEAR_LINE_REC_VRSN_TB

5.   NCH Near Line Record Identification Code

                          1   5   5   CHAR

                                        A code defining the type of claim record being processed.

                                        COMMON   ALIAS : RIC

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

                                 LENGTH         : 1

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

                                 SOURCE         : NCH

                                 CODE TABLE     : NCH_NEAR_LINE_RIC_TB
```

6.   NCH MQA RIC Code
```
                     1     6     6    CHAR

                                 Effective with Version H, the code used (for internal
                                 editing purposes) to identify the record being processed
                                 through CMS' CWFMQA system.

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

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

                                 LENGTH         : 1

                                 SOURCE         : NCH QA PROCESS

                                 CODE TABLE     : NCH_MQA_RIC_TB
```

7.   NCH Claim Type Code
```
                     2     7     8    CHAR

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

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

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                         NOTE2:  During the Version I conversion this field was
                         expanded to include inpatient 'full' encounter
                         claims (for service dates after 6/30/97).

                         NOTE3:  Effective with Version 'J', 3 new code values have
                         been added to include a type code for the Medicare
                         Advantage claims (IME/GME, no-pay and paid as FFS).
                         During the Version 'J' conversion, these type codes were
                         populated throughout history. With Version 'J', these claims
                         are also being stored in NMUD.  Prior to Version 'J' they
                         were only in the NCH.  No history was converted in NMUD.

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

                         LENGTH         : 2

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

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

                         DERIVATION RULES:

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

                         SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
                         WHERE THE FOLLOWING CONDITIONS ARE MET:
                         1.    CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                         2.    PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
```

```
3.    CLM_TRANS_CD EQUAL '0' OR '4'
4.    POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
OR 'Z'

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

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

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

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

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

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

4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (Medicare Advantage IME/GME
CLAIMS - 10/1/05 - FORWARD)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '0'
2. CLM_RLT_COND_CD = '04' & '69'
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 63 (HMO NO-PAY CLAIMS)
WHERE THE FOLLOWING CONDITIONS ARE MET:
CLAIMS PROCESSED ON OR AFTER 10/6/08
1. CLM_THRU_DT ON OR AFTER 10/1/06
2. CLM_MCO_PD_SW = '1'
3. CLM_RLT_COND_CD = '04'
4. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'A', 'B' OR 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS
5. ZERO REIMBURSEMENT (CLM_PMT_AMT)

SET CLM_TYPE_CD TO 63 (HMO NO-PAY CLAIMS)
WHERE THE FOLLOWING CONDITIONS ARE MET:
CLAIMS PROCESSED PRIOR to 10/6/08
1. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'A', 'B' OR 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS
2. ZERO REIMBURSEMENT (CLM_PMT_AMT)

SET CLM_TYPE_CD TO 64 (HMO CLAIMS PAID AS FFS)
WHERE THE FOLLOWING CONDITIONS ARE MET:
CLAIMS PROCESSED PRIOR to 10/6/08
1. MCO_CNTRCT_NUM
MCO_OPTN_CD = '1', '2' OR '4'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 64 (HMO CLAIMS PAID AS FFS)

```
                                WHERE THE FOLLOWING CONDITIONS ARE MET:
                                CLAIMS PROCESSED on or after 10/6/08
                                1.    CLM_RLT_COND_CD = '04'
                                2.    MCO_CNTRCT_NUM
                                MCO_OPTN_CD = '1', '2' OR '4'
                                CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
                                MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
                                ENROLLMENT PERIODS

                                SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
                                WHERE THE FOLLOWING CONDITIONS ARE MET:
                                1.    CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                                2.    HCPCS_CD not on DMEPOS table

                                SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
                                WHERE THE FOLLOWING CONDITIONS ARE MET:
                                1.    CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                                2.    HCPCS_CD on DMEPOS table (NOTE: if one or
                                more line item(s) match the HCPCS on the
                                DMEPOS table).

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

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

                                SOURCE          : NCH

                                LIMITATIONS :

                                  REFER TO :
                                   NCH_CLM_TYPE_CD_LIM

                                CODE TABLE      : NCH_CLM_TYPE_TB

8.   Fiscal Intermediary Claim Link Group
                                125      9    133    GRP
```

Effective with Version 'I', this group
contains those fields necessary to keep
segments together (a claim may have up 10
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 the final action process.

STANDARD ALIAS : FI_CLM_LINK_GRP

9.   Claim Locator Number Group
                              11   9   19   GRP

This number uniquely identifies the beneficiary in
the NCH Nearline.

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

10.   Beneficiary Claim Account Number
                              9   9   17   CHAR

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

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

LENGTH   : 9

SOURCE   : SSA,RRB

LIMITATIONS :

  REFER TO :
   CLM_ACNT_NUM_LIM

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

The code categorizing groups of BICs
representing similar relationships between

the beneficiary and the primary wage earner.

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

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

LENGTH          : 2

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

SOURCE          : BIC EQUATE MODULE

CODE TABLE      : CTGRY_EQTBL_BENE_IDENT_TB
```

12. Beneficiary Identification Code
                              2   20   21   CHAR

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

```
COMMON    ALIAS : BIC
DB2       ALIAS : BENE_IDENT_CD
SAS       ALIAS : BIC
STANDARD ALIAS : BENE_IDENT_CD
TITLE     ALIAS : BIC

LENGTH          : 2

SOURCE          : SSA/RRB

EDIT RULES :
      EDB REQUIRED FIELD
```

```
                                        CODE TABLE      : BENE_IDENT_TB

13.   NCH State Segment Code
                              1     22     22    CHAR

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

                                        DB2      ALIAS : NCH_STATE_SGMT_CD
                                        SAS      ALIAS : ST_SGMT
                                        STANDARD ALIAS : NCH_STATE_SGMT_CD
                                        TITLE    ALIAS : NEAR_LINE_SEGMENT

                                        LENGTH          : 1

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

                                        SOURCE          : NCH

                                        CODE TABLE      : NCH_STATE_SGMT_TB

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

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

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

                                        LENGTH          : 2

                                        COMMENTS :
                                        1. Used in conjunction with a county code, as
                                        selection criteria for the determination of
                                        payment rates for HMO reimbursement.
                                        2. Concerning individuals directly billable for
                                        Part B and/or Part A premiums, this element
                                        is used to determine if the beneficiary
```

```
                              will receive a bill in English or Spanish.
                              3. Also used for special studies.

                              SOURCE          : SSA/EDB

                              EDIT RULES :
                                   OPTIONAL: MAY BE BLANK

                              CODE TABLE      : GEO_SSA_STATE_TB

15.   Claim From Date
                    8     25     32     NUM

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

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

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

                              LENGTH          : 8     SIGNED : N

                              SOURCE          : CWF

                              EDIT RULES :
                                   YYYYMMDD

16.   Claim Through Date
                    8     33     40     NUM

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

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

                              DB2      ALIAS : CLM_THRU_DT
                              SAS      ALIAS : THRU_DT
                              STANDARD ALIAS : CLM_THRU_DT
```

```
                              TITLE     ALIAS : THRU_DATE

                              LENGTH          : 8     SIGNED : N

                              SOURCE          : CWF

                              EDIT RULES :
                                   YYYYMMDD

17.  NCH Weekly Claim Processing Date
                    8      41      48     NUM

                              The date the weekly NCH database load
                              process cycle begins, during which the claim
                              records are loaded into the Nearline file.
                              This date will always be a Friday, although
                              the claims will actually be appended to the
                              database subsequent to the date.

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

                              LENGTH          : 8     SIGNED : N

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

                              SOURCE          : NCH

                              EDIT RULES :
                                   YYYYMMDD

18.  CWF Claim Accretion Date
                    8      49      56     NUM

                              The date the claim record is accreted (posted/
                              processed) to the beneficiary master record
                              at the CWF host site and authorization for
                              payment is returned to the fiscal interme-
                              diary or carrier.

                              DB2       ALIAS : CWF_CLM_ACRTN_DT
                              SAS       ALIAS : ACRTN_DT
                              STANDARD ALIAS : CWF_CLM_ACRTN_DT
```

```
                                  TITLE    ALIAS : ACCRETION_DT

                                  LENGTH           : 8     SIGNED : N

                                  SOURCE           : CWF

                                  EDIT RULES :
                                        YYYYMMDD

19.  CWF Claim Accretion Number
                        2      57      58     PACK

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

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

                                  LENGTH           : 3     SIGNED : Y

                                  SOURCE           : CWF

20.  FI Document Claim Control Number
                       23      59      81     CHAR

                                  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

                                  LENGTH           : 23

                                  SOURCE           : CWF
```

21. FI Original Claim Control Number

```
                          23    82    104    CHAR
```

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

LENGTH         : 23

SOURCE         : CWF
```

22. Claim Query Code

```
                          1     105   105    CHAR
```

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

LENGTH         : 1

SOURCE         : CWF

CODE TABLE     : CLM_QUERY_TB
```

23. Provider Number

```
                          6     106   111    CHAR
```

The identification number of the institutional provider
certified by Medicare to provide services to the
beneficiary.

NOTE: Effective October 1, 2007 the OSCAR Provider
Number has been renamed the CMS Certification
Number (CCN). The name was changed to avoid
confusion with the National Provider Identifier

(NPI). The CCN (OSCAR Provider Number) will
continue to play a critical role in verifying
that a provider has been Medicare certified and
for what type of services.

```
DB2      ALIAS : PRVDR_NUM
SAS      ALIAS : PROVIDER
STANDARD ALIAS : PRVDR_NUM
TITLE    ALIAS : PROVIDER_NUMBER

LENGTH         : 6

CODE TABLE     : PRVDR_NUM_TB
```

24. NCH Daily Process Date

                    8   112   119   NUM

Effective with Version H, the date the claim record was
processed by CMS' CWFMQA system (used for internal editing
purposes).

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

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

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

LENGTH         : 8    SIGNED : N

SOURCE         : NCH

LIMITATIONS :

  REFER TO :
   NCH_DAILY_PROC_DT_LIM

EDIT RULES :
     YYYYMMDD
```

25. NCH Segment Link Number

                        5   120   124   PACK

                               Effective with Version 'I', the system gen-
                               erated number used in conjunction with the
                               NCH daily process date to keep records/segments
                               belonging to a specific claim together.
                               This field was added to ensure that records/
                               segments that come in on the same batch with
                               the same identifying information in the link
                               group are not mixed with each other.

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

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

                               LENGTH   : 9   SIGNED : Y

                               SOURCE   : NCH

26. Claim Total Segment Count

                        2   125   126   NUM

                               Effective with Version I, the count used
                               to identify the total number of segments
                               associated with a given claim. Each claim
                               could have up to 10 segments.

                               NOTE: During the Version I conversion, this
                               field was populated with data throughout
                               history (back to service year 1991).
                               For institutional claims, the count
                               for claims prior to 7/00 will be 1 or 2
                               (1 if 45 or less revenue center lines on a
                               claim and 2 if more than 45 revenue center
                               lines on a claim). For noninstitutional
                               claims, the count will always be 1.

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

```
                                        LENGTH          : 2    SIGNED : N

                                        SOURCE          : CWF

27.  Claim Segment Number
                         2    127    128    NUM

                                        Effective with Version I, the number used
                                        to identify an actual record/segment (1 - 10)
                                        associated with a given claim.

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

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

                                        LENGTH          : 2    SIGNED : N

                                        SOURCE          : CWF

28.  Claim Total Line Count
                         3    129    131    NUM

                                        Effective with Version I, the count used to
                                        identify the total number of revenue center
                                        lines associated with the claim.

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

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

```
                                          LENGTH          : 3    SIGNED : N

                                          SOURCE          : CWF

29.  Claim Segment Line Count
                        2    132    133    NUM

                                          Effective with Version I, the count used
                                          to identify the number of 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
                                          on the revenue center trailer is 45.  The
                                          maximum number of lines on carrier and DMERC
                                          claims are 13.

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

                                          LENGTH          : 2    SIGNED : N

                                          SOURCE          : CWF

30.  FI CLAIM COMMON GROUP
                     1091    134   1224    GRP
                                          ALPHANUM

31.  NCH Payment and Edit Record Identification Code
                        1    134    134    CHAR

                                          The code used for payment and editing purposes that
                                          indicates the type of institutional claim record.
                                          Prior to Version H this field was named:
                                          PMT_EDIT_RIC_CD.

                                          DB2      ALIAS : PMT_EDIT_RIC_CD
                                          SAS      ALIAS : PE_RIC
                                          STANDARD ALIAS : NCH_PMT_EDIT_RIC_CD
                                          TITLE    ALIAS : NCH_PAYMENT_EDIT_RIC

                                          LENGTH          : 1
```

32. Claim Transaction Code
                        1   135   135   CHAR

                               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
                               TITLE   ALIAS : TRANSACTION_CODE

                               LENGTH   : 1

                               SOURCE   : CWF

                               LIMITATIONS :

                                 REFER TO :
                                  CLM_TRANS_CD_LIM

                               CODE TABLE   : CLM_TRANS_TB

33. Claim Bill Type Group
                        2   136   137   GRP

                               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.

                               NOTE: Effective 4/1/2002, TOB code 'XX0' was
                               implemented to identify those claims that are
                               totally non-covered.

                               STANDARD ALIAS : CLM_BILL_TYPE_CD_GRP

                               CODE TABLE   : CLM_BILL_TYPE_TB

34. Claim Facility Type Code
                        1   136   136   CHAR

```
                              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

                              LENGTH          : 1

                              SOURCE          : CWF

                              CODE TABLE      : CLM_FAC_TYPE_TB
```

35. Claim Service Classification Type Code
```
                    1    137    137    CHAR

                              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

                              LENGTH          : 1

                              SOURCE          : CWF

                              CODE TABLE      : CLM_SRVC_CLSFCTN_TYPE_TB
```

36. Claim Frequency Code
```
                    1    138    138    CHAR

                              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
                              TITLE     ALIAS : FREQUENCY_CD
```

```
                                 LENGTH        : 1

                                 SOURCE        : CWF

                                 CODE TABLE    : CLM_FREQ_TB

37.  FILLER
                     1   139   139   CHAR

                                 DB2      ALIAS : FILLER
                                 STANDARD ALIAS : FILLER

                                 LENGTH        : 1

38.  NCH MQA Query Patch Code
                     1   140   140   CHAR

                                 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

                                 LENGTH        : 1

                                 SOURCE        : NCH QA Process

                                 CODE TABLE    : NCH_MQA_QUERY_PATCH_TB

39.  Claim Disposition Code
                     2   141   142   CHAR

                                 Code indicating the disposition or outcome of the processing
                                 of the claim record.

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

```
                                           LENGTH          : 2

                                           SOURCE          : CWF

                                           CODE TABLE      : CLM_DISP_TB

40.  NCH Edit Disposition Code
                          2    143    144   CHAR

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

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

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

                                           LENGTH          : 2

                                           SOURCE          : NCH QA Process

                                           CODE TABLE      : NCH_EDIT_DISP_TB

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

                                           Effective with Version H, the code used (for internal
                                           editing purposes) to identify a claim record that was
                                           submitted with an incorrect HA, HB, or HC BIC.

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

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

                                           LENGTH          : 1
```

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

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

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

LENGTH   : 3

SOURCE   : SSA/EDB

EDIT RULES :
     OPTIONAL: MAY BE BLANK

43. FI Claim Receipt Date
                        8   149   156   NUM

The date the fiscal intermediary received the
institutional claim from the provider.

DB2   ALIAS : FI_CLM_RCPT_DT
SAS   ALIAS : RCPT_DT
STANDARD ALIAS : FI_CLM_RCPT_DT
TITLE   ALIAS : RECEIPT_DT

LENGTH   : 8   SIGNED : N

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

SOURCE   : CWF

EDIT RULES :
     YYYYMMDD

44. FI Claim Scheduled Payment Date
                        8   157   164   NUM

The scheduled date of payment to the institu-

tional 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.

```
DB2      ALIAS : FI_SCHLD_PMT_DT
SAS      ALIAS : SCHLD_DT
STANDARD ALIAS : FI_CLM_SCHLD_PMT_DT
TITLE    ALIAS : SCHEDULED_PMT_DT

LENGTH         : 8    SIGNED : N

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

SOURCE         : CWF

EDIT RULES :
     YYYYMMDD
```

45. CWF Forwarded Date

                         8   165   172   NUM

Effective with Version H, the date CWF forwarded the claim
record to CMS (used for internal editing purposes).

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

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

LENGTH         : 8    SIGNED : N

SOURCE         : CWF

EDIT RULES :
     YYYYMMDD
```

46. FI Number

                         5   173   177   CHAR

The identification number assigned by CMS to a fiscal
intermediary authorized to process institutional claim
records.

Effective October 2006, the Medicare Administrative
Contractors (MACs) began replacing the existing
fiscal intermediaries and started processing institu-
tional claim records for states assigned to its
jurisdiction.

NOTE: The 5-position MAC number will be housed in
the existing FI_NUM field. During the transition
from an FI to a MAC the FI_NUM field could contain
either a FI number or a MAC number. See the
FI_NUM table of codes to identify the new MAC
numbers and their effective dates.

```
DB2      ALIAS : FI_NUM
SAS      ALIAS : FI_NUM
STANDARD ALIAS : FI_NUM
TITLE    ALIAS : INTERMEDIARY

LENGTH         : 5

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

SOURCE         : CWF

CODE TABLE     : FI_NUM_TB
```

47. CWF Claim Assigned Number
                    8   178   185   CHAR

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

                                      LENGTH          : 8

                                      SOURCE          : CWF

48.  CWF Transmission Batch Number
                           4    186    189    CHAR


                                      Effective with Version H, the number assigned
                                      to each batch of claims transactions sent from
                                      CWF(used for internal editing purposes).

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

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

                                      LENGTH          : 4

                                      SOURCE          : CWF

49.  Beneficiary Mailing Contact ZIP Code
                           9    190    198    CHAR


                                      The ZIP code of the mailing address where the
                                      beneficiary may be contacted.

                                      DB2      ALIAS : BENE_MLG_ZIP_CD
                                      SAS      ALIAS : BENE_ZIP
                                      STANDARD ALIAS : BENE_MLG_CNTCT_ZIP_CD
                                      TITLE    ALIAS : BENE_ZIP

                                      LENGTH          : 9

                                      SOURCE          : EDB

50.  Beneficiary Sex Identification Code
                           1    199    199    CHAR


                                      The sex of a beneficiary.
```

```
                              COMMON    ALIAS : SEX_CD
                              DB2       ALIAS : BENE_SEX_IDENT_CD
                              SAS       ALIAS : SEX
                              STANDARD ALIAS : BENE_SEX_IDENT_CD
                              TITLE     ALIAS : SEX_CD

                              LENGTH           : 1

                              SOURCE           : SSA,RRB,EDB

                              EDIT RULES :
                                   REQUIRED FIELD

                              CODE TABLE       : BENE_SEX_IDENT_TB

51.   Beneficiary Race Code
                 1    200    200    CHAR

                              The race of a beneficiary.

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

                              LENGTH           : 1

                              SOURCE           : SSA

                              CODE TABLE       : BENE_RACE_TB

52.   Beneficiary Birth Date
                 8    201    208    NUM

                              The beneficiary's date of birth.

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

                              LENGTH           : 8    SIGNED : N

                              SOURCE           : CWF

                              EDIT RULES :
```

53. CWF Beneficiary Medicare Status Code

                        2   209   210   CHAR

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

                               COMMON   ALIAS : MSC
                               DB2   ALIAS : BENE_MDCR_STUS_CD
                               SAS   ALIAS : MS_CD
                               STANDARD ALIAS : CWF_BENE_MDCR_STUS_CD
                               TITLE   ALIAS : MSC

                               LENGTH   : 2

                               DERIVATIONS :
                               CWF derives MSC from the following:
                               1. Date of Birth
                               2. Claim Through Date
                               3. Original/Current Reasons for entitlement
                               4. ESRD Indicator
                               5. Beneficiary Claim Number
                               Items 1,3,4,5 come from the CWF Beneficiary
                               Master Record; item 2 comes from the FI/Carrier
                               claim record. MSC is assigned as follows:

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

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

                               SOURCE   : CWF

                               CODE TABLE   : BENE_MDCR_STUS_TB

54. Claim Patient 6 Position Surname

```
                    6     211    216     CHAR

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

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

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

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

                                        LENGTH          : 6

                                        SOURCE          : CWF

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

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

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

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

                                        COMMON    ALIAS : PATIENT_GIVEN_NAME
                                        DB2       ALIAS : 1ST_INITL_GVN_NAME
```

```
                                    SAS       ALIAS : FRSTINIT
                                    STANDARD ALIAS : CLM_PTNT_1ST_INITL_GVN_NAME
                                    TITLE    ALIAS : PATIENT_FIRST_INITIAL

                                    LENGTH         : 1

                                    SOURCE         : CWF

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

                                    The first initial of the Medicare patient's
                                    middle name as reported by the provider on
                                    the claim.

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

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

                                    COMMON   ALIAS : PATIENT_MIDDLE_NAME
                                    DB2      ALIAS : 1ST_INITL_MDL_NAME
                                    SAS      ALIAS : MDL_INIT
                                    STANDARD ALIAS : CLM_PTNT_1ST_INITL_MDL_NAME
                                    TITLE    ALIAS : PATIENT_MIDDLE_INITIAL

                                    LENGTH         : 1

                                    SOURCE         : CWF

57.  Beneficiary CWF Location Code
                    1    219    219    CHAR

                                    The code that identifies the Common Working File
                                    (CWF) location (the host site) where a beneficiary's
                                    Medicare utilization records are maintained.

                                    COMMON   ALIAS : CWF_HOST
                                    DB2      ALIAS : BENE_CWF_LOC_CD
                                    SAS      ALIAS : CWFLOCCD
                                    STANDARD ALIAS : BENE_CWF_LOC_CD
```

```
                                    TITLE     ALIAS : CWF_HOST

                                    LENGTH          : 1

                                    SOURCE          : CWF

                                    CODE TABLE      : BENE_CWF_LOC_TB

58.  Claim Principal Diagnosis Group
                         8    220    227    GRP


                                    Effective with Version 'J', the group used to identify
                                    the principal diagnosis code.
                                    This group contains the principal diagnosis code
                                    and the principal diagnosis version code.

                                    STANDARD ALIAS : CLM_PRNCPAL_DGNS_GRP

59.  Claim Principal Diagnosis Version Code
                         1    220    220    CHAR

                                    Effective with Version 'J', the code used to indicate
                                    if the diagnosis is ICD-9 or ICD-10.

                                    NOTE:  With 5010, the diagnosis and procedure codes
                                    have been expanded to accommodate ICD-10, even though
                                    ICD-10 is not scheduled for implementation until 10/2013.

                                    DB2       ALIAS : UNDEFINED
                                    SAS       ALIAS : PDVRSNCD
                                    STANDARD ALIAS : CLM_PRNCPAL_DGNS_VRSN_CD

                                    LENGTH          : 1

                                    CODE TABLE      : CLM_DGNS_VRSN_TB

60.  Claim Principal Diagnosis Code
                         7    221    227    CHAR

                                    The 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.

NOTE1: Effective with Version 'J', this field has been
expanded from 5 bytes to 7 bytes to accommodate
the future implementation of ICD-10.

DB2   ALIAS : PRNCPAL_DGNS_CD
SAS   ALIAS : PDGNS_CD
STANDARD ALIAS : CLM_PRNCPAL_DGNS_CD

LENGTH   : 7

SOURCE   : CWF

EDIT RULES :
     ICD-9-CM

61. FILLER

                    1   228   228   CHAR

DB2   ALIAS : FILLER
STANDARD ALIAS : FILLER

LENGTH   : 1

62. Claim Medicare Non Payment Reason Code

                    2   229   230   CHAR

The reason that no Medicare payment is made for
services on an institutional claim.

NOTE1: This field was put on all institutional
claim types but data did not start coming in on
OP/HHA/Hospice until 4/1/02. Prior to 4/1/02,
data only came in Inpatient/SNF claims.

NOTE2: Effective 4/1/02, this field was also
expanded to two bytes to accommodate new values.
The NCH Nearline file did not expand the current
1-byte field but instituted a crosswalk of the
2-byte field to the 1-byte character value.
See table of code for the crosswalk.

NOTE3: Effective with Version 'J', the field has been
expanded on the NCH claim to 2 bytes.   With this
expansion the NCH will no longer use the character

values to represent the official two byte values being
sent in by CWF since 4/2002.

During the Version 'J' conversion, all character values
were converted to the two byte values.

```
DB2      ALIAS : MDCR_NPMT_RSN_CD
SAS      ALIAS : NOPAY_CD
STANDARD ALIAS : CLM_MDCR_NPMT_RSN_CD

LENGTH         : 2

CODE TABLE     : CLM_MDCR_NPMT_RSN_TB
```

63. Claim Excepted/Nonexcepted Medical Treatment Code
                        1   231   231   CHAR

Effective with Version I, the code used to identify
whether or not the medical care or treatment received
by a beneficiary, who has elected care from a
Religious Nonmedical Health Care Institution (RNHCI),
is excepted or nonexcepted. Excepted is medical care
or treatment that is received involuntarily or is re-
quired under Federal, State or local law. Nonexcepted is
defined as medical care or treatment other than excepted.

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

LENGTH         : 1

SOURCE         : CWF

CODE TABLE     : CLM_EXCPTD_NEXCPTD_TRTMT_TB
```

64. Claim Payment Amount
                        6   232   237   PACK

Amount of payment made from the Medicare trust fund for the
services covered by the claim record. Generally, the amount
is calculated by the FI or carrier; and represents what was
paid to the institutional provider, physician, or supplier,
with the exceptions noted below. ***NOTE: In some
situations, a negative claim payment amount may be pre-
sent; e.g., (1) when a beneficiary is charged the full

deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)

Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program.   On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). After 4/1/03, the payment amount could also include a "new technology" add-on amount. After 7/5/2011, the payment amount could also include a payment adjustment given to hospitals to account for the higher costs per discharge for "low-income hospitals". After 10/1/2012, the payment amount could also include adjustments for value based purchasing, readmissions, and Model 1, Bundled Payments for Care Improvement. After 10/1/2014, the payment amount could also include the uncompensated care payment (UCP).

It does NOT include the pass-thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any any other payer reimbursement.

Under IRFPPS, inpatient rehabilitation services are paid based on a predetermined rate per discharge, using the Case Mix Group (CMG) classification system and the PRICER program. From the CMG on the IRF PPS claim, payment is based on a standard payment amount for operating and capital cost for that facility (including routine and ancillary services).   The payment is adjusted for wage, the % of low-income patients (LIP), locality, transfers, interrupted stays, short stay cases, deaths, and high cost outliers.   Some or all of these adjustments could apply. The CMG payment does NOT include certain pass-through costs (i.e. bad debts, approved education activities); beneficiary-paid amounts, other payer reim-bursement,and other services outside of the scope of PPS.

Under LTCH PPS, long term care hospital services are paid based on a predetermined rate per discharge based on the

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

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

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

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

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

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

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

For demo Ids '01','02','03','04' -- claims contain
amount paid to the provider, except that special

'differentials' paid outside the normal payment system
are not included.

For demo Ids '05','15' -- encounter data 'claims'
contain amount Medicare would have paid under FFS,
instead of the actual payment to the MCO.

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

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

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

LENGTH   : 9.2   SIGNED : Y

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

SOURCE   : CWF

LIMITATIONS :

  REFER TO :
   PMT_AMT_EXCEDG_CHRG_AMT_LIM

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

65. NCH Primary Payer Claim Paid Amount

                      6   238   243   PACK

                             The amount of a payment made on behalf of a Medicare
                             beneficiary by a primary payer other than Medicare, that the
                             provider is applying to covered Medicare charges on an
                             institutional, carrier, or DMERC claim.

                             DB2   ALIAS : PRMRY_PYR_PD_AMT
                             STANDARD ALIAS : NCH_PRMRY_PYR_CLM_PD_AMT
                             TITLE   ALIAS : PRIMARY_PAYER_AMOUNT

                             LENGTH   : 9.2   SIGNED : Y

                             COMMENTS :
                             Prior to Version H this field was named:
                             BENE_PRMRY_PYR_CLM_PMT_AMT and the field size
                             was S9(7)V99.

                             SOURCE   : NCH

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

66. NCH Primary Payer Code

                      1   244   244   CHAR

                             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

                             LENGTH   : 1

                             DERIVATIONS :
                             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'

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

                                      SOURCE          : NCH

                                      CODE TABLE      : BENE_PRMRY_PYR_TB

67.  FI Requested Claim Cancel Reason Code
                      1    245    245    CHAR

                                      The reason that an intermediary requested cancelling
                                      a previously submitted institutional claim.

                                      DB2      ALIAS : RQST_CNCL_RSN_CD
                                      SAS      ALIAS : CANCELCD
                                      STANDARD ALIAS : FI_RQST_CLM_CNCL_RSN_CD
```

```
                                        TITLE    ALIAS : CANCEL_CD

                                        LENGTH          : 1

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

                                        SOURCE          : CWF

                                        CODE TABLE      : FI_RQST_CLM_CNCL_RSN_TB
68.  FI Claim Action Code
                          1    246   246    CHAR

                                        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

                                        LENGTH          : 1

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

                                        SOURCE          : CWF

                                        CODE TABLE      : FI_CLM_ACTN_TB
69.  FI Claim Process Date
                          8    247   254    NUM

                                        The date the fiscal intermediary completes
                                        processing and releases the institutional
                                        claim to the CWF host.

                                        DB2      ALIAS : FI_CLM_PROC_DT
                                        SAS      ALIAS : APRVL_DT
                                        STANDARD ALIAS : FI_CLM_PROC_DT
                                        TITLE    ALIAS : FI_PROCESS_DT

                                        LENGTH          : 8    SIGNED : N
```

```
                              SOURCE         : CWF

                              EDIT RULES :
                                  YYYYMMDD

70.  NCH Provider State Code
                         2    255    256    CHAR

                              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

                              LENGTH         : 2

                              DERIVATIONS :
                              DERIVED FROM:
                              NCH PRVDR_NUM

                              DERIVATION RULES:

                              SET NCH_PRVDR_STATE_CD TO
                              PRVDR_NUM POS1-2.
                              FOR PRVDR_NUM POS1-2 EQUAL '55' OR '75'
                              OR '92'
                              SET NCH_PRVDR_STATE_CD TO '05'.
                              FOR PRVDR_NUM POS1-2 EQUAL '67' OR '74'
                              OR '97'
                              SET NCH_PRVDR_STATE_CD TO '45'.
                              FOR PRVDR_NUM POS1-2 EQUAL '68' OR '69'
                              SET NCH_PRVDR_STATE_CD TO '10'.
                              FOR PRVDR_NUM POS1-2 EQUAL '78'
                              SET NCH_PRVDR_STATE_CD TO '14'
                              FOR PRVDR_NUM POS1-2 EQUAL TO '76'
                              SET NCH_PRVDR_STATE_CD TO '16'
                              FOR PRVDR_NUM POS1-2 EQUAL '70'
                              SET NCH_PRVDR_STATE_CD TO '17'
                              FOR PRVDR_NUM POS1-2 EQUAL '71' OR '95'
                              SET NCH_PRVDR_STATE_CD TO '19'
                              FOR PRVDR_NUMBER POS1-2 EQUAL '77'
```

```
                                     SET NCH_PRVDR_STATE_CD TO '24'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '72'
                                     SET NCH_PRVDR_STATE_CD TO '36'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '73'
                                     SET NCH_PRVDR_STATE_CD TO '39'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '81'
                                     SET NCH_PRVDR_STATE_CD TO '07'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '22'
                                     SET NCH_PRVDR_STATE_CD TO '22'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '83'
                                     SET NCH_PRVDR_STATE_CD TO '31'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '84'
                                     SET NCH_PRVDR_STATE_CD TO '40'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '85'
                                     SET NCH_PRVDR_STATE_CD TO '11'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '86'
                                     SET NCH_PRVDR_STATE_CD TO '34'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '87'
                                     SET NCH_PRVDR_STATE_CD TO '42'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '88'
                                     SET NCH_PRVDR_STATE_CD TO '44'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '89'
                                     SET NCH_PRVDR_STATE_CD TO '04'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '90'
                                     SET NCH_PRVDR_STATE_CD TO '37'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '91'
                                     SET NCH_PRVDR_STATE_CD TO '06'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '93'
                                     SET NCH_PRVDR_STATE_CD TO '38'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '94'
                                     SET NCH_PRVDR_STATE_CD TO '50'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '96'
                                     SET NCH_PRVDR_STATE_CD TO '32'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '00'
                                     SET NCH_PRVDR_STATE_CD TO '03'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '54'
                                     SET NCH_PRVDR_STATE_CD TO '13'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '57'
                                     SET NCH_PRVDR_STATE_CD TO '33'
                                     FOR PRVDR_NUM POS1-2 EQUAL TO '58'
                                     SET NCH_PRVDR_STATE_CD TO '51'

                                     SOURCE          : NCH

                                     CODE TABLE      : GEO_SSA_STATE_TB
```

71.   Organization NPI Number

```
                       10      257    266    CHAR

                              On an institutional claim, the National
                              Provider Identifier (NPI) number assigned
                              to uniquely identify the institutional provider
                              certified by Medicare to provide services to the
                              beneficiary.

                              NOTE:  Effective May 2007, the NPI will be-
                              come the national standard identifier for
                              covered health care providers.  NPIs will
                              replace current OSCAR provider number, UPINs,
                              NSC numbers, and local contractor provider
                              identification numbers (PINs) on standard
                              HIPPA claim transactions. (During the NPI
                              transition phase (4/3/06 - 5/23/07) the
                              capability was there for the NCH to receive NPIs
                              along with an existing legacy number (UPIN,
                              PIN, OSCAR provider number, etc.)).

                              NOTE1:  CMS has determined that dual provider
                              identifiers (old legacy numbers and new NPI)
                              must be available in the NCH. After the 5/07
                              NPI implelmentation, the standard system main-
                              tainers will add the legacy number to the claim
                              when it is adjudicated.  We will continue to
                              receive the OSCAR provider number and any currently
                              issued UPINs.  Effective May 2007, no NEW UPINs
                              (legacy number) will be generated for NEW
                              physicians (Part B and outpatient claims),
                              so there will only be NPIs sent in to the NCH
                              for those physicians.

                              DB2      ALIAS : ORG_NPI_NUM
                              SAS      ALIAS : ORGNPINM
                              STANDARD ALIAS : ORG_NPI_NUM
                              TITLE    ALIAS : ORG_NPI

                              LENGTH         : 10

                              SOURCE         : CWF

72.  Attending Physician ID Group
                       24      267    290    GRP


                              Name and identification numbers associated
```

with the primary care physician.

STANDARD ALIAS : ATNDG_PHYSN_ID_GRP

73. Claim Attending Physician UPIN Number
                           6   267   272   CHAR

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).

COMMON   ALIAS : ATTENDING_PHYSICIAN_UPIN
DB2   ALIAS : ATNDG_UPIN_NUM
SAS   ALIAS : AT_UPIN
STANDARD ALIAS : CLM_ATNDG_PHYSN_UPIN_NUM
TITLE   ALIAS : ATTENDING_PHYSICIAN

LENGTH   : 6

COMMENTS :
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

74. Claim Attending Physician NPI Number
                          10   273   282   CHAR

On an institutional claim, the national
provider identifier (NPI) number assigned
to uniquely identify the physician who has
overall responsibility for the beneficiary's
care and treatment.

NOTE: Effective May 2007, the NPI will be-
come the national standard identifier for
covered health care providers. NPIs will
replace current OSCAR provider number, UPINs,
NSC numbers, and local contractor provider
identification numbers (PINs) on standard
HIPPA claim transactions. (During the NPI

transition phase (4/3/06 - 5/23/07) the
capability was there for the NCH to receive NPIs
along with an existing legacy number (UPIN,
PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider
identifiers (old legacy numbers and new NPI)
must be available in the NCH. After the 5/07
NPI implementation, the standard system main-
tainers will add the legacy number to the claim
when it is adjudicated. We will continue to
receive the OSCAR provider number and any currently
issued UPINs. Effective May 2007, no NEW UPINs
(legacy number) will be generated for NEW
physicians (Part B and Outpatient claims),
so there will only be NPIs sent in to the NCH
for those physicians.

```
COMMON   ALIAS : ATTENDING_PHYSICIAN_NPI
DB2      ALIAS : ATNDG_NPI_NUM
SAS      ALIAS : AT_NPI
STANDARD ALIAS : CLM_ATNDG_PHYSN_NPI_NUM
TITLE    ALIAS : ATNDG_NPI

LENGTH         : 10

SOURCE         : CWF
```

75. Claim Attending Physician Surname
                     6   283   288   CHAR

Effective with Version H, the last name of the
attending physician (used for internal editing
purpose in CMS' 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

LENGTH         : 6
```

76. Claim Attending Physician Given Name
                              1   289   289   CHAR

                                      Effective with Version H, the first name of the
                                      attending physician (used for internal editing
                                      purposes in CMS' 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_GVN_NAME
                                      SAS   ALIAS : AT_GVNNM
                                      STANDARD ALIAS : CLM_ATNDG_PHYSN_GVN_NAME
                                      TITLE   ALIAS : ATNDG_PHYSN_FIRSTNAME

                                      LENGTH   : 1

                                      SOURCE   : CWF

77. Claim Attending Physician Middle Initial Name
                              1   290   290   CHAR

                                      Effective with Version H, the middle initial
                                      of the attending physician (used for internal
                                      editing purposes in CMS' 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

                                      LENGTH   : 1

                                      SOURCE   : CWF

78. Operating Physician ID Group
                             24   291   314   GRP

Name and identification numbers associated
with the physician who performed the principal
procedure.

STANDARD ALIAS : OPRTG_PHYSN_ID_GRP

79. Claim Operating Physician UPIN Number
                          6   291   296   CHAR

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

LENGTH   : 6

COMMENTS :
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.

SOURCE   : CWF

80. Claim Operating Physician NPI Number
                          10   297   306   CHAR

On an institutional claim, the National Provider
Identifier (NPI) number assigned to uniquely
identify the physician with the primary
responsibility for performing the surgical
procedure(s).

NOTE: Effective May 2007, the NPI will become

the national standard identifier for covered
health care providers. NPIs will replace
the current OSCAR provider number, UPINs, NSC
numbers, and local contractor provider identi-
fication numbers (PINs) on standard HIPPA claim
transactions. (During the NPI transition phase
(4/3/06 - 5/23/07) the capability was there
for the NCH to receive NPIs along with an
existing legacy number (UPIN, PIN, OSCAR provider
number, etc.)).

NOTE1: CMS has determined that dual provider
identifiers (old legacy number and new NPI)
must be available in the NCH. After the 5/07
NPI implementation, the standard system maint-
tainers will add the legacy number to the claim
when its adjudicated. We will continue to re-
ceive the OSCAR provider number and any currently
issued UPINs. Effective May 2007, no NEW UPINs
(legacy numbers) will be generated for NEW
physicians (Part B and outpatient claims), so
there will only be NPIs sent in to the NCH
for those physicians.

```
DB2      ALIAS : OPRTG_NPI
SAS      ALIAS : OP_NPI
STANDARD ALIAS : CLM_OPRTG_PHYSN_NPI_NUM
TITLE    ALIAS : OPRTG_NPI

LENGTH         : 10

SOURCE         : CWF
```

81. Claim Operating Physician Surname
                         6   307   312   CHAR

Effective with Version H, the last name of the
operating physician (used for internal editing
purposes in CMS' 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

                                            LENGTH         : 6

                                            SOURCE         : CWF

82.  Claim Operating Physician Given Name
                        1    313    313    CHAR

                                            Effective with Version H, the first name
                                            of the operating physician (used for internal
                                            editing purposes in CMS' 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

                                            LENGTH         : 1

                                            SOURCE         : CWF

83.  Claim Operating Physician Middle Initial Name
                        1    314    314    CHAR

                                            Effective with Version H, the middle initial
                                            of the operating physician (used for internal
                                            editing purposes in CMS' 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_MI_NAME
                                            SAS      ALIAS : OP_MDL
                                            STANDARD ALIAS : CLM_OPRTG_PHYSN_MDL_INITL_NAME
                                            TITLE    ALIAS : OPRTG_PHYSN_MI

                                            LENGTH         : 1
```

84. Other Operating Physician ID Group
                        24   315   338   GRP

              Name and identification numbers associated with
              the other physician.

              STANDARD ALIAS : OTHR_OPRTG_PHYSN_ID_GRP

              COMMENTS :
              This field was renamed from OTHR_PHYSN_ID_GRP to
              OTHR_OPRTG_PHYSN_ID_GRP as part of the CR#7 updates.

85. Claim Other Physician UPIN Number
                        6   315   320   CHAR

              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

              LENGTH   : 6

              COMMENTS :
              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

86. Claim Other Physician NPI Number
                        10   321   330   CHAR

              On an institutional claim, the National

Provider Identifier (NPI) number assigned
to uniquely identify the other physician
associated with the institutiohal claim.

NOTE: Effective May 2007, the NPI will be-
come the national standard identifier for
covered health care providers. NPIs will
replace current OSCAR provider number, UPINs,
NSC numbers, and local contractor provider
identification numbers (PINs) on standard
HIPPA claim transactions. (During the NPI
transition phase (4/3/06 - 5/23/07) the
capability was there for the NCH to receive NPIs
along with an existing legacy number (UPIN,
PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider
identifiers (old legacy numbers and new NPI)
must be available in the NCH. After the 5/07
NPI implementation, the standard system main-
tainers will add the legacy number to the claim
when it is adjudicated. We will continue to
receive the OSCAR provider number and any currently
issued UPINs. Effective May 2007, no NEW UPINs
(legacy number) will be generated for NEW
physicians (Part B AND outpatient claims),
so there will only be NPIs sent in to the NCH
for those physicians.

DB2   ALIAS : OTHR_NPI
SAS   ALIAS : OT_NPI
STANDARD ALIAS : CLM_OTHR_PHYSN_NPI_NUM

LENGTH   : 10

SOURCE   : CWF

87.   Claim Other Physician Surname
                     6   331   336   CHAR

Effective with Version H, the last name of the
other physician (used for internal editing
purposes in CMS' 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

LENGTH         : 6

SOURCE         : CWF
```

88. Claim Other Physician Given Name
                     1   337   337   CHAR

Effective with Version H, the first name of the
other physician (used for internal editing
purposes in CMS' 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

LENGTH         : 1

SOURCE         : CWF
```

89. Claim Other Physician Middle Initial Name
                     1   338   338   CHAR

Effective with Version H, the middle initial of
the other physician (used for internal editing
purposes in CMS' 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

                                LENGTH           : 1

                                SOURCE           : CWF

90.  Medicaid Provider Identification Number
                    13    339    351    CHAR

                                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

                                LENGTH           : 13

                                COMMENTS :
                                Prior to Version H the field size was X(12).

                                SOURCE           : CWF

91.  Claim Medicaid Information Code
                     4    352    355    CHAR

                                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

                                LENGTH           : 4

                                SOURCE           : CWF

                                CODE TABLE       : CLM_MDCD_INFO_TB

92.  Claim MCO Paid Switch
                     1    356    356    CHAR
```

A switch indicating whether or not a Managed Care
Organization (MCO) has paid the provider for an
institutional claim.

```
DB2      ALIAS : CLM_MCO_PD_SW
SAS      ALIAS : MCOPDSW
STANDARD ALIAS : CLM_MCO_PD_SW
TITLE    ALIAS : MCO_PAID_SW

LENGTH         : 1

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

SOURCE         : CWF

LIMITATIONS :

  REFER TO :
   MCO_PD_SW_LIM

CODE TABLE     : CLM_MCO_PD_TB
```

93. Claim Treatment Authorization Number
                   18   357   374   CHAR

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

                                        LENGTH   : 18

                                        SOURCE   : CWF

94. Patient Control Number
                         20   375   394   CHAR

                                        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

                                        LENGTH   : 20

                                        SOURCE   : CWF

95. Claim Medical Record Number
                         17   395   411   CHAR

                                        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

                                        LENGTH   : 17

                                        SOURCE   : CWF

96. Claim PRO Control Number
                         12   412   423   CHAR

                                        Effective with Version G, the unique identifier
                                        assigned by the Peer Review Organization (PRO)
                                        for control purposes.

                                        DB2   ALIAS : CLM_PRO_CNTL_NUM

```
                                      SAS      ALIAS : PRO_CNTL
                                      STANDARD ALIAS : CLM_PRO_CNTL_NUM
                                      TITLE    ALIAS : PRO_CONTROL_NUM

                                      LENGTH         : 12

                                      SOURCE         : CWF

97.  Claim PRO Process Date
                          8    424    431    NUM

                                      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.

                                      DB2      ALIAS : CLM_PRO_PROC_DT
                                      SAS      ALIAS : PRO_DT
                                      STANDARD ALIAS : CLM_PRO_PROC_DT
                                      TITLE    ALIAS : PRO_PROC_DT

                                      LENGTH         : 8    SIGNED : N

                                      SOURCE         : CWF

                                      EDIT RULES :
                                           YYYYMMDD

98.  Patient Discharge Status Code
                          2    432    433    CHAR

                                      The code used to identify the status of the
                                      patient as of the CLM_THRU_DT.

                                      DB2      ALIAS : PTNT_DSCHRG_STUS
                                      SAS      ALIAS : STUS_CD
                                      STANDARD ALIAS : PTNT_DSCHRG_STUS_CD
                                      TITLE    ALIAS : PTNT_DSCHRG_STUS_CD

                                      LENGTH         : 2

                                      COMMENTS :
                                      Prior to Version H this field was named:
                                      CLM_STUS_CD.
```

```
                                          SOURCE          : CWF

                                          CODE TABLE      : PTNT_DSCHRG_STUS_TB

99.  Claim 1st Diagnosis E Code Group
                          8    434    441    GRP


                                          Effective with Version 'J', the group used to identify the
                                          1st diagnosis E code in the diagnosis E trailer.  This group
                                          contains the 1st diagnosis E code and the 1st diagnosis E
                                          version code.

                                          STANDARD ALIAS : CLM_1ST_DGNS_E_CD_GRP

100. Claim 1st Diagnosis E Version Code
                          1    434    434    CHAR

                                          Effective with Version 'J', the code used to indicate if
                                          the diagnosis code is ICD-9 or ICD-10.

                                          NOTE:  With 5010, the diagnosis and procedure codes have
                                          been expanded to accomodate ICD-10, even though ICD-10 is
                                          not scheduled for implementation until 10/2013.

                                          DB2      ALIAS : UNDEFINED
                                          SAS      ALIAS : E1VRSNCD
                                          STANDARD ALIAS : CLM_1ST_DGNS_E_VRSN_CD

                                          LENGTH          : 1

                                          CODE TABLE      : CLM_DGNS_VRSN_TB

101. Claim 1st Diagnosis E Code
                          7    435    441    CHAR

                                          The code used to identify the 1st external cause of
                                          injury, poisoning, or other adverse effect.  This
                                          diagnosis E code is also stored as the 1st occurrence
                                          of the diagnosis E code trailer.

                                          NOTE:  Effective with Version 'J', this field has been
                                          expanded from 5 bytes to 7 bytes to accommodate the
                                          future implementation of ICD-10.

                                          DB2      ALIAS : CLM_1ST_DGNS_E_CD
```

```
                                 SAS       ALIAS : DGNS_E
                                 STANDARD ALIAS : CLM_1ST_DGNS_E_CD

                                 LENGTH         : 7

                                 COMMENTS :
                                 Prior to version 'J',  this field was named:
                                 CLM_DGNS_E_CD.

                                 SOURCE         : CWF

                                 EDIT RULES :
                                      ICD-9-CM

102. Claim PPS Indicator Code
                     1    442    442    CHAR

                                 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.

                                 DB2       ALIAS : CLM_PPS_IND_CD
                                 SAS       ALIAS : PPS_IND
                                 STANDARD ALIAS : CLM_PPS_IND_CD
                                 TITLE     ALIAS : PPS_IND

                                 LENGTH         : 1

                                 SOURCE         : CWF

                                 CODE TABLE     : CLM_PPS_IND_TB

103. Claim Total Charge Amount
                     6    443    448    PACK

                                 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.

                                              DB2      ALIAS : CLM_TOT_CHRG_AMT
                                              SAS      ALIAS : TOT_CHRG
                                              STANDARD ALIAS : CLM_TOT_CHRG_AMT
                                              TITLE    ALIAS : CLAIM_TOTAL_CHARGES

                                              LENGTH          : 9.2    SIGNED : Y

                                              COMMENTS :
                                              Prior to Version H the size of this field was
                                              S9(7)V99.

                                              SOURCE          : CWF

                                              LIMITATIONS :

                                                REFER TO :
                                                 TOT_CHRG_AMT_LIM

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

104. Claim Pricer Return Code
                          2    449    450    CHAR

                                              Effective 1/1/2004 with the implementation of NCH/NMUD
                                              CR#1, the code used to identify various PPS payment
                                              adjustment types.  This code identifies the
                                              payment return code or the error return code for
                                              every claim type calculated by a PRICER (Inpatient,
                                              Outpatient, SNF, Inpatient Rehab Facility (IRF),
                                              Home Health and Hospice).

                                              The payment return code identifies the type of
                                              payment calculated by the PRICER software.

                                              The error return code identifies a condition in
                                              a claim that prevents the PRICER software from
                                              calculating a correct payment.

                                              NOTE:  Prior to 10/2005 (implementation of NCH/NMUD
                                              CR#2), this data was stored in positions 443-444
                                              (FILLER) on all institutional claim types.

                                              DB2      ALIAS : CLM_PRCR_RTRN_CD
                                              SAS      ALIAS : PRCRRTRN
```

```
                                        STANDARD ALIAS : CLM_PRCR_RTRN_CD

                                        LENGTH         : 2

                                        SOURCE         : CWF

                                        CODE TABLE     : CLM_PRCR_RTRN_TB

105. Claim Business Segment Identifier Code
                    4    451    454    CHAR

                                        Effective 10/1/2005 with the implementation of NCH/NMUD
                                        CR#2, the identifier that captures the 2-byte juris-
                                        diction code (represents the USPS state/territory
                                        abbreviation (i.e. NY = New York) and the 2-byte
                                        modifier that identifies the type of Medicare FFS
                                        contract (intermediary, RHHI, carrier or DMERC).
                                        This 4-byte identifier along with the 5-byte
                                        FI/Carrier number comprises the Contractor
                                        Workload Identifier number.  The business segment
                                        identifier (BSI) is intended to help sort work-
                                        loads that may be redistributed with the implemen-
                                        tation of contracting reform as required by MMA.

                                        DB2      ALIAS : BUSNS_SGMT_ID_CD
                                        SAS      ALIAS : SGMT_ID
                                        STANDARD ALIAS : CLM_BUSNS_SGMT_ID_CD

                                        LENGTH         : 4

                                        SOURCE         : CWF

106. Recovery Audit Contractor (RAC) Adjustment Indicator Code
                    1    455    455    CHAR

                                        Effective January 5, 2009 with the implementation of
                                        CR#4, the code used to identify a Recovery Audit
                                        Contractor (RAC) requested adjustment.  This occurs
                                        as a result of post-payment review activities done by
                                        the RAC.

                                        DB2      ALIAS : RAC_ADJSTMT_CD
                                        SAS      ALIAS : RACINDCD
                                        STANDARD ALIAS : CLM_RAC_ADJSTMT_IND_CD

                                        LENGTH         : 1
```

```
                                        CODE TABLE     : CLM_RAC_ADJSTMT_TB

107. Worker's Compensation Indicator Code
                          1    456    456    CHAR

                                        This indicator is used to determine whether the
                                        diagnosis codes on the claims are related to the
                                        diagnosis codes on the MSP auxiliary file in CWF.

                                        DB2      ALIAS : CLM_WC_IND_CD
                                        SAS      ALIAS : WCINDCD
                                        STANDARD ALIAS : CLM_WC_IND_CD

                                        LENGTH         : 1

                                        CODE TABLE     : CLM_WC_IND_TB

108. Claim Service Facility Zip Code
                          9    457    465    CHAR

                                        Effective with Version 'J', the zip code used to identify
                                        the location of the facility where the service
                                        was performed.

                                        DB2      ALIAS : SRVC_FAC_ZIP_CD
                                        SAS      ALIAS : SRVCFAC
                                        STANDARD ALIAS : CLM_SRVC_FAC_ZIP_CD

                                        LENGTH         : 9

109. Claim Paperwork (PWK) Code
                          2    466    467    CHAR

                                        Effective with CR#6, the code used to indicate a provider
                                        has submitted an electronic claim that requires
                                        additional documentation.

                                        DB2      ALIAS : CLM_PWK_CD
                                        STANDARD ALIAS : CLM_PWK_CD

                                        LENGTH         : 2

                                        CODE TABLE     : CLM_PWK_TB

110. Claim Care Improvement Model 1 Code
                          2    468    469    CHAR
```

Effective with CR#7, the code used to identify that
the care improvement model 1 is being used for
bundling payments. The valid value for care
improvement model 1 is '61'.

```
DB2       ALIAS : CARE_MODEL_1_CD
SAS       ALIAS : CMODEL1
STANDARD ALIAS : CLM_CARE_IMPRVMT_MODEL_1_CD

LENGTH        : 2

CODE TABLE    : CLM_CARE_IMPRVMT_MODEL_TB
```

111. Claim Care Improvement Model 2 Code
                        2   470   471   CHAR

Effective with CR#7, the code used to identify that
the care improvement model 2 is being used for
bundling payments. The valid value for care
improvement model 2 is '62'.

```
DB2       ALIAS : CARE_MODEL_2_CD
SAS       ALIAS : CMODEL2
STANDARD ALIAS : CLM_CARE_IMPRVMT_MODEL_2_CD

LENGTH        : 2

CODE TABLE    : CLM_CARE_IMPRVMT_MODEL_TB
```

112. Claim Care Improvement Model 3 Code
                        2   472   473   CHAR

Effective with CR#7, the code used to identify that
the care improvement model 3 is being used for
bundling payments. The valid value for care
improvement model 3 is '63'.

```
DB2       ALIAS : CARE_MODEL_3_CD
SAS       ALIAS : CMODEL3
STANDARD ALIAS : CLM_CARE_IMPRVMT_MODEL_3_CD

LENGTH        : 2

CODE TABLE    : CLM_CARE_IMPRVMT_MODEL_TB
```

113. Claim Care Improvement Model 4 Code
                        2   474   475   CHAR

Effective with CR#7, the code used to identify that the care improvement model 4 is being used for bundling payments. The valid value for care improvement model 4 is '64'.

```
DB2      ALIAS : CARE_MODEL_4_CD
SAS      ALIAS : CMODEL4
STANDARD ALIAS : CLM_CARE_IMPRVMT_MODEL_4_CD

LENGTH         : 2

CODE TABLE     : CLM_CARE_IMPRVMT_MODEL_TB
```

114. Rendering Physician ID Group

26   476   501   GRP

CR 7115 titled, Primary Care Incentive payment Program (PCIP), Section 5501(a) of the Patient Protection and Affordable Care Act (ACA), Payment to a Critical Access Hospital (CAH) paid under the Optional Method, instructed CAH providers to submit their NPI using the "Other Provider" field. With the implementation of 5010, the "Other Physician Group" was redefined to "Other Operating Physician" and thus, not appropriate for usage for PCIP reporting. With the implementation of CR7686, CAH providers must use the rendering provider fields to populate the eligible primary care practitioner NPI in order for the primary care services to qualify for the incentive bonus.

```
STANDARD ALIAS : RNDRNG_PHYSN_ID_GRP
```

115. Claim Rendering Physician UPIN Number

6   476   481   CHAR

Effective with CR#7, the unique physician identification number (UPIN) of the rendering physician whose services qualify for an incentive bonus under the Primary Care Incentive Payment Program (PCIP).

NOTE: CR7115 titled, Primary Care Incentive Payment Program (PCIP), Section 5501(a) of the Patient

Protection and Affordable Care Act (ACA), payment
to Critical Access Hospitals (CAH) paid under the
Optional Method, instructed CAH providers to submit
their NPI using the "Other Provider" field.   With the
implementation of 5010, the "Other Physician Group" as
redefined to "Other Operating Physician" and thus, not
appropriate for usage for PCIP reporting. With the
implementation of CR7686, CAH providers must use the
rendering provider fields to populate the eligible
primary care practitioner NPI in order for primary
care services to qualify for the incentive bonus.

```
DB2      ALIAS : RNDRNG-UPIN
SAS      ALIAS : R-UPIN
STANDARD ALIAS : CLM_RNDRNG_PHYSN_UPIN_NUM

LENGTH         : 6
```

116. Claim Rendering Physician NPI Number
                        10   482   491   CHAR

Effective with CR#7, the national provider
identifier (NPI) number assigned to uniquely
identify the rendering physician whose services
qualify for an incentive bonus under the Primary Care
Incentive Payment Program (PCIP).

NOTE: CR7115 titled, Primary Care Incentive Payment
Program (PCIP), Section 5501(a) of the Patient
Protection and Affordable Care Act (ACA), payment
to Critical Access Hospitals (CAH) paid under the
Optional Method, instructed CAH providers to submit
their NPI using the "Other Provider" field.   With the
implementation of 5010, the "Other Physician Group" as
redefined to "Other Operating Physician" and thus, not
appropriate for usage for PCIP reporting. With the
implementation of CR7686, CAH providers must use the
rendering provider fields to populate the eligible
primary care practitioner NPI in order for primary
care services to qualify for the incentive bonus.

```
DB2      ALIAS : RNDRNG-NPI
SAS      ALIAS : R-NPI
STANDARD ALIAS : CLM_RNDRNG_PHYSN_NPI_NUM

LENGTH         : 10
```

117. Claim Rendering Physician Surname Name
                           6   492   497   CHAR

                                  Effective with CR#7, the last name of the rendering
                                  physician whose services qualify for an incentive
                                  bonus under the Primary Care Incentive Payment
                                  Program.

                                  NOTE: CR7115 titled, Primary Care Incentive Payment
                                  Program (PCIP), Section 5501(a) of the Patient
                                  Protection and Affordable Care Act (ACA), payment
                                  to Critical Access Hospitals (CAH) paid under the
                                  Optional Method, instructed CAH providers to submit
                                  their NPI using the "Other Provider" field.   With the
                                  implementation of 5010, the "Other Physician Group" as
                                  redefined to "Other Operating Physician" and thus, not
                                  appropriate for usage for PCIP reporting. With the
                                  implementation of CR7686, CAH providers must use the
                                  rendering provider fields to populate the eligibile
                                  primary care practitioner NPI in order for primary
                                  care services to qualify for the incentive bonus.

                                  DB2   ALIAS : UNDEFINED
                                  SAS   ALIAS : R-SRNM
                                  STANDARD ALIAS : CLM_RNDRNG_PHYSN_SRNM_NAME

                                  LENGTH   : 6

118. Claim Rendering Physician Given Name
                           1   498   498   CHAR

                                  Effective with CR#7, the first name of the rendering
                                  physician whose services qualify for an incentive
                                  bonus under the Primary Care Incentive Payment
                                  Program.

                                  NOTE: CR7115 titled, Primary Care Incentive Payment
                                  Program (PCIP), Section 5501(a) of the Patient
                                  Protection and Affordable Care Act (ACA), payment
                                  to Critical Access Hospitals (CAH) paid under the
                                  Optional Method, instructed CAH providers to submit
                                  their NPI using the "Other Provider" field.   With the
                                  implementation of 5010, the "Other Physician Group" as
                                  redefined to "Other Operating Physician" and thus, not
                                  appropriate for usage for PCIP reporting. With the
                                  implementation of CR7686, CAH providers must use the
                                  rendering provider fields to populate the eligibile

primary care practitioner NPI in order for primary
care services to qualify for the incentive bonus.

```
DB2      ALIAS : UNDEFINED
SAS      ALIAS : R-GVN
STANDARD ALIAS : CLM_RNDRNG_PHYSN_GVN_NAME

LENGTH         : 1
```

119. Claim Rendering Physician Middle Name
                     1   499   499   CHAR

Effective with CR#7, the middle initial name of the
rendering physician whose services qualify for an
incentive bonus under the Primary Care Incentive
Payment Program.

NOTE: CR7115 titled, Primary Care Incentive Payment
Program (PCIP), Section 5501(a) of the Patient
Protection and Affordable Care Act (ACA), payment
to Critical Access Hospitals (CAH) paid under the
Optional Method, instructed CAH providers to submit
their NPI using the "Other Provider" field.   With the
implementation of 5010, the "Other Physician Group" as
redefined to "Other Operating Physician" and thus, not
appropriate for usage for PCIP reporting. With the
implementation of CR7686, CAH providers must use the
rendering provider fields to populate the eligibile
primary care practitioner NPI in order for primary
care services to qualify for the incentive bonus.

```
DB2      ALIAS : UNDEFINED
SAS      ALIAS : R-MDL
STANDARD ALIAS : CLM_RNDRNG_PHYSN_MDL_NAME

LENGTH         : 1
```

120. Claim Rendering Physician Specialty Code
                     2   500   501   CHAR

Effective with CR#7, the code used to identify the CMS
specialty code of the rendering physician/practitioner.

NOTE: A 10 percent initiative payment will be provided to
primary care practitioners, identified as: (1) in the
case of physicians, enrolled in Medicare with a primary
specialty code designation of 08-family practice, 11-

```
                              internal medicine, 37-pediatrics, or 38-geriatrics; or
                              (2) in the case of non-physician practitioners, enrolled
                              in Medicare with a primary care speciality code designation
                              of 50-nurse practitioner, 89-certified clinical nurse
                              specialist, or 97-physician assistant; and (3) for whom
                              the primary care services displayed in the above table
                              accounted for at least 60 perent of the allowed charged
                              under the PFS (excluding hospital inpatient care and
                              emergency department visits)for such practitioners.

                              DB2      ALIAS : RNDRNG_SPCLTY_CD
                              SAS      ALIAS : RPSPCLTY
                              STANDARD ALIAS : CLM_RNDRNG_PHYSN_SPCLTY_CD

                              LENGTH         : 2

                              CODE TABLE     : CMS_PRVDR_SPCLTY_TB

121. Claim Patient Relationship Code
                         2    502    503   CHAR

                              Effective with CR#7, the code used to identify the
                              patient relationship to the beneficiary.

                              DB2      ALIAS : CLM_PTNT_RLTNSHP_C
                              SAS      ALIAS : PRLTNSHP
                              STANDARD ALIAS : CLM_PTNT_RLTNSHP_CD

                              LENGTH         : 2

                              COMMENTS :
                              CMS CR7523

                              CODE TABLE     : CLM_PTNT_RLTNSHP_TB

122. Claim Fraud Prevention System (FPS) Model Number
                         2    504    505   CHAR

                              Effective with Version 'K', this field identifies an
                              FPS analytic model that identifies claims that may
                              be high risk for fraud based on specific information.

                              DB2      ALIAS : CLM_FPS_MODEL_NUM
                              SAS      ALIAS : FPSMODEL
                              STANDARD ALIAS : CLM-FPS-MODEL-NUM

                              LENGTH         : 2
```

```
                                          COMMENTS :
                                          Valid Values:   0 - 9, A -Z


123. Claim FPS Reason Code
                         3    506    508   CHAR

                                          Effective with Version 'K', this field identifies the
                                          reason codes used to explain why a claim was not
                                          paid or how the claim was paid.  These codes also
                                          show the reason for any claim financial adjustment
                                          such as denial, reductions or increases in payment.

                                          DB2       ALIAS : CLM_FPS_RSN_CD
                                          SAS       ALIAS : FPSRSN
                                          STANDARD ALIAS : CLM_FPS_RSN_CD

                                          LENGTH         : 3

                                          CODE TABLE     : CLM_ADJ_RSN_TB

124. Claim FPS Remarks Code
                         5    509    513   CHAR

                                          Effective with Version 'K', the codes used to
                                          convey information about remittance processing or
                                          to provide a supplemental explanation for an
                                          adjustment already described by a
                                          Claim Adjustment Reason Code.

                                          DB2       ALIAS : CLM_FPS_RMRK_CD
                                          SAS       ALIAS : FPSRMRK
                                          STANDARD ALIAS : CLM_FPS_RMRK_CD

                                          LENGTH         : 5

                                          CODE TABLE     : CLM_RMTNC_ADVC_TB

125. Claim FPS MSN 1 Code
                         5    514    518   CHAR

                                          Effective with Version 'K', the field used to
                                          identify the Medicare Secondary Notice Code.

                                          DB2       ALIAS : CLM_FPS_MSN_1_CD
                                          SAS       ALIAS : FPSMSN1
                                          STANDARD ALIAS : CLM-FPS-MSN-1-CD
```

```
                                      LENGTH          : 5

                                      CODE TABLE      : CLM_FPS_MSN_CD_TB

126. Claim FPS MSN 2 Code
                          5    519    523    CHAR

                                      Effective with Version 'K', the field used to
                                      identify the Medicare Secondary Notice Code.

                                      DB2      ALIAS : CLM_FPS_MSN_2_CD
                                      SAS      ALIAS : FPSMSN2
                                      STANDARD ALIAS : CLM-FPS-MSN-2-CD

                                      LENGTH          : 5

                                      CODE TABLE      : CLM_FPS_MSN_CD_TB

127. Claim Mass Adjustment Indicator Code
                          1    524    524    CHAR

                                      Effective with Version 'K', the field used to
                                      identify if the adjustment claim is part of a mass
                                      adjustment project.

                                      DB2      ALIAS : MASS_ADJSTMT_CD
                                      SAS      ALIAS : MADJSTMT
                                      STANDARD ALIAS : CLM_MASS_ADJSTMT_IND_CD

                                      LENGTH          : 1

                                      CODE TABLE      : CLM_MASS_ADJSTMT_IND_CD_TB

128. Claim Next Generation (NG) Affordable Care Organization (ACO) Indicator 1 Code
                          1    525    525    CHAR

                                      Effective with CR#11, this field represents the benefit enhancement
                                      indicator that identifies claims that qualify for a specific
                                      claims processing edit.

                                      NOTE:  There are 5 occurrences of this field on a claim, but each
                                      value can only be represented once.

                                      NOTE2:  The 5 occurrences of this field are found at the claim level
                                      on all institutional claim types and at the line level on Carrier
                                      claims.
```

```
                                    DB2      ALIAS : CLM_NG_ACO_1_CD
                                    SAS      ALIAS : CNGACO1
                                    STANDARD ALIAS : CLM_NG_ACO_IND_1_CD

                                    LENGTH         : 1

                                    SOURCE         : CWF

                                    CODE TABLE     : NG_ACO_IND_TB
```

129. Claim Next Generation (NG) Affordable Care Organization (ACO) Indicator 2 Code
```
                1    526    526    CHAR
```

Effective with CR#11, this field represents the benefit enhancement indicator that identifies claims that qualify for a specific claims processing edit.

NOTE: There are 5 occurrences of this field on a claim, but each value can only be represented once.

NOTE2: The 5 occurrences of this field are found at the claim level on all institutional claim types and at the line level on Carrier claims.

```
                                    DB2      ALIAS : CLM_NG_ACO_2_CD
                                    SAS      ALIAS : CNGACO2
                                    STANDARD ALIAS : CLM_NG_ACO_IND_2_CD

                                    LENGTH         : 1

                                    SOURCE         : CWF

                                    CODE TABLE     : NG_ACO_IND_TB
```

130. Claim Next Generation (NG) Affordable Care Organization (ACO) Indicator 3 Code
```
                1    527    527    CHAR
```

Effective with CR#11, this field represents the benefit enhancement indicator that identifies claims that qualify for a specific claims processing edit.

NOTE: There are 5 occurrences of this field on a claim, but each value can only be represented once.

NOTE2: The 5 occurrences of this field are found at the claim level on all institutional claim types and at the line level on Carrier

```
                              claims.

                              DB2       ALIAS : CLM_NG_ACO_3_CD
                              SAS       ALIAS : CNGACO3
                              STANDARD ALIAS : CLM_NG_ACO_IND_3_CD

                              LENGTH         : 1

                              SOURCE         : CWF

                              CODE TABLE     : NG_ACO_IND_TB

131. Claim Next Generation (NG) Affordable Care Organization (ACO) Indicator 4 Code
                    1     528     528     CHAR

                              Effective with CR#11, this field represents the benefit enhancement
                              indicator that identifies claims that qualify for a specific
                              claims processing edit.

                              NOTE:  There are 5 occurrences of this field on a claim, but each
                              value can only be represented once.

                              NOTE2:  The 5 occurrences of this field are found at the claim level
                              on all institutional claim types and at the line level on Carrier
                              claims.

                              DB2       ALIAS : CLM_NG_ACO_4_CD
                              SAS       ALIAS : CNGACO4
                              STANDARD ALIAS : CLM_NG_ACO_IND_4_CD

                              LENGTH         : 1

                              SOURCE         : CWF

                              CODE TABLE     : NG_ACO_IND_TB

132. Claim Next Generation (NG) Affordable Care Organization (ACO) Indicator 5 Code
                    1     529     529     CHAR

                              Effective with CR#11, this field represents the benefit enhancement
                              indicator that identifies claims that qualify for a specific
                              claims processing edit.

                              NOTE:  There are 5 occurrences of this field on a claim, but each
                              value can only be represented once.

                              NOTE2:  The 5 occurrences of this field are found at the claim level
```

```
                                on all institutional claim types and at the line level on Carrier
                                claims.

                                DB2      ALIAS : CLM_NG_ACO_5_CD
                                SAS      ALIAS : CNGACO5
                                STANDARD ALIAS : CLM_NG_ACO_IND_5_CD

                                LENGTH          : 1

                                SOURCE          : CWF

                                CODE TABLE      : NG_ACO_IND_TB

133. Claim Residual Payment Indicator Code
                     1    530    530    CHAR

                                Effective with CR#11, this field is used by CWF claims processing
                                for the purpose of bypassing its normal MSP editing that would
                                otherwise apply for ongoing responsibility for medicals (ORM) or
                                worker's compensation Medicare Set-Aside Arrangements (WCMSA).
                                Normally, CWF does not allow a secondary payment on MSP involving
                                ORM or WCMSA, so the residual payment indicator will be used to
                                allow CWF to make an exception to its normal routine.

                                DB2      ALIAS : CLM_RSDL_PMT_CD
                                SAS      ALIAS : RSDLPMT
                                STANDARD ALIAS : CLM_RSDL_PMT_IND_CD

                                LENGTH          : 1

                                SOURCE          : CWF

                                CODE TABLE      : RSDL_PMT_IND_TB

134. Claim Accountable Care Organization (ACO) Identification Number
                    10    531    540    CHAR

                                Effective with CR#12, this field identifies the unique identifi-
                                cation number assigned to the Accountable Care Organization (ACO).

                                DB2      ALIAS : CLM_ACO_ID_NUM
                                SAS      ALIAS : ACOIDNUM
                                STANDARD ALIAS : CLM_ACO_ID_NUM

                                LENGTH          : 10

                                COMMENTS :
```

135. Medicare Beneficiary Identification (MBI) Number
                            11   541   551   CHAR

                                    Effective with CR#12, this field represents the Medicare beneficiary
                                    identification number. This field is being added due to the removal
                                    of the Social Security Number from the Medicare card (SSNRI project).
                                    The MBI will replace the HICN on the Medicare card. CMS will
                                    continue to use the HICN within internal systems.

                                    NOTE: We will not see MBI's on the claims until October 2017
                                    (start of the transition period).

                                    DB2   ALIAS : MBI_ID
                                    SAS   ALIAS : MBIID
                                    STANDARD ALIAS : MBI_ID

                                    LENGTH   : 11

                                    COMMENTS :
                                    SSNRI Project
                                    CWF October 2017 Release

136. Claim Beneficiary Identifier Type Code
                             1   552   552   CHAR

                                    Effective with CR#12, this field identifies whether the claim was
                                    submitted by the provider, during the transition period, with a
                                    HICN or MBI.

                                    NOTE: This field will not be populated with data until the start
                                    of the transition period (October 2017).

                                    DB2   ALIAS : BENE_ID_TYPE_CD
                                    SAS   ALIAS : BENEIDCD
                                    STANDARD ALIAS : CLM_BENE_ID_TYPE_CD

                                    LENGTH   : 1

                                    COMMENTS :
                                    (SSNRI Project)
                                    CWF October 2017 Release

                                    CODE TABLE   : CLM_BENE_ID_TYPE_TB

137. Claim Provider Validation Code

```
                    2     553     554     CHAR

                                Effective with CR#14 (April 2019 release), this field is used to
                                inform the Common Working File (CWF) to perform an edit check
                                to ensure that the provider that was submitted on the Prior
                                Authorization (PA) request is the same provider on the claim.

                                DB2       ALIAS : UNDEFINED
                                SAS       ALIAS : CVLDTNCD

                                LENGTH         : 2

                                CODE TABLE     : CLM_PRVDR_VLDTN_TB

138. Claim Railroad Board (RRB) Exclusion Indicator Switch
                    1     555     555     CHAR

                                Effective with CR#14 (April 2019 release), this field informs the
                                Shared System Maintainer (SSM) and Common Working File (CWF) if
                                the Railroad Board (RRB) beneficiary claim should either be in-
                                cluded or excluded from Prior Authorization (PA) processing.

                                For example, if the field is valued "Y", and it is an RRB bene-
                                ficiary claim, it will be excluded from PA processing.

                                DB2       ALIAS : UNDEFINED
                                SAS       ALIAS : CEXCLSN

                                LENGTH         : 1

                                CODE TABLE     : CLM_RRB_EXCLSN_IND_TB

139. FILLER
                  669     556    1224     CHAR

                                DB2       ALIAS : H_FILLER_3

                                LENGTH         : 669

140. Inpatient/SNF NCH Edit Code Count
                    2    1225    1226     NUM

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

```
                                DB2      ALIAS : IP_NCH_EDIT_CD_CNT
                                SAS      ALIAS : IPEDCNT
                                STANDARD ALIAS : IP_NCH_EDIT_CD_CNT

                                LENGTH        : 2    SIGNED : N

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

                                SOURCE        : NCH

141. Inpatient/SNF NCH Patch Code Count
                      2    1227   1228    NUM

                                Effective with Version H, the count of the
                                number of HCFA patch codes annotated to the
                                inpatient/SNF 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).

                                DB2      ALIAS : IP_PATCH_CD_CNT
                                SAS      ALIAS : IPPATCNT
                                STANDARD ALIAS : IP_NCH_PATCH_CD_I_CNT

                                LENGTH        : 2    SIGNED : N

                                SOURCE        : NCH

142. Inpatient/SNF MCO Period Count
                      1    1229   1229    NUM

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

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


                         DB2       ALIAS : IP_MCO_PRD_CNT
                         SAS       ALIAS : IPMCOCNT
                         STANDARD ALIAS : IP_MCO_PRD_CNT


                         LENGTH         : 1    SIGNED : N


                         SOURCE         : NCH


                         EDIT RULES :
                             RANGE: 0 TO 2

143. Inpatient/SNF Claim Dem
                    1    1230    1230    NUM


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


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


                         DB2       ALIAS : IP_CLM_DEMO_ID
                         SAS       ALIAS : IPDEMCNT
                         STANDARD ALIAS : IP_CLM_DEMO_ID_CNT


                         LENGTH         : 1    SIGNED : N

144. Inpatient Claim POA Diagnosis Code Count
                    2    1231    1232    NUM


                         Effective with Version 'J', the count of the number
                         of Present on Admission (POA) codes reported on the
                         Inpatient/SNF claim.
                         The purpose of this count is to indicate
                         how many claim POA diagnosis trailers are present.


                         DB2       ALIAS : CLM_POA_TRLR_CNT
                         SAS       ALIAS : IPPOACNT
                         STANDARD ALIAS : IP_CLM_POA_DGNS_CD_CNT


                         LENGTH         : 2    SIGNED : N
```

```
                                           SOURCE           : CWF

                                           EDIT RULES :
                                              Range:  0 to 25

145. Inpatient Claim POA Diagnosis E Code Count
                            2    1233    1234   NUM

                                           Effective with Version 'J', the count of the number
                                           of Present on Admission (POA) codes associated with
                                           the diagnosis E codes reported on the Inpatient/SNF
                                           claim.  The purpose of this count is to indicate
                                           how many claim POA diagnosis E trailers are present.

                                           DB2       ALIAS : CLM_POA_E_TRLR_CNT
                                           SAS       ALIAS : IPPECNT
                                           STANDARD ALIAS : IP_CLM_POA_DGNS_E_CD_CNT

                                           LENGTH          : 2     SIGNED : N

                                           SOURCE          : CWF

                                           EDIT RULES :
                                              Range:  0 to 12

146. Inpatient/SNF Claim Diagnosis Code J Count
                            2    1235    1236   NUM

                                           The count of the number of diagnosis codes (both
                                           principal and secondary) reported on an Inpatient/SNF
                                           claim.  The purpose of this count is to indicate how many
                                           claim diagnosis code trailers are present.  Prior to
                                           Version 'J', this field was named:  IP_CLM_DGNS_CD_CNT.

                                           NOTE:  Effective with Version 'J', the count of the
                                           number of diagnosis code trailers was expanded from 10 to
                                           25.

                                           DB2       ALIAS : IP_CLM_DGNS_CD_CNT
                                           SAS       ALIAS : IPDGNCNT
                                           STANDARD ALIAS : IP_CLM_DGNS_CD_J_CNT

                                           LENGTH          : 2     SIGNED : N

                                           COMMENTS :
```

```
                                   Prior to Version H this field was named:
                                   CLM_OTHR_DGNS_CD_CNT and the principal was
                                   not included in the count.

                                   SOURCE          : CWF

                                   EDIT RULES :
                                       Range: 0 to 25

147. Inpatient Claim Diagnosis E Code Count
                        2    1237    1238    NUM

                                   Effective with Version 'J', the count of the number
                                   of diagnosis E codes reported on the Inpatient/SNF
                                   claim.  The purpose of this count is to indicate
                                   how many diagnosis E trailers are present.

                                   DB2      ALIAS : DGNS_E_TRLR_CNT
                                   SAS      ALIAS : IPDECNT
                                   STANDARD ALIAS : IP_CLM_DGNS_E_CD_CNT

                                   LENGTH          : 2     SIGNED : N

                                   SOURCE          : CWF

                                   EDIT RULES :
                                       Range: 0 to 12

148. Inpatient/SNF Claim Procedure Code Count
                        2    1239    1240    NUM

                                   The count of the number of procedure codes (both
                                   principal and secondary) reported on an Inpatient/SNF
                                   claim. The purpose of this count is to indicate how many
                                   claim procedure trailers are present.  Prior to Version
                                   'J', this field was named:   IP_CLM_PRCDR_CD_CNT.

                                   NOTE: Effective with Version 'J', the count of the number
                                   of procedure code trailers was expanded from 6 to 25.

                                   DB2      ALIAS : IP_PRCDR_CD_CNT
                                   SAS      ALIAS : IPPRCNT
                                   STANDARD ALIAS : IP_CLM_PRCDR_CD_J_CNT

                                   LENGTH          : 2     SIGNED : N

                                   COMMENTS :
```

Prior to Version H this field was named:
CLM_PRCDR_CD_CNT.

SOURCE   : CWF

EDIT RULES :
     RANGE: 0 TO 25

149. Inpatient/SNF Claim Related Condition Code Count
                        2   1241   1242   NUM

                    The count of the number of condition codes reported on an
                    inpatient/SNF claim. The purpose of this count is to
                    indicate how many condition code trailers are present.

                    DB2   ALIAS : IP_RLT_COND_CD_CNT
                    SAS   ALIAS : IPCONCNT
                    STANDARD ALIAS : IP_CLM_RLT_COND_CD_CNT

                    LENGTH   : 2   SIGNED : N

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

                    SOURCE   : CWF

                    EDIT RULES :
                         RANGE: 0 TO 30

150. Inpatient/SNF Claim Related Occurrence Code Count
                        2   1243   1244   NUM

                    The count of the number of occurrence codes reported on an
                    inpatient/SNF claim. The purpose of this count is to
                    indicate how many occurrence code trailers are present.

                    DB2   ALIAS : IP_OCRNC_CD_CNT
                    SAS   ALIAS : IPOCRCNT
                    STANDARD ALIAS : IP_CLM_RLT_OCRNC_CD_CNT

                    LENGTH   : 2   SIGNED : N

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

```
                              SOURCE          : CWF

                              EDIT RULES :
                                   RANGE: 0 TO 30

151. Inpatient/SNF Claim Occurrence Span Code Count
                         2    1245   1246    NUM

                              The count of the number of occurrence span codes
                              reported on an inpatient/SNF claim.  The purpose
                              of the count is to indicate how many span code
                              trailers are present.

                              DB2      ALIAS : IP_OCRNC_SPAN_CNT
                              SAS      ALIAS : IPSPNCNT
                              STANDARD ALIAS : IP_CLM_OCRNC_SPAN_CD_CNT

                              LENGTH         : 2    SIGNED : N

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

                              SOURCE          : CWF

152. Inpatient/SNF Claim Value Code Count
                         2    1247   1248    NUM

                              The count of the number of value codes reported on
                              an inpatient/SNF claim.  The purpose of the count
                              is to indicate how many value code trailers are
                              present.

                              DB2      ALIAS : IP_VAL_CD_CNT
                              SAS      ALIAS : IPVALCNT
                              STANDARD ALIAS : IP_CLM_VAL_CD_CNT

                              LENGTH         : 2    SIGNED : N

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

                              SOURCE          : CWF

                              EDIT RULES :
                                   RANGE: 0 TO 36
```

153. Inpatient/SNF Revenue Center Code Count
```
                        2    1249    1250    NUM
```

The count of the number of revenue codes
reported on an inpatient/SNF claim. The
purpose of the count is to indicate how
many revenue center trailers are present.

```
DB2       ALIAS : IP_REV_CNTR_CD_CNT
SAS       ALIAS : IPREVCNT
STANDARD ALIAS : IP_REV_CNTR_CD_I_CNT

LENGTH        : 2    SIGNED : N
```

COMMENTS :
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, but in the conversion
we made all claims back to service year
1991 contain only 45 revenue center lines.
It is possible that claims prior to 1991
will have 2 segments if they contained
more than 45 revenue lines.

```
SOURCE        : CWF
```

EDIT RULES :
      RANGE: 0 TO 45

154. FILLER
```
                        4    1251    1254    CHAR

DB2       ALIAS : FILLER
STANDARD ALIAS : FILLER

LENGTH        : 4
```

155. FI INPATIENT SNF CLAIM SPECIFIC GROUP
```
                      804    1255    2058    GRP
                                             ALPHANUM
```

156. Claim Admission Date

                      8   1255   1262   NUM

                              On an institutional claim, the date the beneficiary
                              was admitted to the hospital, skilled nursing
                              facility, or christian science sanitorium.
                              Note: The admission date is a required field
                              on inpatient and HHA claims. The Medicare rule is the
                              admission date and from date must be the same.

                              DB2   ALIAS : CLM_ADMSN_DT
                              SAS   ALIAS : ADMSN_DT
                              STANDARD ALIAS : CLM_ADMSN_DT

                              LENGTH   : 8   SIGNED : N

                              SOURCE   : CWF

                              EDIT RULES :
                                   YYYYMMDD

157. Claim Inpatient Admission Type Code

                      1   1263   1263   CHAR

                              The code indicating the type and priority of an
                              inpatient admission associated with the service
                              on an intermediary submitted claim.

                              DB2   ALIAS : IP_ADMSN_TYPE_CD
                              SAS   ALIAS : TYPE_ADM
                              STANDARD ALIAS : CLM_IP_ADMSN_TYPE_CD
                              TITLE   ALIAS : IP_ADMISSION_TYPE

                              LENGTH   : 1

                              SOURCE   : CWF

                              CODE TABLE   : CLM_IP_ADMSN_TYPE_TB

158. Claim Source Inpatient Admission Code

                      1   1264   1264   CHAR

                              The code indicating the source of the referral for
                              the admission or visit.

                              DB2   ALIAS : SRC_IP_ADMSN_CD
                              SAS   ALIAS : SRC_ADMS

```
                                          STANDARD ALIAS : CLM_SRC_IP_ADMSN_CD
                                          TITLE    ALIAS : IP_ADMISSION_SOURCE

                                          LENGTH         : 1

                                          SOURCE         : CWF

                                          CODE TABLE     : CLM_SRC_IP_ADMSN_TB

159. Claim Admitting Diagnosis Group
                    8    1265    1272    GRP


                                          Effective with Version 'J', the group used to identify the
                                          admitting diagnosis code on an Inpatient/SNF claim.  This
                                          group contains the admitting diagnosis code and the
                                          admitting diagnosis version code.

                                          STANDARD ALIAS : CLM_ADMTG_DGNS_GRP

160. Claim Admitting Diagnosis Version Code
                    1    1265    1265    CHAR

                                          Effective with Version 'J', the code used to indicate
                                          if the diagnosis code is ICD-9 or ICD-10.

                                          NOTE:  With 5010 the diagnosis and procedure codes have
                                          been expanded to accommodate ICD-10, even though ICD-10
                                          is not scheduled for implementation until 10/2014.

                                          DB2      ALIAS : UNDEFINED
                                          SAS      ALIAS : ADVRSNCD
                                          STANDARD ALIAS : CLM_ADMTG_DGNS_VRSN_CD

                                          LENGTH         : 1

                                          CODE TABLE     : CLM_ADMTG_DGNS_VRSN_TB

161. Claim Admitting Diagnosis Code
                    7    1266    1272    CHAR

                                          A diagnosis code on the institutional claim
                                          indicating the beneficiary's initial diagnosis
                                          at admission.

                                          NOTE1:  Effective 1/1/2004 with the implementa-
                                          tion of NCH/NMUD CR#1, the admitting diagnosis (also
```

known as reason for patient visit) was added to the
Outpatient claim. This data was stored in positions
572-576 (FILLER) until the implementation of NCH/NMUD
CR#2. Prior to 1/1/2004, this field was only present
on inpatient claims.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services.

NOTE1: Effective with Version 'J' this field expanded
from 5 bytes to 7 bytes.

```
DB2      ALIAS : CLM_ADMTG_DGNS_CD
SAS      ALIAS : AD_DGNS
STANDARD ALIAS : CLM_ADMTG_DGNS_CD

LENGTH        : 7
```

162. NCH Patient Status Indicator Code
```
                    1   1273   1273   CHAR
```

Effective with Version H, the code on an
inpatient/SNF and Hospice claim, indicating
whether the beneficiary was discharged, died
or still a patient (used for internal CWFMQA
editing purposes.)

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

```
DB2      ALIAS : NCH_PTNT_STUS_IND
SAS      ALIAS : PTNTSTUS
STANDARD ALIAS : NCH_PTNT_STUS_IND_CD
TITLE    ALIAS : NCH_PATIENT_STUS

LENGTH        : 1
```

DERIVATIONS :
DERIVED FROM:
NCH PTNT_DSCHRG_STUS_CD

DERIVATION RULES:

SET NCH_PTNT_STUS_IND_CD TO 'A' WHERE THE
PTNT_DSCHRG_STUS_CD NOT EQUAL TO '20'- '30'
OR '40' - '42'.

```
                                SET NCH_PTNT_STUS_IND_CD TO 'B' WHERE THE
                                PTNT_DSCHRG_STUS_CD EQUAL TO '20'- '29'
                                OR '40' - '42'.

                                SET NCH_PTNT_STUS_IND_CD TO 'C' WHERE THE
                                PTNT_DSCHRG_STUS_CD EQUAL TO '30'

                                SOURCE          : NCH QA Process

                                CODE TABLE      : NCH_PTNT_STUS_IND_TB

163. NCH Inpatient Pro Approval Type Code
                    1   1274   1274    CHAR

                                The Peer Review Organization (PRO) determination on the type
                                of approval or denial of an inpatient claim.

                                DB2      ALIAS : IP_PRO_APRVL_CD
                                SAS      ALIAS : APRVL_CD
                                STANDARD ALIAS : NCH_IP_PRO_APRVL_TYPE_CD
                                TITLE    ALIAS : PRO_IP_APPROVAL_CODE

                                LENGTH          : 1

                                DERIVATIONS :
                                Set based upon presence of condition code
                                equal TO C1, C3, C4, C5, C6 OR C7.

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

                                SOURCE          : NCH

                                CODE TABLE      : NCH_IP_PRO_APRVL_TYPE_TB

164. NCH Inpatient PRO Approval Service From Date
                    8   1275   1282    NUM

                                On an institutional claim, the start date of
                                service that has been approved by the Peer
                                Review Organization (PRO).

                                DB2      ALIAS : IP_PRO_FROM_DT
                                SAS      ALIAS : PRO_FROM
                                STANDARD ALIAS : NCH_IP_PRO_SRVC_FROM_DT
```

```
                              TITLE    ALIAS : PRO_FROM_DT

                              LENGTH        : 8    SIGNED : N

                              DERIVATIONS :
                              DERIVED FROM:
                              CLM_OCRNC_SPAN_CD
                              CLM_OCRNC_SPAN_FROM_DT

                              DERIVATION RULES:
                              Based on the presence of occurrence span code
                              equal to 'MO' move the corresponding occurrence
                              span from date to the NCH_IP_PRO_SRVC_FROM_DT.

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

                              SOURCE        : NCH

                              EDIT RULES :
                                   YYYYMMDD

165. NCH Inpatient PRO Approval Service Thru Date
                    8    1283   1290   NUM

                              On an institutional claim, the last day of
                              service that has been approved by the Peer
                              Review Organization (PRO).

                              DB2      ALIAS : IP_PRO_THRU_DT
                              SAS      ALIAS : PRO_THRU
                              STANDARD ALIAS : NCH_IP_PRO_SRVC_THRU_DT
                              TITLE    ALIAS : PRO_THRU

                              LENGTH        : 8    SIGNED : N

                              DERIVATIONS :
                              DERIVED FROM:
                              CLM_OCRNC_SPAN_CD
                              CLM_OCRNC_SPAN_THRU_DT

                              DERIVATION RULES:
                              Based on the presence of occurrence span code
                              equal to 'MO' move the corresponding occurrence
                              span thru date to the NCH_IP_PRO_SRVC_THRU_DT.
```

```
                                  COMMENTS :
                                  Prior to Version H this field was named:
                                  CLM_PRO_APRVL_SRVC_THRU_DT.


                                  SOURCE          : NCH


                                  EDIT RULES :
                                       YYYYMMDD

166. NCH Inpatient PRO Approval Grace Day Count
                     1    1291    1291    NUM


                                  On an institutional claim, the number of days
                                  determined by a Peer Review Organization (PRO)
                                  to be necessary to arrange post-discharge care.


                                  DB2      ALIAS : IP_PRO_GRC_CNT
                                  SAS      ALIAS : GRC_DAY
                                  STANDARD ALIAS : NCH_IP_PRO_GRC_DAY_CNT
                                  TITLE    ALIAS : GRACE_DAYS


                                  LENGTH          : 1     SIGNED : N


                                  DERIVATIONS :
                                  DERIVED FROM:
                                  CLM_VAL_CD
                                  CLM_VAL_AMT


                                  DERIVATION RULES:
                                  Based on the presence of value code equal to '46'
                                  move the corresponding value amount to the
                                  NCH_IP_PRO_GRC_DAY_CNT.


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


                                  SOURCE          : NCH

167. Claim Pass Thru Per Diem Amount
                     6    1292    1297    PACK


                                  The amount of the established reimbursable costs
                                  for the current year divided by the estimated
                                  Medicare days for the current year (all PPS
                                  claims), as calculated by the FI and reim-
                                  bursement staff.  Items reimbursed as a pass
```

through include capital-related costs; direct
medical education costs; kidney acquisition
costs for hospitals approved as RTCs; and
bad debts (per Provider Reimbursement Manual,
Part 1, Section 2405.2). **Note: Pass throughs
are not included in the Claim Payment Amount.

```
DB2       ALIAS : PASS_THRU_PER_DIEM
SAS       ALIAS : PER_DIEM
STANDARD ALIAS : CLM_PASS_THRU_PER_DIEM_AMT
TITLE    ALIAS : PER_DIEM

LENGTH         : 9.2    SIGNED : Y
```

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

```
SOURCE         : CWF
```

168. NCH Beneficiary Inpatient Deductible Amount
                          6   1298   1303   PACK

The amount of the deductible the beneficiary paid
for inpatient services, as originally submitted on
the institutional claim.

```
DB2       ALIAS : BENE_IP_DDCTBL_AMT
SAS       ALIAS : DED_AMT
STANDARD ALIAS : NCH_BENE_IP_DDCTBL_AMT
TITLE    ALIAS : BENE_DED_AMT

LENGTH         : 9.2    SIGNED : Y
```

DERIVATIONS :
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to
A1, B1, or C1 move the corresponding value
amount to the NCH_BENE_IP_DDCTBL_AMT.

COMMENTS :
Prior to Version H this field was named:
BENE_IP_DDCTBL_AMT and the field size was

S9(5)V99).

SOURCE   : NCH

169. NCH Beneficiary Part A Coinsurance Liability Amount
                              6   1304   1309   PACK

The amount of money for which the intermediary has
determined that the beneficiary is liable for
Part A coinsurance on the institutional claim.

DB2   ALIAS : PTA_COINSRNC_AMT
SAS   ALIAS : COIN_AMT
STANDARD ALIAS : NCH_BENE_PTA_COINSRNC_AMT
TITLE   ALIAS : BENE_PTA_COINSURANCE

LENGTH   : 9.2   SIGNED : Y

DERIVATIONS :
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to
8, 9, 10 or 11 move the corresponding value
amount to the NCH_BENE_IP_PTA_COINSRC_AMT.

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

SOURCE   : NCH

170. NCH Beneficiary Blood Deductible Liability Amount
                              6   1310   1315   PACK

The amount of money for which the intermediary
determined the beneficiary is liable for the blood
deductible.

DB2   ALIAS : BLOOD_DDCTBL_AMT
SAS   ALIAS : BLDDEDAM
STANDARD ALIAS : NCH_BENE_BLOOD_DDCTBL_AMT
TITLE   ALIAS : BLOOD_DEDUCTIBLE

```
                                   LENGTH          : 9.2    SIGNED : Y

                                   DERIVATIONS :
                                   DERIVED FROM:
                                   CLM_VAL_CD
                                   CLM_VAL_AMT

                                   DERIVATION RULES:
                                   Based on the presence of value code equal to
                                   '06' move the corresponding value amount to
                                   NCH_BENE_BLOOD_DDCTBL_AMT.

                                   COMMENTS :
                                   Prior to Version H, this field was named:
                                   BENE_BLOOD_DDCTBL_LBLTY_AMT and the field
                                   size was S9(5)V99.  Also, for OP claims, this
                                   field was stored in a blood trailer.  Version
                                   H eliminated the OP blood trailer.

                                   SOURCE          : NCH QA PROCESS

171. NCH Blood Total Charge Amount
                    6    1316    1321    PACK

                                   Effective with Version H, the total charge for
                                   blood usage (for internal CWFMQA editing
                                   purposes).

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


                                   DB2      ALIAS : BLOOD_TOT_CHRG_AMT
                                   SAS      ALIAS : BLDTCHRG
                                   STANDARD ALIAS : NCH_BLOOD_TOT_CHRG_AMT
                                   TITLE    ALIAS : BLOOD_CHARGES

                                   LENGTH          : 9.2    SIGNED : Y

                                   DERIVATIONS :
                                   DERIVED FROM:
                                   REV_CNTR_CD
                                   REV_CNTR_TOT_CHRG_AMT

                                   DERIVATION RULES:
                                   Based on the presence of revenue center codes
```

0380 thru 0389 move the related total charge
amount to the NCH_BLOOD_TOT_CHRG_AMT.

SOURCE   : NCH QA Process

172. NCH Blood Non-Covered Charge Amount
                          6   1322   1327   PACK

Effective with Version H, the total noncovered
charges for blood usage (for internal CWFMQA
editing purposes).

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

DB2   ALIAS : BLOOD_NCVR_AMT
SAS   ALIAS : BLDNCHRG
STANDARD ALIAS : NCH_BLOOD_NCOV_CHRG_AMT
TITLE   ALIAS : BLOOD_NCV_CHARGES

LENGTH   : 9.2   SIGNED : Y

DERIVATIONS :
DERIVED FROM:
REV_CNTR_CD
REV_CNTR_NCOV_CHRG_AMT

DERIVATION RULES:
Based on the presence of revenue center codes equal
to 0380 thru 0389 move the related noncovered
charges to NCH_BLOOD_NCOV_CHRG_AMT.

SOURCE   : NCH QA Process

173. NCH Professional Component Charge Amount
                          6   1328   1333   PACK

Effective with Version H, for inpatient and out-
patient claims, the amount of physician and other
professional charges covered under Medicare Part B
(used for internal CWFMQA editing purposes and other
internal processes (e.g. if computing interim payment
these charges are deducted)).

NOTE: During the Version H conversion this field
was populated with data throughout history (back to

service year 1991).

```
DB2       ALIAS : PROFNL_CMPNT_AMT
SAS       ALIAS : PCCHGAMT
STANDARD ALIAS : NCH_PROFNL_CMPNT_CHRG_AMT
TITLE     ALIAS : PROFNL_CMPNT_CHARGES

LENGTH         : 9.2    SIGNED : Y
```

DERIVATIONS :

1. IF INPATIENT - DERIVED FROM:
CLM_VAL_CD
Clm_VAL_AMT

DERIVATION RULES:
Based on the presence of value code 04 or 05
move the related value amount to the
NCH_PROFNL_CMPNT_CHRG_AMT.

2. IF OUTPATIENT - DERIVED FROM:
REV_CNTR_CD
REV_CNTR_TOT_CHRG_AMT

DERIVATION RULES (Effective 10/98):
Based on the presence of revenue center codes
096X, 097X & 098X move the related total charge
amount to NCH_PROFNL_CMPNT_CHRG_AMT.

NOTE1: During the Version H conversion, this
field was populated with data throughout history
BUT the derivation rule applied to the outpatient
claim was incomplete (i.e., revenue codes 0972,
0973, 0974 and 0979 were omitted from the calcu-
lation).

SOURCE   : NCH QA Process

174. NCH Inpatient Noncovered Charge Amount
                          6   1334   1339   PACK

Effective with Version H, the noncovered charges
for all accommodations and services, reported on
an inpatient claim (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).

```
DB2      ALIAS : IP_NCVR_CHRG_AMT
SAS      ALIAS : NCCHGAMT
STANDARD ALIAS : NCH_IP_NCOV_CHRG_AMT
TITLE    ALIAS : IP_NCOV_CHARGES

LENGTH         : 9.2    SIGNED : Y

DERIVATIONS :
DERIVED FROM:
REV_CNTR_CD
REV_CNTR_NCVR_CHRG_AMT

DERVIATION RULES:
Based on the presence of revenue center code
equal to 0001 move the related noncovered charge
amount to NCH_IP_NCOV_CHRG_AMT.

SOURCE         : NCH QA Process
```

175. NCH Inpatient Total Deduction Amount

                     6   1340   1345   PACK

Effective with Version H, the total Part A
deductions reported on the Inpatient claim (used
for internal CWFMQA editing purposes).

NOTE: During the Version H conversion this field
was populated with data throughout history (back
to 1991), but the derivation rule applied was in-
complete for claims processed prior to 10/93.
Disregard any data present in this field on claims
with NCH weekly process date earlier than 10/93.

```
DB2      ALIAS : IP_TOT_DDCTN_AMT
SAS      ALIAS : TDEDAMT
STANDARD ALIAS : NCH_IP_TOT_DDCTN_AMT
TITLE    ALIAS : IP_TOT_DEDUCTIONS

LENGTH         : 9.2    SIGNED : Y

DERIVATIONS :
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT
```

```
                              DERIVATION RULES (Effective 10/93):
                              Accumulate the value amounts associated with
                              value codes equal to 06, 08 thru 11 and A1, B1
                              or C1 and move to IP_TOT_DDCTN_AMT.
                              NOTE:  Value codes 08-11 did not exist in the
                              NCH prior to 2/93; values codes A1, B1, C1 did
                              not exist prior to 10/93.

                              SOURCE          : NCH QA Process
```

176. Claim Total PPS Capital Amount

```
              6    1346   1351    PACK

                              The total amount that is payable for capital
                              PPS for the claim.   This is the sum of the
                              capital hospital specific portion, federal
                              specific portion, outlier portion,
                              disproportionate share portion, indirect
                              medical education portion, exception payments,
                              and hold harmless payments.

                              DB2      ALIAS : TOT_PPS_CPTL_AMT
                              SAS      ALIAS : PPS_CPTL
                              STANDARD ALIAS : CLM_TOT_PPS_CPTL_AMT
                              TITLE    ALIAS : PPS_CAPITAL

                              LENGTH          : 9.2    SIGNED : Y

                              COMMENTS :
                              Prior to Version H the size of this field was:
                              S9(7)V99.

                              SOURCE          : CWF
```

177. Claim PPS Capital HSP Amount

```
              6    1352   1357    PACK

                              Effective 3/2/92, the hospital specific portion
                              of the PPS payment for capital.

                              DB2      ALIAS : PPS_CPTL_HSP_AMT
                              SAS      ALIAS : CPTL_HSP
                              STANDARD ALIAS : CLM_PPS_CPTL_HSP_AMT
                              TITLE    ALIAS : PPS_CAPITAL_HSP

                              LENGTH          : 9.2    SIGNED : Y
```

```
                              COMMENTS :
                              Prior to Version H the size of this field was:
                              S9(7)V99.

                              SOURCE         : CWF

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

178. Claim PPS Capital FSP Amount
                      6    1358    1363    PACK

                              Effective 3/2/92, the amount of the federal specific
                              portion of the PPS payment for capital.

                              DB2      ALIAS : PPS_CPTL_FSP_AMT
                              SAS      ALIAS : CPTL_FSP
                              STANDARD ALIAS : CLM_PPS_CPTL_FSP_AMT
                              TITLE    ALIAS : PPS_CAPITAL_FSP

                              LENGTH         : 9.2    SIGNED : Y

                              COMMENTS :
                              Prior to Version H the size of this field was:
                              S9(7)V99.

                              SOURCE         : CWF

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

179. Claim PPS Capital Outlier Amount
                      6    1364    1369    PACK

                              Effective 3/2/92, the amount of the outlier portion
                              of the PPS payment for capital.

                              DB2      ALIAS : PPS_OUTLIER_AMT
                              SAS      ALIAS : CPTLOUTL
                              STANDARD ALIAS : CLM_PPS_CPTL_OUTLIER_AMT
                              TITLE    ALIAS : PPS_CPTL_OUTLIER

                              LENGTH         : 9.2    SIGNED : Y

                              COMMENTS :
                              Prior to Version H the size of this field was:
```

```
                              S9(7)V99.

                              SOURCE        : CWF

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

180. Claim PPS Capital Disproportionate Share Amount
                    6    1370    1375    PACK

                              Effective 3/2/92, the amount of disproportionate
                              share (rate reflecting indigent population served)
                              portion of the PPS payment for capital.

                              DB2      ALIAS : PPS_DSPRPRTNT_AMT
                              SAS      ALIAS : DISP_SHR
                              STANDARD ALIAS : CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT
                              TITLE    ALIAS : PPS_DISP_SHR

                              LENGTH        : 9.2    SIGNED : Y

                              COMMENTS :
                              Prior to Version H the size of the field was:
                              S9(7)V99.

                              SOURCE        : CWF

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

181. Claim PPS Capital IME Amount
                    6    1376    1381    PACK

                              Effective 3/2/92, the amount of the indirect medical
                              education (IME) (reimbursable amount for teaching
                              hospitals only; an added amount passed by Congress
                              to augment normal PPS payments for teaching
                              hospitals to compensate them for higher patient
                              costs resulting from medical education programs for
                              interns and residents) portion of the PPS payment
                              for capital.

                              DB2      ALIAS : PPS_CPTL_IME_AMT
                              SAS      ALIAS : IME_AMT
                              STANDARD ALIAS : CLM_PPS_CPTL_IME_AMT
                              TITLE    ALIAS : PPS_CPTL_IME
```

```
                                  LENGTH          : 9.2     SIGNED : Y

                                  COMMENTS :
                                  Prior to Version H the size of this field was:
                                  S9(7)V99.

                                  SOURCE          : CWF

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

182. Claim PPS Capital Exception Amount
                   6    1382    1387    PACK

                                  Effective 3/2/92, the capital PPS amount of
                                  exception payments provided for hospitals
                                  with inordinately high levels of capital
                                  obligations. Exception payments expire at the
                                  end of the 10-year transition period.

                                  DB2      ALIAS : PPS_EXCPTN_AMT
                                  SAS      ALIAS : CPTL_EXP
                                  STANDARD ALIAS : CLM_PPS_CPTL_EXCPTN_AMT
                                  TITLE    ALIAS : PPS_CPTL_EXCP

                                  LENGTH          : 9.2     SIGNED : Y

                                  COMMENTS :
                                  Prior to Version H the size of this field was:
                                  S9(7)V99.

                                  SOURCE          : CWF

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

183. Claim PPS Old Capital Hold Harmless Amount
                   6    1388    1393    PACK

                                  Effective 3/2/92, this amount is the hold harmless amount
                                  payable for old capital as computed by PRICER for
                                  providers with a payment code equal to 'A'. The hold
                                  harmless amount-old capital is 100 percent of the
                                  reasonable costs of old capital for sole community
                                  sole community hospitals, or 85 percent of
                                  the reasonable costs associated with old capital for
                                  all other hospitals, plus a payment for new capital.
```

```
                              DB2      ALIAS : PPS_CPTL_HRMLS_AMT
                              SAS      ALIAS : HLDHRMLS
                              STANDARD ALIAS : CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT
                              TITLE    ALIAS : PPS_CPTL_HOLD_HRMLS

                              LENGTH         : 9.2    SIGNED : Y

                              COMMENTS :
                              Prior to Version H the size of this field was:
                              S9(7)V99.

                              SOURCE         : CWF

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

184. Claim PPS Capital Discharge Fraction Percent
```
                 3   1394  1396   PACK

                              Effective 3/2/92, the percent resulting from
                              dividing the days by the average length of stay
                              for capital PPS transfer cases (PRICER review
                              codes 03, 05, 06) not to exceed 1.

                              DB2      ALIAS : PPS_DSCHRG_PCT
                              SAS      ALIAS : DSCHFRCT
                              STANDARD ALIAS : CLM_PPS_CPTL_DSCHRG_FRCTN_PCT
                              TITLE    ALIAS : PPS_CAPITL_DSCHRG_FRACTION_PCT

                              LENGTH         : 1.4    SIGNED : Y

                              SOURCE         : CWF

                              LIMITATIONS :

                                REFER TO :
                                 PPS_CPTL_DSCHRG_FRCTN_PCT_LIM
```

185. Claim PPS Capital DRG Weight Number
```
                 4   1397  1400   PACK

                              Effective 3/2/92, the number used to determine
                              a transfer adjusted case mix index for capital
                              PPS.  The number is determined by multiplying
                              the DRG weight times the discharge fraction.
```

```
                         DB2      ALIAS : PPS_DRG_WT_NUM
                         SAS      ALIAS : DRGWTAMT
                         STANDARD ALIAS : CLM_PPS_CPTL_DRG_WT_NUM
                         TITLE    ALIAS : PPS_CAPITAL_DRG_WEIGHT_NUM

                         LENGTH          : 3.4    SIGNED : Y

                         SOURCE          : CWF

                         LIMITATIONS :

                           REFER TO :
                            PPS_CPTL_DRG_WT_NUM_LIM

186. Claim Utilization Day Count
                    2   1401   1402   PACK

                         On an institutional claim, the number of
                         covered days of care that are chargeable
                         to Medicare facility utilization that
                         includes full days, coinsurance days, and
                         lifetime reserve days.  It excludes any days
                         classified as non-covered, leave of absence
                         days, and the day of discharge or death.

                         DB2      ALIAS : CLM_UTLZTN_DAY_CNT
                         SAS      ALIAS : UTIL_DAY
                         STANDARD ALIAS : CLM_UTLZTN_DAY_CNT
                         TITLE    ALIAS : UTILIZATION_DAYS

                         LENGTH          : 3     SIGNED : Y

187. Claim Cost Report Days Count
                    2   1403   1404   PACK

                         The number of days on an institutional claim which
                         would have been Medicare covered days if another
                         primary payer were not involved or if a beneficiary
                         had fewer days available than were needed by a PPS
                         bill.

                         DB2      ALIAS : CLM_CR_DAY_CNT
                         SAS      ALIAS : CR_DAY
                         STANDARD ALIAS : CLM_CR_DAY_CNT

                         LENGTH          : 3     SIGNED : Y
```

188. Beneficiary Total Coinsurance Days Count
                          2   1405   1406   PACK

                                   The count of the total number of coinsurance days
                                   involved with the beneficiary's stay in a facility.

                                   DB2   ALIAS : COINSRNC_DAY_CNT
                                   SAS   ALIAS : COIN_DAY
                                   STANDARD ALIAS : BENE_TOT_COINSRNC_DAY_CNT
                                   TITLE   ALIAS : COINSRNC_DAYS

                                   LENGTH   : 3   SIGNED : Y

                                   SOURCE   : CWF

189. Claim Coinsurance Year 1 Day Count
                          2   1407   1408   PACK

                                   Effective with Version H, the count of the number
                                   of coinsurance days during the first year of the
                                   bill (used for internal CWFMQA editing purposes).

                                   NOTE: Beginning with NCH weekly process date
                                   10/3/97 this field was populated with data.
                                   Claims processed prior to 10/3/97 should contain
                                   zeroes in this field. Exception: during the
                                   Version 'H' conversion invalid data may have
                                   been populated for prior periods. Disregard
                                   any data in this field on claims with NCH
                                   weekly process date earlier than 10/3/97.

                                   DB2   ALIAS : COINS_YR1_DAY_CNT
                                   SAS   ALIAS : COYR1DAY
                                   STANDARD ALIAS : CLM_COINSRNC_YR_1_DAY_CNT
                                   TITLE   ALIAS : COINS_YR1_DAYS

                                   LENGTH   : 3   SIGNED : Y

                                   SOURCE   : CWF

190. NCH Coinsurance Year 1 Rate Amount
                          6   1409   1414   PACK

                                   Effective with Version H, the charge for each day
                                   of coinsurance during the first year in the bill
                                   (used for internal CWFMQA editing purposes).

NOTE: Beginning with NCH weekly process date
10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 should contain
zeroes in this field. Exception: during the
Version 'H' conversion invalid data may have been
populated for prior periods.   Disregard any
data present in this field on claims with NCH
weekly process date earlier than 10/3/97.

DB2   ALIAS : COINS_YR1_RATE_AMT
SAS   ALIAS : COYR1AMT
STANDARD ALIAS : NCH_COINSRNC_YR_1_RATE_AMT
TITLE   ALIAS : COINS_YR1_RATE

LENGTH   : 9.2   SIGNED : Y

DERIVATIONS :
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT
CLM_COINSRNC_YR_1_DAY_CNT

DERIVATION RULES:
Divide the value amount associated with value code
equal to 09 by the coinsurance year 1 days and move
to NCH_COINSRNC_YR_1_RATE_AMT.

SOURCE   : NCH QA Process

191. Claim Coinsurance Year 2 Day Count
                    2   1415   1416   PACK

Effective with Version H, the count of the
number of coinsurance days during the second
year of the bill which spans two years (used
for internal CWFMQA editing purposes.)

NOTE: Beginning with NCH weekly process date
10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 should contain
zeroes in this field. Exception: during the
Version 'H' conversion invalid data may have
been populated for prior periods. Disregard
any data in this field on claims with NCH
weekly process date earlier than 10/3/97.

DB2   ALIAS : COINS_YR2_DAY_CNT

```
                               SAS      ALIAS : COYR2DAY
                               STANDARD ALIAS : CLM_COINSRNC_YR_2_DAY_CNT
                               TITLE    ALIAS : COINS_YR2_DAYS

                               LENGTH        : 3    SIGNED : Y

                               SOURCE        : CWF

192. NCH Coinsurance Year 2 Rate Amount
                   6    1417   1422   PACK

                               Effective with Version H, the charge for each
                               day of coinsurance during the second year in a
                               bill which spans two years (used for internal
                               CWFMQA editing purposes.)

                               NOTE:  Beginning with NCH weekly process date
                               10/3/97 this field was populated with data.
                               Claims processed prior to 10/3/97 should contain
                               zeroes in this field.  Exception: during the
                               Version 'H' conversion invalid data may have
                               been populated for prior periods.  Disregard
                               any data in this field on claims with NCH
                               weekly process date earlier than 10/3/97.

                               DB2      ALIAS : COINS_YR2_RATE_AMT
                               SAS      ALIAS : COYR2AMT
                               STANDARD ALIAS : NCH_COINSRNC_YR_2_RATE_AMT
                               TITLE    ALIAS : COINS_YR2_RATE

                               LENGTH        : 9.2    SIGNED : Y

                               DERIVATIONS :
                               DERIVED FROM:
                               CLM_VAL_CD
                               CLM_VAL_AMT
                               CLM_COINSRNC_YR_2_DAY_CNT

                               DERIVATION RULES:
                               Divide the value amount associated with value code
                               equal to 11 by the coinsurance year 2 days and move
                               to NCH_COINSRNC_YR_2_RATE_AMT.

                               SOURCE        : NCH QA Process

193. Beneficiary LRD Used Count
                   2    1423   1424   PACK
```

The number of lifetime reserve days that the
beneficiary has elected to use during the period
covered by the institutional claim. Under Medicare,
each beneficiary has a one-time reserve of sixty
additional days of inpatient hospital coverage
that can be used after 90 days of inpatient care
have been provided in a single benefit period.
This count is used to subtract from the total
number of lifetime reserve days that a beneficiary
has available.

```
DB2       ALIAS : BENE_LRD_USE_CNT
SAS       ALIAS : LRD_USE
STANDARD ALIAS : BENE_LRD_USE_CNT
```

```
LENGTH        : 3    SIGNED : Y
```

194. Claim Non Utilization Days Count
                 3   1425   1427   PACK

On an institutional claim, the number of days of
care that are not chargeable to Medicare facility
utilization.

```
DB2       ALIAS : NUTLZTN_DAY_CNT
SAS       ALIAS : NUTILDAY
STANDARD ALIAS : CLM_NUTLZTN_DAY_CNT
TITLE     ALIAS : NUTLZTN_DAYS
```

```
LENGTH        : 5    SIGNED : Y
```

```
SOURCE        : CWF
```

195. Beneficiary Prior Psychiatric Day Count
                 2   1428   1429   PACK

Effective with Version H, the number of days
in a psychiatric hospital prior to the
entitlement to Medicare.

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

```
DB2       ALIAS : PRIOR_PSYCH_CNT
```

```
                              SAS       ALIAS : PSYCHDAY
                              STANDARD ALIAS : BENE_PRIOR_PSYCH_DAY_CNT
                              TITLE    ALIAS : PRIOR_PSYCH_DAYS

                              LENGTH         : 3    SIGNED : Y

                              SOURCE         : CWF

196. NCH Blood Pints Furnished Quantity
                   2   1430   1431   PACK

                              Number of whole pints of blood furnished to the
                              beneficiary.

                              DB2       ALIAS : NCH_BLOOD_PT_FRNSH
                              STANDARD ALIAS : NCH_BLOOD_PT_FRNSH_QTY
                              TITLE    ALIAS : BLOOD_PINTS_FURNISHED

                              LENGTH         : 3    SIGNED : Y

                              DERIVATIONS :
                              DERIVED FROM:
                              CLM_VAL_CD
                              CLM_VAL_AMT

                              DERIVATION RULES:
                              Based on the presence of value code equal to
                              37 move the related value amount to the
                              NCH_BLOOD_PT_FRNSH_QTY.

                              COMMENTS :
                              Prior to Version H this field was named:
                              CLM_BLOOD_PT_FRNSH_QTY.  Also for outpatient
                              claims this field was stored in a blood
                              trailer.  Version H eliminated the outpatient
                              blood trailer.

                              SOURCE         : NCH QA Process

                              EDIT RULES :
                                   NUMERIC

197. NCH Blood Pints Replaced Quantity
                   2   1432   1433   PACK

                              Number of whole pints of blood replaced.
```

```
                             DB2      ALIAS : BLOOD_PT_RPLC_QTY
                             SAS      ALIAS : BLD_RPLC
                             STANDARD ALIAS : NCH_BLOOD_PT_RPLC_QTY
                             TITLE    ALIAS : BLOOD_PINTS_REPLACED

                             LENGTH        : 3    SIGNED : Y

                             DERIVATIONS :
                             DERIVED FROM:
                             CLM_VAL_CD
                             CLM_VAL_AMT

                             DERIVATION RULES:
                             Based on the presence of value code equal to
                             39 move the related value amount to the
                             NCH_BLOOD_PT_RPLC_QTY.

                             COMMENTS :
                             Prior to Version H this field was named:
                             CLM_BLOOD_PT_RPLC_QTY.  Also for outpatient
                             claims this field was stored in a blood
                             trailer.  Version H eliminated the outpatient
                             blood trailer.


                             SOURCE        : NCH QA Process

                             EDIT RULES :
                                  NUMERIC

198. NCH Blood Pints Not Replaced Quantity
                         2   1434   1435   PACK

                             Number of whole pints of blood not replaced.

                             DB2      ALIAS : BLOOD_PT_NRPLC_QTY
                             SAS      ALIAS : BLDNRPLC
                             STANDARD ALIAS : NCH_BLOOD_PT_NRPLC_QTY
                             TITLE    ALIAS : BLOOD_PINTS_NOT_REPLACED

                             LENGTH        : 3    SIGNED : Y

                             DERIVATIONS :
                             DERIVED FROM:
                             CLM_VAL_CD
                             CLM_VAL_AMT
```

```
                         DERIVATION RULES:
                         Subtract value code 39 amount from value code
                         37 amount and move the result to
                         NCH_BLOOD_PT_NRPLC_QTY.

                         COMMENTS :
                         Prior to Version H this field was named:
                         CLM_BLOOD_PT_NRPLC_QTY.  Also for outpatient
                         claims this field was stored in a blood
                         trailer.  Version H eliminated the outpatient
                         blood trailer.


                         SOURCE          : NCH QA Process

                         EDIT RULES :
                              NUMERIC

199. NCH Blood Deductible Pints Quantity
                    2    1436   1437    PACK

                         The quantity of blood pints applied (blood
                         deductible).

                         DB2      ALIAS : BLOOD_DDCTBL_QTY
                         SAS      ALIAS : BLDDEDPT
                         STANDARD ALIAS : NCH_BLOOD_DDCTBL_PT_QTY
                         TITLE    ALIAS : BLOOD_PINTS_DEDUCTIBLE

                         LENGTH          : 3    SIGNED : Y

                         DERIVATIONS :
                         DERIVED FROM:
                         CLM_VAL_CD
                         CLM_VAL_AMT

                         DERIVATION RULES:
                         Based on the presence of value code equal to
                         38 move the related value amount to the
                         NCH_BLOOD_DDCTBL_PT_QTY.

                         COMMENTS :
                         Prior to Version H this field was named:
                         CLM_BLOOD_DDCTBL_PT_QTY.  Also for outpatient
                         claims this field was stored in a blood
                         trailer.  Version H eliminated the outpatient
                         blood trailer.
```

200. NCH Qualified Stay From Date
                   8   1438   1445   NUM

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).

DB2   ALIAS : QLFY_STAY_FROM_DT
SAS   ALIAS : QLFYFROM
STANDARD ALIAS : NCH_QLFY_STAY_FROM_DT
TITLE   ALIAS : QLFYG_STAY_FROM_DT

LENGTH   : 8   SIGNED : N

DERIVATIONS :
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

EDIT RULES :
     YYYYMMDD

201. NCH Qualify Stay Through Date

                        8   1446   1453   NUM

                                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
                                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).

                                DB2   ALIAS : QLFY_STAY_THRU_DT
                                SAS   ALIAS : QLFYTHRU
                                STANDARD ALIAS : NCH_QLFY_STAY_THRU_DT
                                TITLE   ALIAS : QLFYG_STAY_THRU_DT

                                LENGTH   : 8   SIGNED : N

                                DERIVATIONS :
                                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

                                EDIT RULES :
                                     YYYYMMDD

202. NCH Verified Noncovered Stay From Date

                        8   1454   1461   NUM

                                Effective with Version H, the beginning date of
                                the beneficiary's noncovered stay (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).

```
DB2      ALIAS : VRFY_NCVR_FROM_DT
SAS      ALIAS : NCOVFROM
STANDARD ALIAS : NCH_VRFY_NCOV_STAY_FROM_DT
TITLE    ALIAS : VERIFIED_NCOV_FROM_DT
```

```
LENGTH         : 8    SIGNED : N
```

DERIVATIONS :
DERIVED FROM:
CLM_OCRNC_SPAN_CD
CLM_OCRNC_SPAN_FROM_DT

DERIVATION RULES:
Based on the presence of occurrence code 74, 76,
77 or 79 move the related occurrence from date to
NCH_VRFY_NCOV_STAY_FROM_DT.

SOURCE   : NCH QA Process

EDIT RULES :
     YYYYMMDD

203. NCH Verified Noncovered Stay Through Date
                        8   1462   1469   NUM

Effective with Version H, the ending date of
the beneficiary's noncovered stay (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).

```
DB2      ALIAS : VRFY_NCVR_THRU_DT
SAS      ALIAS : NCOVTHRU
STANDARD ALIAS : NCH_VRFY_NCOV_STAY_THRU_DT
TITLE    ALIAS : VERIFIED_NCOV_THRU_DT
```

```
LENGTH         : 8    SIGNED : N
```

DERIVATIONS :
DERIVED FROM:
CLM_OCRNC_SPAN_CD

```
                                                CLM_OCRNC_SPAN_THRU_DT

                                                DERIVATION RULES:
                                                Based on the presence of occurrence code 74, 76,
                                                77 or 79 move the related occurrence thru date to
                                                NCH_VRFY_NCOV_STAY_THRU_DT.

                                                SOURCE          : NCH QA Process

                                                EDIT RULES :
                                                     YYYYMMDD

204. NCH Provider Guaranteed Payment Start Date
                        8    1470   1477    NUM

                                                The date that the guaranteed payment to the
                                                institutional provider started.

                                                DB2     ALIAS : GUARNT_PMT_STRT_DT
                                                SAS     ALIAS : GURPMTDT
                                                STANDARD ALIAS : NCH_PRVDR_GUARNT_PMT_STRT_DT
                                                TITLE   ALIAS : GARNT_PMT_DT

                                                LENGTH          : 8    SIGNED : N

                                                DERIVATIONS :
                                                DERIVED FROM:
                                                CLM_RLT_OCRNC_CD
                                                CLM_RLT_OCRNC_DT

                                                DERIVATION RULES:
                                                Based on the presence of occurrence code 20
                                                move the related occurrence date to
                                                NCH_PRVDR_GUARNT_PMT_STRT_DT.

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

                                                SOURCE          : NCH QA Process

                                                EDIT RULES :
                                                     YYYYMMDD

205. NCH Utilization Review Notice Received Date
                        8    1478   1485    NUM
```

The date of receipt by the skilled nursing
facility of a utilization review committee's
finding that an admission or further stay was no
longer medically necessary.

```
DB2      ALIAS : NCH_UR_NTC_RCV_DT
SAS      ALIAS : URNTCDT
STANDARD ALIAS : NCH_UR_NTC_RCV_DT


LENGTH        : 8    SIGNED : N


DERIVATIONS :
DERIVED FROM:
CLM_RLT_OCRNC_CD
CLM_RLT_OCRNC_DT


DERIVATION RULES:
Based on the presence of occurrence code 21
move the related occurrence date to
NCH_UR_NTC_RCV_DT.


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


SOURCE        : NCH QA Process


EDIT RULES :
     YYYYMMDD
```

206. NCH Active or Covered Level Care Thru Date

                         8   1486   1493   NUM

The date on a claim for which the covered level of
care ended in a general hospital or the active care
ended in a psychiatric/TB hospital.

```
DB2      ALIAS : ACTV_CARE_THRU_DT
SAS      ALIAS : CARETHRU
STANDARD ALIAS : NCH_ACTV_CVR_LVL_CARE_THRU_DT
TITLE    ALIAS : ACTIVE_CARE_THRU_DT


LENGTH        : 8    SIGNED : N


DERIVATIONS :
DERIVED FROM:
CLM_RLT_OCRNC_CD
```

```
                              CLM_RLT_OCRNC_DT

                              DERIVATION RULES:
                              Based on the presence of occurrence code 22
                              move the related occurrence date to
                              NCH_ACTV_CVR_LVL_CARE_THRU_DT.

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

                              SOURCE          : NCH QA Process

                              EDIT RULES :
                                  YYYYMMDD

207. NCH Beneficiary Medicare Benefits Exhausted Date
                         8    1494   1501   NUM

                              The last date for which the beneficiary has
                              Medicare coverage. This is completed only where
                              where benefits were exhausted before the date of
                              discharge and during the billing period covered
                              by this institutional claim.

                              DB2      ALIAS : MDCR_BNFT_EXHST_DT
                              SAS      ALIAS : EXHST_DT
                              STANDARD ALIAS : NCH_MDCR_BNFT_EXHST_DT
                              TITLE    ALIAS : BENEFIT_EXHST_DT

                              LENGTH          : 8    SIGNED : N

                              DERIVATIONS :
                              DERIVED FROM:
                              CLM_RLT_OCRNC_CD
                              CLM_RLT_OCRNC_DT

                              DERIVATION RULES (Effective 10/93):
                              Based on the presence of occurrence code A3,
                              B3 or C3 move the related occurrence date to
                              NCH_MDCR_BNFT_EXHST_DT.  *NOTE:  Prior to
                              10/93, the date associated with occurrence
                              code 23 was moved to this field.

                              COMMENTS :
                              Prior to Version H this field was named:
                              CLM_MDCR_BNFT_EXHST_DT.
```

EDIT RULES :
     YYYYMMDD

208. NCH Beneficiary Discharge Date
                    8   1502   1509   NUM

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.)

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

LENGTH   : 8   SIGNED : N

DERIVATIONS :
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

EDIT RULES :
     YYYYMMDD

209. Claim Diagnosis Related Group Code
                    3   1510   1512   CHAR

The diagnostic related group to which a hospital
claim belongs for prospective payment purposes.

DB2   ALIAS : CLM_DRG_CD

```
                                   SAS        ALIAS : DRG_CD
                                   STANDARD ALIAS : CLM_DRG_CD

                                   LENGTH         : 3

                                   COMMENTS :
                                   GROUPER is the software that determines the DRG
                                   from data elements reported by the hospital.
                                   Once determined, the DRG code is one of the
                                   elements used to determine the price upon which
                                   to base the reimbursement to the hospitals
                                   under prospective payment.  Nonpayment claims
                                   (zero reimbursement) may not have a DRG present.

210. Claim Diagnosis Related Group Outlier Stay Code
                  1    1513   1513    CHAR

                                   On an institutional claim, the code that
                                   indicates the beneficiary stay under the
                                   prospective payment system which, although
                                   classified into a specific diagnosis related
                                   group, has an unusually long length (day
                                   outlier) or exceptionally high cost
                                   (cost outlier).

                                   DB2        ALIAS : DRG_OUTLIER_CD
                                   SAS        ALIAS : OUTLR_CD
                                   STANDARD ALIAS : CLM_DRG_OUTLIER_STAY_CD
                                   TITLE    ALIAS : DRG_OUTLIER_STAY_CODE

                                   LENGTH         : 1

                                   SOURCE         : CWF

                                   CODE TABLE     : DRG_OUTLIER_STAY_TB

211. NCH DRG Outlier Approved Payment Amount
                  6    1514   1519    PACK

                                   On an institutional claim, the additional
                                   payment amount approved by the Peer Review
                                   Organization due to an outlier situation for
                                   a beneficiary's stay under the prospective
                                   payment system, which has been classified
                                   into a specific diagnosis related group.

                                   DB2        ALIAS : DRG_OUTLIER_AMT
```

```
                                   SAS      ALIAS : OUTLRPMT
                                   STANDARD ALIAS : NCH_DRG_OUTLIER_APRV_PMT_AMT
                                   TITLE    ALIAS : DRG_OUTLIER_PMT


                                   LENGTH          : 9.2    SIGNED : Y


                                   DERIVATIONS :
                                   DERIVED FROM:
                                   CLM_VAL_CD
                                   CLM_VAL_AMT


                                   DERIVATION RULES:
                                   Based on the presence of value code equal
                                   to 17 move the related amount to
                                   NCH_DRG_OUTLIER_APRV_PMT_AMT.


                                   COMMENTS :
                                   Prior to Version H this field was named:
                                   CLM_DRG_OUTLIER_APRV_PMT_AMT and field size
                                   was S9(7)V99.


                                   SOURCE          : NCH QA Process

212. Claim KRON Indicator Code
                        1   1520   1520   CHAR


                                   Effective with Version H, on inpatient claims
                                   only, the code indicating that the bill must force
                                   a new spell even if it is within 60 days of a
                                   prior spell.


                                   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 : CLM_KRON_IND_CD
                                   SAS      ALIAS : KRON_IND
                                   STANDARD ALIAS : CLM_KRON_IND_CD


                                   LENGTH          : 1

213. Claim Inpatient Low Volume Payment Amount
                        5   1521   1525   PACK


                                   Effective with CR#6, the amount field used to identify
                                   a payment adjustment given to hospitals to account for
```

the higher costs per discharge for low income hospitals
under the Inpatient Prospective Payment System (IPPS).

```
DB2       ALIAS : CLM_LOW_VOL_AMT
STANDARD ALIAS : CLM_IP_LOW_VOL_PMT_AMT

LENGTH         : 7.2    SIGNED : Y

SOURCE         : CWF
```

214. Claim Attending Physician Specialty Code
                        2   1526   1527   CHAR

Effective with CR#7, the code used to identify the CMS
specialty code corresponding to the attending physician.
The Affordable Care Act (ACA) provides for incentive
payments for attending physicians and non-physician
practitioners with specific primary specialty designations.
In order to determine if the physician or non-physician is
eligible for the incentive payment, the specialty code,
NPI and name must be carried on the claims.

NOTE: These fields were added on Outpatient, Home Health
and Hospice claims with CR#6 but was added to the Inpatient/
SNF claims with CR#7.

```
DB2       ALIAS : CLM_ATNDG_SPCLTY_C
SAS       ALIAS : ASPCLTY
STANDARD ALIAS : CLM_ATNDG_PHYSN_SPCLTY_CD

LENGTH         : 2

CODE TABLE     : CMS_PRVDR_SPCLTY_TB
```

215. Claim Operating Physician Specialty Code
                        2   1528   1529   CHAR

Effective with CR#7, the code used to identify the CMS
specialty code corresponding to the operating physician.
The Affordable Care Act (ACA) provides for incentive
payments for physicians and non-physician practitioners
with specific primary specialty designations. In order
to determine if the physician or non-physicians is
eligible for the incentive payment, the specialty code,
NPI and name must be carried on the claims.

NOTE: These fields were added on Outpatient, Home Health

and Hospice claims with CR#6 but was added to the Inpatient/
SNF claims with CR#7.

```
DB2      ALIAS : CLM_OPRTG_SPCLTY_C
SAS      ALIAS : OPSPCLTY
STANDARD ALIAS : CLM_OPRTG_PHYSN_SPCLTY_CD

LENGTH         : 2

CODE TABLE     : CMS_PRVDR_SPCLTY_TB
```

216. Claim Other Physician Specialty Code
                    2   1530   1531   CHAR

Effective with CR#7, the code used to identify the CMS
specialty code corresponding to the other physician.
The Affordable Care Act (ACA) provides for incentive
payments for physicians and non-physician practitioners
with specific primary specialty designations. In order
to determine if the physician or non-physicians is
eligible for the incentive payment, the specialty code,
NPI and name must be carried on the claims.

NOTE: These fields were added on Outpatient, Home Health
and Hospice claims with CR#6 but was added to the Inpatient/
SNF claims with CR#7.

```
DB2      ALIAS : CLM_OTHR_SPCLTY_CD
SAS      ALIAS : OTSPCLTY
STANDARD ALIAS : CLM_OTHR_PHYSN_SPCLTY_CD

LENGTH         : 2

CODE TABLE     : CMS_PRVDR_SPCLTY_TB
```

217. Claim Bundled Model 1 Discount Percent
                    2   1532   1533   PACK

Effective with CR#7, this field identifies the discount
percentage which will be applied to payment for all
hospitals' DRG over the lifetime of the initiative.
The hospital must be participating in the Model 1
of the Bundled Payments for Care Improvement initiative.

Effective with CR#9, the field size changed from V9(2) to
SV9(3).

```
                            DB2      ALIAS : BNDLD_MODEL_1_PCT
                            SAS      ALIAS : M1PCT
                            STANDARD ALIAS : CLM_BNDLD_MODEL_1_DSCNT_PCT


                            LENGTH         : .3    SIGNED : Y

218. Claim Base Operating DRG Amount
                    6    1534    1539    PACK


                            Effective with CR#7, the amount used to identify the
                            wage-adjusted DRG operating payment plus the new
                            technology add-on payment.


                            DB2      ALIAS : BASE_OPRTG_DRG_AMT
                            SAS      ALIAS : OPRTGDRG
                            STANDARD ALIAS : CLM_BASE_OPRTG_DRG_AMT


                            LENGTH         : 8.2    SIGNED : Y

219. Claim Operating HSP Amount
                    6    1540    1545    PACK


                            Effective with CR#7, the amount used to identify the
                            difference between the HSP rate payment (updated HSP
                            x DRG weight) and the federal rate payment (includes
                            DSH, IME, outliers, etc. as applicable) when HSP rate
                            payment exceeds Federal rate payment (otherwise $0).


                            DB2      ALIAS : CLM_OPRTG_HSP_AMT
                            SAS      ALIAS : OPRTGHSP
                            STANDARD ALIAS : CLM_OPRTG_HSP_AMT


                            LENGTH         : 8.2    SIGNED : Y

220. Claim VBP Participant Indicator Code
                    1    1546    1546    CHAR


                            Effective with CR#7, the code used to identify
                            a reason a hospital is excluded from the Hospital
                            Value Based Purchasing (HVBP) progam. The ACA (Section
                            3001) excludes from the HVBP program hospitals that
                            meet certain conditions.


                            DB2      ALIAS : VBP_PRTCPNT_IND_CD
                            SAS      ALIAS : VBPIND
                            STANDARD ALIAS : CLM_VBP_PRTCPNT_IND_CD
```

```
                                         LENGTH          : 1

                                         CODE TABLE      : CLM_VBP_PRTCPNT_IND_TB

221. Claim VBP Adjustment Percent
                        7    1547   1553    PACK

                                         Effective with CR#7, under the Hospital Value Based
                                         Purchasing (HVBP) program, an adjustment made to
                                         certain subsection (d) IPPS hosptial base operating
                                         DRG amount, in accordance with their Total Performance
                                         Score (TPS) as required by the Affordable Care Act
                                         (ACA).  This is the Value Based Purchasing Score.

                                         Effective with CR#9, the picture clause changed from
                                         9V9(11) to S9V9(11).

                                         DB2      ALIAS : CLM_VBP_ADJSTMT_PC
                                         SAS      ALIAS : VBPPCT
                                         STANDARD ALIAS : CLM_VBP_ADJSTMT_PCT

                                         LENGTH          : 1.11    SIGNED : Y

222. Claim HRR Participant Indicator Code
                        1    1554   1554    CHAR

                                         Effective with CR#7, the code used to identify whether
                                         the facility is participating in the Hospital
                                         Readmission Reduction Program.

                                         DB2      ALIAS : HRR_PRTCPNT_IND_CD
                                         SAS      ALIAS : HRRIND
                                         STANDARD ALIAS : CLM_HRR_PRTCPNT_IND_CD

                                         LENGTH          : 1

                                         CODE TABLE      : CLM_HRR_PRTCPNT_IND_TB

223. Claim HRR Adjustment Percent
                        3    1555   1557    PACK

                                         Effective with CR#7, Under the Hospital Readmission
                                         Reduction (HRR) Program, the amount used to identify
                                         the readmission adjustment factor that will be applied
                                         in determining a "subsection (d)" hospital's
                                         operating IPPS payment amount in accordance with
                                         Section 3025 of the Affordable Care Act (ACA).
```

Effective with CR#9, we changed the field picture
clause from 9V9(4) COMP-3 to S9V9(4) COMP-3.

```
DB2       ALIAS : CLM_HRR_ADJSTMT_PC
SAS       ALIAS : HRRPCT
STANDARD ALIAS : CLM_HRR_ADJSTMT_PCT

LENGTH         : 1.4    SIGNED : Y
```

224. Claim Model 4 Readmission Indicator Code
```
            1    1558    1558    CHAR
```

Effective with Version 'K', this field identifies the
method of payment of a claim billed within 30 days of a
Model 4 Bundled Payments for Care Improvement (BPCI)
admission. Bundling payment for services that patients
receive across a single episode of care, such as heart
bypass surgery or a hip replacement, is one way to
encourage doctors, hospitals and other health care
providers to work together to better coordinate care for
patients. Under the Model 4 BPCI pilot, CMS will reimburse
qualified acute care hospitals a blended payment for
hospital inpatient care and physician services connected
with a single episode of care. This will occur in
association with inpatient hospital claims that the BPCI
participating hospital will bill to their jurisdictional
A/B MAC as type of bill 11X claims.

```
DB2       ALIAS : MODEL_4_READMSN_CD
SAS       ALIAS : READMSN
STANDARD ALIAS : CLM_MODEL_4_READMSN_IND_CD

LENGTH         : 1

CODE TABLE     : CLM_MODEL_4_READMSN_IND_CD_TB
```

225. Claim Uncompensated Care Payment Amount
```
            6    1559    1564    PACK
```

Effective with CR#8, this field identifies the
payment for DSH hospitals as part of Section 3133 of
the Affordable Care Act (ACA). It represents the
uncompensated care amount of the payment.

This amount is included in the claim payment amount.

Prior to CR#9, this field was named:
CLM_IPPS_FLEX_PMT_1_AMT.

DB2   ALIAS : CLM_UNCOMPD_CARE_P
SAS   ALIAS : CAREAMT
STANDARD ALIAS : CLM_UNCOMPD_CARE_PMT_AMT

LENGTH   : 9.2   SIGNED : Y

SOURCE   : CWF

EDIT RULES :
      $$$$$$$$$cc

226. Claim Bundled Adjustment Payment Amount
                        6   1565   1570   PACK

Effective with CR#8, this field represents the
amount the claim was reduced by for those hospitals
participating in BPCI Model 1.

Prior to CR#9, this field was named:
CLM_IPPS_FLEX_PMT_2_AMT.

DB2   ALIAS : CLM_BNDLD_ADJSTMT_
SAS   ALIAS : BNDLDAMT
STANDARD ALIAS : CLM_BNDLD_ADJSTMT_PMT_AMT

LENGTH   : 9.2   SIGNED : Y

227. Claim Value Based Purchasing Adjustment Payment Amount
                        6   1571   1576   PACK

Effective with CR#8, this field represents the
Hospital Value Based Purchasing Amount. This could
be an additional payment on the claim or a
reduction, depending on the hospital's score.

Effective with CR#9, this field was renamed:
CLM_VBP_ADJSTM_PMT_AMT. Prior to CR#9, the field was
named: CLM_IPPS_FLEX_PMT_3_AMT.

DB2   ALIAS : CLM_VBP_ADJSTMT_AM
SAS   ALIAS : VBPAMT
STANDARD ALIAS : CLM_VBP_ADJSTMT_PMT_AMT

LENGTH   : 9.2   SIGNED : Y

228. Claim Hospital Readmission Reduction (HRR) Adjustment Payment Amount
                            6   1577   1582   PACK

                                  Effective with CR#8, this field represents the
                                  Hospital Readmission Reduction Program Amount.   The
                                  amount is the reduction to the claim for
                                  readmissions.

                                  Effective with CR#9, this field was renamed:
                                  CLM_HRR_ADJSTM_PMT_AMT.   Prior to CR#9, this field was
                                  named: CLM_IPPS_FLEX_PMT_4_AMT.

                                  DB2   ALIAS : CLM_HRR_ADJSTMT_AM
                                  SAS   ALIAS : HRRAMT
                                  STANDARD ALIAS : CLM_HRR_ADJSTMT_PMT_AMT

                                  LENGTH   : 9.2   SIGNED : Y

229. Claim Electronic Health Record (EHR) Payment Adjustment Amount
                            6   1583   1588   PACK

                                  Effective with CR#9 (October 2014 release), this field
                                  represents the dollar amount of the Electronic Health
                                  Record (EHR) reduction for eligible hospitals that are
                                  not meaningful EHR users.

                                  NOTE: This field only applies to Inpatient claims.

                                  DB2   ALIAS : CLM_EHR_AMT
                                  SAS   ALIAS : EHRAMT
                                  STANDARD ALIAS : CLM_EHR_PMT_ADJSTMT_AMT

                                  LENGTH   : 9.2   SIGNED : Y

230. Claim PPS Standard Value Payment Amount
                            6   1589   1594   PACK

                                  This amount identifies the PRICER output standardized
                                  amount. This amount is never used for payments. It is
                                  used for comparisons across different regions of the
                                  country for the value-based purchasing initiatives and for
                                  research. It is a standard amount, without the geographical
                                  payment adjustments and some of the other add-on payments
                                  that actually go to the hospitals.

                                  NOTE: This field was added to Inpatient claims with CR#9

```
                                    (October 2014 release) and to Home Health claims with the
                                    Part A expanstion changes (January 2019 release).

                                    DB2      ALIAS : CLM_STD_VAL_AMT
                                    SAS      ALIAS : PSTDAMT
                                    STANDARD ALIAS : CLM_PPS_STD_VAL_PMT_AMT

                                    LENGTH        : 9.2    SIGNED : Y

231. Claim Final Standard Amount
                        6    1595   1600    PACK


                                    Effective with CR#9 (October 2014 release), this amount
                                    field identifies the result of application of additional
                                    standardization requirements (e.g. sequestration) to the
                                    PPS Standardized Payment Amount.  This amount is never
                                    used for payments.  It is used for comparisons across
                                    different regions of the country for the value- based
                                    purchasing initiatives and for research.  It is a
                                    standard amount, without the geographical payment
                                    adjustments and some of the other add-on payments that
                                    actually go to the providers.

                                    NOTE:  With CR#9, the field only applied to Inpatient claims.

                                    Effective with CR#13 (January 2018 release), this amount
                                    field identifies the result of application of additional
                                    standardization requirements (e.g. sequestration) to the
                                    PPS Standardized Payment Amount.  This amount is never
                                    used for payments.  It is used for comparisons across
                                    different regions of the country for the value- based
                                    purchasing initiatives and for research.  It is a
                                    standard amount, without the geographical payment
                                    adjustments and some of the other add-on payments that
                                    actually go to the providers.

                                    NOTE1:  With CR#13, the field was added to Home Health claims.

                                    NOTE2: Even though the field will be found on the Home
                                    Health claims with the January 2018 release, data will not
                                    be found in the field until October 2018.

                                    DB2      ALIAS : CLM_FINL_STD_AMT
                                    SAS      ALIAS : FSTDAMT
                                    STANDARD ALIAS : CLM_FINL_STD_AMT

                                    LENGTH        : 9.2    SIGNED : Y
```

232. Claim Hospital Acquired Condition (HAC) Reduction Payment Amount
                        6   1601   1606   PACK

                        Effective with CR#10, this field identifies the reduction
                        amount from the IPPS payment for hospitals that rank in
                        the lowest performing quartile of selected Hospital
                        Acquired Conditions.

                        The total payment amount is reduced by 1%.

                        NOTE: Prior to CR#10, this field was a placeholder field
                        and was named: CLM_IPPS_FLEX_PMT_6_AMT.

                        DB2   ALIAS : HAC_RDCTN_PMT_AMT
                        SAS   ALIAS : HACAMT
                        STANDARD ALIAS : CLM_HAC_RDCTN_PMT_AMT

                        LENGTH   : 9.2   SIGNED : Y

                        COMMENTS :
                        Renamed in CR10. Previous name was
                        CLM-IPPS-FLEX-PMT-6-AMT.

                        SOURCE   : CWF

                        EDIT RULES :
                              $$$$$$$$$cc

233. Claim IPPS Flex Payment 7 Amount
                        6   1607   1612   PACK

                        Effective with CR#9 (October 2014 release), this field is a
                        placeholder for a dollar amount to be used for future
                        policy.

                        NOTE: This field only applies to Inpatient claims.

```
                              DB2      ALIAS : CLM_FLEX_PMT_7_AMT
                              SAS      ALIAS : FLEX7
                              STANDARD ALIAS : CLM_IPPS_FLEX_PMT_7_AMT

                              LENGTH         : 9.2    SIGNED : Y
```

234. Claim Hospital Acquired Condition (HAC) Program Reduction Indicator Switch
                    1   1613   1613   CHAR

```
                              Effective with CR#9 (October 2014 release), this field
                              identifies hospitals subject to a Hospital Acquired
                              Condition (HAC) reduction of what they would otherwise be
                              paid under IPPS.

                              NOTE1:  This field only applies to Inpatient claims.

                              DB2      ALIAS : CLM_HAC_RDCTN_SW
                              SAS      ALIAS : HACIND
                              STANDARD ALIAS : CLM_HAC_PGM_RDCTN_IND_SW

                              LENGTH         : 1

                              CODE TABLE     : CLM_HAC_PGM_RDCTN_IND_TB
```

235. Claim Electronic Health Records (EHR) Program Reduction Indicator Switch
                    1   1614   1614   CHAR

```
                              Effective with CR#9 (October 2014 release), this field identifies
                              which hospitals are Electronic Health Record meaningful users.

                              This field only applies to Inpatient claims.

                              DB2      ALIAS : CLM_EHR_RDCTN_SW
                              SAS      ALIAS : EHRIND
                              STANDARD ALIAS : CLM_EHR_PGM_RDCTN_IND_SW

                              LENGTH         : 1

                              CODE TABLE     : CLM_EHR_PGM_RDCTN_IND_TB
```

236. Claim Prior Authorization Indicator Code
                    4   1615   1618   CHAR

```
                              Effective with CR#9 (October 2014 release), this field
                              represents the indicator assigned by CMS for each prior
                              authorization program to define the applicable line of
```

business (i.e. Part A, Part B, DME, Home Health and
Hospice).

```
DB2       ALIAS : PRIOR_AUTHRZTN_CD
SAS       ALIAS : CLMPRIOR
STANDARD ALIAS : CLM_PRIOR_AUTHRZTN_IND_CD

LENGTH        : 4

CODE TABLE    : CLM_PRIOR_AUTHRZTN_TB
```

237. Claim Unique Tracking Number

                    14   1619   1632   CHAR

Effective with CR#9 (October 2014 release), this field
represents the number assigned to each prior
authorization request.

NOTE: This field only applies to Inpatient/SNF claims.

```
DB2       ALIAS : CLM_UNIQ_TRKNG_NUM
SAS       ALIAS : CLMTRKNG

LENGTH        : 14
```

DERIVATIONS :
Position 1 - 2 = MAC Identifier (e.g. RR for Railroad,
OF = Jurisdiction F, 05 = Jurisdiction
5, etc.)
Position 3   = Line of Business (e.g. A = Part A,
B = Part B, D = DME & H = Home Health
Hospice)
Position 4- 14 = a unique sequence number assigned by
the Shared System

238. Claim Site Neutral Payment Based on Cost Amount

                    6   1633   1638   PACK

Effective with CR#10, under the Long Term Care (LTCH) PPS,
the claim payment amount based on estimated cost of the
case.

This amount is included in the claim payment amount.

```
DB2       ALIAS : SITE_NTRL_CST_AMT
SAS       ALIAS : SITECOST
STANDARD ALIAS : CLM_SITE_NTRL_PMT_CST_AMT
```

```
                                LENGTH          : 9.2    SIGNED : Y

                                SOURCE          : CWF

                                EDIT RULES :
                                      $$$$$$$$$cc
239. Claim Site Neutral Payment Based on Inpatient Prospective Payment System (IPPS) Amount
                     6    1639   1644    PACK

                                Effective with CR#10, under the Long Term Care Hospital
                                (LTCH) Prospective Payment System (PPS), the claim payment
                                amount based on the Inpatient Prospective Payment System
                                (IPPS) comparable amount. This amount does not include any
                                applicable outlier payment amount.

                                This amount is included in the claim payment amount.

                                DB2      ALIAS : SITE_NTRL_IPPS_AMT
                                SAS      ALIAS : SITEIPPS
                                STANDARD ALIAS : CLM_SITE_NTRL_PMT_IPPS_AMT

                                LENGTH          : 9.2    SIGNED : Y

                                SOURCE          : CWF

                                EDIT RULES :
                                      $$$$$$$$$cc
240. Claim Full Standard Payment Amount
                     6    1645   1650    PACK

                                Effective with CR #10, under the Long Term Care Hospital
                                (LTCH) Prospective Payment System (PPS), the payment amount based
                                on the MS-LTC-DRG. This amount does not include any applicable
                                outlier payment amount.

                                This amount is included in the claim payment amount.

                                DB2      ALIAS : CLM_FULL_STD_AMT
                                SAS      ALIAS : FULLSTD
                                STANDARD ALIAS : CLM_FULL_STD_PMT_AMT

                                LENGTH          : 9.2    SIGNED : Y

                                SOURCE          : CWF
```

```
                              EDIT RULES :
                                   $$$$$$$$$$cc

241. Claim Short Stay Outlier (SSO) Standard Payment Amount
                        6    1651    1656     PACK

                              Effective CR#10, under the Long Term Care Hospital (LTCH)
                              Prospective Payment System (PPS), the payment based on the
                              MS-LTC-DRG payment with a short stay outlier (SSO) adjustment.
                              This amount does not include any applicable outlier payment
                              amount.

                              This amount is included in the claim payment amount.

                              DB2       ALIAS : CLM_SSO_STD_AMT
                              SAS       ALIAS : SSOSTD
                              STANDARD ALIAS : CLM_SSO_STD_PMT_AMT

                              LENGTH          : 9.2    SIGNED : Y

                              SOURCE          : CWF

                              EDIT RULES :
                                   $$$$$$$$$$cc

242. Claim Representative Payee (RP) Indicator Code
                        1    1657    1657     CHAR

                              Effective with CR#11, this field will be used to designate by-
                              passing of the prior authorization processing for claims with a
                              representative payee when an 'R' is present in the field.

                              NOTE:  Data will not start coming in until April 2016.  This field
                              was added to the January 2016 release because our workload (FA fix)
                              will not allow us to implement another CR in April.

                              DB2       ALIAS : CLM_RP_IND_CD
                              SAS       ALIAS : RPIND
                              STANDARD ALIAS : CLM_RP_IND_CD

                              LENGTH          : 1

                              SOURCE          : CWF

                              CODE TABLE      : RP_IND_TB
```

243. Claim Inpatient Initial MS DRG Code
                          4   1658   1661   CHAR

                                     Effective with CR#14 (April 2019 release), This field identifies the
                                     initial MS DRG code assigned by MS DRG Grouper prior to application
                                     Hospital Acquired Condition (HAC) logic. The data will only be
                                     populated on Inpatient claims.

                                     NOTE: Field is being added during the April 2019 release as a
                                     placeholder. Data will not start coming in until July 1, 2019.

                                     DB2   ALIAS : UNDEFINED
                                     SAS   ALIAS : MSDRGCD
                                     STANDARD ALIAS : CLM_IP_INITL_MS_DRG_CD

                                     LENGTH   : 4

244. FILLER
                        397   1662   2058   CHAR

                                     DB2   ALIAS : H_FILLER_5
                                     STANDARD ALIAS : FILLER

                                     LENGTH   : 397

245. FI Inpatient/SNF Claim Variable Group
                        VAR   2059 31656   GRP

                                     STANDARD ALIAS : FI_IP_SNF_CLM_VAR_GRP

246. NCH Edit Group
                         65   2059   2123   GRP

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

                                     STANDARD ALIAS : NCH_EDIT_GRP

                                     OCCURS MIN: 0 OCCURS MAX: 13

                                        DEPENDING ON : IP_NCH_EDIT_CD_CNT

247. NCH Edit Trailer Indicator Code
                          1   2059   2059   CHAR

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

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

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

LENGTH         : 1

SOURCE         : NCH QA Process

CODE TABLE     : NCH_EDIT_TRLR_IND_TB
```

248. NCH Edit Code

     4   2060   2063   CHAR

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

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

```
COMMON   ALIAS : QA_ERROR_CODE
DB2      ALIAS : NCH_EDIT_CD
SAS      ALIAS : EDIT_CD
STANDARD ALIAS : NCH_EDIT_CD
TITLE    ALIAS : QA_ERROR_CD

LENGTH         : 4

SOURCE         : NCH QA EDIT PROCESS

CODE TABLE     : NCH_EDIT_TB
```

249. NCH Patch Group

   330   2124   2453   GRP

```
STANDARD ALIAS : NCH_PATCH_GRP

OCCURS MIN: 0 OCCURS MAX: 30
```

250. NCH Patch Trailer Indicator Code
                          1   2124   2124   CHAR

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

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

                                                DB2   ALIAS : PATCH_TRLR_IND_CD
                                                SAS   ALIAS : PATCHIND
                                                STANDARD ALIAS : NCH_PATCH_TRLR_IND_CD

                                                LENGTH   : 1

                                                SOURCE   : NCH

                                                CODE TABLE   : NCH_PATCH_TRLR_IND_TB

251. NCH Patch Code
                          2   2125   2126   CHAR

                                                Effective with Version H, the code annotated
                                                to the claim indicating a patch was applied
                                                to the record during an NCH Nearline record
                                                conversion and/or during current processing.

                                                NOTE: Prior to Version H this field was located
                                                in the third and fourth occurrence of the
                                                CLM_EDIT_CD.

                                                DB2   ALIAS : NCH_PATCH_CD
                                                SAS   ALIAS : PATCHCD
                                                STANDARD ALIAS : NCH_PATCH_CD
                                                TITLE   ALIAS : NCH_PATCH

                                                LENGTH   : 2

                                                SOURCE   : NCH

                                                CODE TABLE   : NCH_PATCH_TB

252. NCH Patch Applied Date

```
                              8   2127   2134    NUM

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


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

                                      LENGTH          : 8    SIGNED : N

                                      SOURCE          : NCH

                                      EDIT RULES :
                                            YYYYMMDD


253. MCO Period Group
                             74   2454   2527    GRP



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

                                      STANDARD ALIAS : MCO_PRD_GRP

                                      OCCURS MIN: 0 OCCURS MAX: 2

                                         DEPENDING ON : IP_MCO_PRD_CNT

254. NCH MCO Trailer Indicator Code
                              1   2454   2454    CHAR

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

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

```
                                           DB2      ALIAS : MCO_TRLR_IND_CD
                                           SAS      ALIAS : MCOIND
                                           STANDARD ALIAS : NCH_MCO_TRLR_IND_CD
                                           TITLE    ALIAS : MCO_INDICATOR

                                           LENGTH         : 1

                                           SOURCE         : NCH QA Process

                                           CODE TABLE     : NCH_MCO_TRLR_IND_TB

255. MCO Contract Number
                      5    2455   2459   CHAR

                                           Effective with Version H, this field represents
                                           the plan contract number of the Managed Care
                                           Organization (MCO).

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

                                           DB2      ALIAS : MCO_CNTRCT_NUM
                                           SAS      ALIAS : MCONUM
                                           STANDARD ALIAS : MCO_CNTRCT_NUM
                                           TITLE    ALIAS : MCO_NUM

                                           LENGTH         : 5

                                           SOURCE         : CWF

256. MCO Option Code
                      1    2460   2460   CHAR

                                           Effective with Version H, the code indicating
                                           Managed Care Organization (MCO) lock-in
                                           enrollment status of the beneficiary.

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

                                           DB2      ALIAS : MCO_OPTN_CD
                                           SAS      ALIAS : MCOOPTN
                                           STANDARD ALIAS : MCO_OPTN_CD
```

```
                                    TITLE    ALIAS : MCO_OPTION_CD

                                    LENGTH          : 1

                                    SOURCE          : CWF

                                    CODE TABLE      : MCO_OPTN_TB

257. MCO Period Effective Date
                    8   2461   2468   NUM

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

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

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

                                    LENGTH          : 8    SIGNED : N

                                    SOURCE          : CWF

                                    EDIT RULES :
                                         YYYYMMDD

258. MCO Period Termination Date
                    8   2469   2476   NUM

                                    Effective with Version H, the date the bene-
                                    ficiary's enrollment in the Managed Care
                                    Organization (MCO) was terminated.

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

                                    DB2      ALIAS : MCO_PRD_TRMNTN_DT
                                    SAS      ALIAS : MCOTRMDT
                                    STANDARD ALIAS : MCO_PRD_TRMNTN_DT
```

```
                                   TITLE    ALIAS : MCO_PERIOD_TERM_DT

                                   LENGTH           : 8    SIGNED : N

                                   SOURCE           : CWF

                                   EDIT RULES :
                                        YYYYMMDD

259. MCO Health PLANID Number
                        14   2477   2490    CHAR

                                   A placeholder field (effective with Version H)
                                   for storing the Health PlanID associated with
                                   the Managed Care Organization (MCO).  Prior to
                                   Version 'I' this field was named:
                                   MCO_PAYERID_NUM.

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

                                   LENGTH           : 14

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

                                   SOURCE           : CWF

260. Claim Demonstration Identification Group
                        90   2528   2617    GRP

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

                                   STANDARD ALIAS : CLM_DEMO_ID_GRP

                                   OCCURS MIN: 0 OCCURS MAX: 5

                                      DEPENDING ON : IP_CLM_DEMO_ID_CNT

261. NCH Demonstration Trailer Indicator Code
                        1    2528   2528    CHAR
```

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

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

```
DB2      ALIAS : NCH_DEMO_TRLR_IND_
SAS      ALIAS : DEMOIND
STANDARD ALIAS : NCH_DEMO_TRLR_IND_CD
TITLE    ALIAS : DEMO_INDICATOR

LENGTH         : 1

SOURCE         : NCH

CODE TABLE     : NCH_DEMO_TRLR_IND_TB
```

262. Claim Demonstration Identification Number

                     2   2529   2530   CHAR

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

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

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

NOTE1: Effective for SNF claims with NCH weekly
process date after 2/8/96 (and service date after
12/31/95) -- beginning 4/97, Demo ID '01' was
derived in NCH based on presence of RUGS phase #

'2','3' or '4' on incoming claim; since 7/97, CWF
has been adding ID to claim.

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

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

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

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

03 = Telemedicine Demo -- testing covering tradi-
tionally noncovered physician services for
medical consultation furnished via two-way, inter-
active 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 desig-
nated counties in 3 states.   Under the demo,

UMWA will waive the 3-day qualifying hospital stay for a SNF admission.   The claims contain TOB '18X','21X','28X' and '51X'; condition code = W0; claim MCO paid switch = not '0'; and MCO contract # = '90091'.

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

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

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

NOTE2: During the Version H conversion, Demo ID '05' was populated back to NCH weekly process date 8/97 based on the presence of the Choices indicator (stored as an alpha character cross-walked from MCO plan contract # in the Claim Edit Group, 4th occurrence, 2nd position, in Version 'G').

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

NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit Date no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID '06' on the claim. The FI adds the ID to the claim based on the presence of DRG '106' or '107' from specific providers for specified time periods; the

carrier adds the ID to the claim based on
receiving 'Daily Census List' from parti-
cipating hospitals. ***Demo terminated in
1998.***

NOTE2: During the Version H conversion, any
claims where Medicare is the primary payer
that were not already identified as Demo ID
'06' (stored in the redefined Claim Edit
Group, 4th occurrence, positions 3 and 4,
Version G) were annotated based on the 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 = Virginia Cardiac Surgery Initiative (VCSI)
(formerly referred to as Medicare Quality Partner-
ships Demo) -- this is a voluntary consortium of
the cardiac surgery physician groups and the non-
Veterans Administration hospitals providing open
heart surgical services in the Commonwealth of
Virginia. The goal of the demo is to share data on
quality and process innovations in an attempt to
improve the care for all cardiac patients. The
demonstration only affects those FIs that process
claims from hospitals in Virginia and the carriers
that process claims from physicians providing
inpatient services at those hospitals. The
hospitals will be reimbursed on a global payment
basis for selected cardiac surgical diagnosis
related groups (DRGs). The inpatient claims will
contain a DRG '104', '105', '106', '107', '109';
the related physician/supplier claims will contain
the claim payment denial reason code = 'D'.

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

08 = Provider Partnership Demo -- testing per-case

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

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

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

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

30 = Lung Volume Reduction Surgery (LVRS) or
National Emphysema Treatment Trial (NETT)
Clinical Study -- evaluating the effective-
ness of LVRS and maximum medical therapy (in-
cluding pulmonary rehab) for Medicare bene-
ficiaries 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 SEN-
SITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE
TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE
CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO
HCFA BUT NOT STORED IN THE NEARLINE FILE (access
is restricted to study evaluators only).

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

37 = Medicare Coordinated Care Demonstration -- to test
whether coordinated care services furnished to
certain beneficiaries improves outcome of care
and reduces Medicare expenditures under Part A and
Part B. There will be at least 14 Coordinated
Care Entities (CCEs). The selected entities will
be assigned a provider number specifically for the
demonstration services.

NOTE: All claims will be processed by carriers;
no FI processing (except for Georgetown site)

37 = Medicare Disease Management (DMD) -- the purpose
of this demonstration is to study the impact on costs
and health outcomes of applying disease management
services supplemented with coverage for prescription
drugs for certain Medicare beneficiaries with diag-
nosed, advanced-stage congestive heart failure,
diabetes, or coronary heart disease. Three demon-
stration sites will be used for this demonstration
and it will last for 3 years. (Effective 4/1/2003).

NOTE: All claims will be processed by NHIC-California
(Carrier). FIs will only serve as a conduit for trans-
mitting information to and from CWF about the NOEs.

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.**

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

39 = Centralized Billing of Flu and PPV Claims -- The

purpose of this demo is to facilitate the processing carrier, Trailblazers, paying flu and PPV claims based on payment localities. Providers will be giving the shots throughout the country and transmitting the claims to Trailblazers for processing.

NOTE: Effective October, 2000 for carrier claims.

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

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

45 = Chiropractic

48 = Medical Adult Day-Care Services -- the purpose of this demonstration is to provide, as part of the episode of care for home health services, medical adult day care services to Medicare beneficiaries as a substitute for a portion of home health services that would otherwise be provided in the beneficiaries home. This demo would last approx. 3 years in not more than 5 sites. Payment for each home health service episode of care will be set at 95% of the amount that would otherwise be paid for home health services provided entirely in the home.

NOTE: Effective July 5, 2005 for HHA claims.

49 = Hemodialysis

53 = Extended Stay

54 = ACE Demo

56 = ACA 3113 Lab Demo

58 = used to identify the Multi-payer Advanced Primary
Care Practice (MAPCP) demonstration.
(eff. 7/2/12 - CR7693/7283)

59 = ACO Pioneer Demonstration
(CMS CR8140) - eff. 1/2014

60 = Power Motorized Device (PMD)

61 = CLM-CARE-IMPRVMT-MODEL-1

62 = CLM-CARE-IMPRVMT-MODEL-2

63 = CLM-CARE-IMPRVMT-MODEL-3

64 = CLM-CARE-IMPRVMT-MODEL-4

65 = rebilled claims due to auditor denials -- code being
implemented for a demonstration to determine the efficiency
of allowing providers to rebill for all outpatient services,
minus a penalty, when an inpatient claim is denied in full
because of medical review because the beneficiary did not
require inpatient services. (eff. 7/2/12 -- CR7738)

66 = rebilled claims due to provider self-audit after
claim submission/payment -- code being implemented for
a demonstration to determine the efficiency of allowing
providers to rebill for all outpatient services, minus a
penalty, when an inpatient claim is denied in full be-
cause of medical review because the beneficiary did not
require inpatient services. (eff. 7/2/12 -- CR7738)

67 = rebilled claims due to provider self-audit after
the patient has been discharged,but prior to payment --
code being implemented for a demonstration to determine
the efficiency of allowing providers to rebill for all
outpatient services, minus a penalty, when an inpatient
claim is denied in full because of medical review because
the beneficiary did not require inpatient services.
(eff. 7/2/12 -- CR7738)

68 = CWF will not apply the 3-day hospital stay requirement
when processing a SNF claim.
(CMS CR8215) - eff. 1/2014

70 = used for Electrical Workers Insurance Fund claims.

```
                                           (eff. 7/2/12)
                                           71 = Intravenous Immune Globin (IVIG)
                                           75 = Comprehensive Care for Joint Replacement (CCJR)
                                           (eff. 4/2016)
                                           77 = Shared Savings Program (eff. 10/2016)
                                           78 = Comprehensive Primary Care Plus (CPC+) (eff. 4/2017)
                                           79 = Acute Myocardial Infarction (AMI) Episode Payment
                                           Model (EPM) ( (eff. 1/2018)
                                           80 = Coronary Artery Bypass Graft (CABG) Episode Payment
                                           Model (EPM)  (eff. 1/2018)
                                           81 = Surgical Hip and Femur Fracture Treatment (SHFFT)
                                           Episode Payment Model (EMP) (eff. 1/2018)
                                           82 = Medicare Diabetes Prevention Program (MDPPs)
                                           (eff. 4/2018)
                                           83 = Maryland Primary Care Program (MDPCP)
                                           (eff. 1/2018)


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

                                           LENGTH         : 2

                                           SOURCE         : CWF

263. Claim Demonstration Information Text
                        15   2531   2545   CHAR

                                           Effective with Version H, the text field that
                                           contains related demo information.  For example,
                                           a claim involving a CHOICES demo id '05' would
                                           contain the MCO plan contract number in the first
                                           five positions of this text field.

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

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

                                           LENGTH         : 15

                                           DERIVATIONS :
```

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

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

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

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

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

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

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

Demo ID = 38 (Physician Encounter Claims) --

text field will contain the MCO plan number.
When MCO plan number not present the field will
reflect 'INVALID'.

SOURCE   : CWF

LIMITATIONS :

  REFER TO :
   CHOICES_DEMO_LIM

264. Claim Present on Admission (POA) Diagnosis Group
                  50   2618   2667   GRP

The number of claim POA trailers is determined by the
claim POA diagnosis code count. This group contains
those POA codes associated with the diagnosis (principal
and other) codes (excluding diagnosis E codes). The POAs
for the diagnosis E codes are stored in the POA diagnosis
E trailer.

STANDARD ALIAS : CLM_POA_DGNS_GRP

OCCURS MIN: 0 OCCURS MAX: 25

   DEPENDING ON : IP_CLM_POA_DGNS_CD_CNT

265. NCH POA Diagnosis Trailer Indicator Code
                  1   2618   2618   CHAR

Effective with Version 'J', the code indicating the
presence of a POA Diagnosis trailer.

NOTE: During the Version J conversion, this field
was populated throughout history.

DB2   ALIAS : UNDEFINED
SAS   ALIAS : PTRLRIND
STANDARD ALIAS : NCH_POA_DGNS_TRLR_IND_CD

LENGTH   : 1

SOURCE   : NCH

CODE TABLE   : NCH_POA_DGNS_TRLR_IND_TB

266. Claim POA Diagnosis Indicator Code
                          1   2619   2619   CHAR

                                  Effective September 1, 2008, with the implementation
                                  of CR#3, on Inpatient claims only, the code used to
                                  indicate a condition was present at the time the
                                  beneficiary was admitted to a general acute care
                                  facility.

                                  NOTE: Prior to Version 'J', the POA indicators were
                                  housed in a 10 byte field. There could be up to 9
                                  POA indicators for each diagnosis code reflected in
                                  the diagnosis trailer. The field also contained a
                                  1 byte indicator ('Z' or 'X' to identify the end
                                  of the POA codes.

                                  NOTE1: Effective with Version 'J', a POA trailer
                                  was created for both diagnosis codes and diagnosis
                                  'E' codes. There is a POA diagnosis trailer (up to
                                  25 occurrences) that is associated with the diagnosis
                                  trailer.   There is also a POA diagnosis 'E' trailer
                                  (up to 12 occurrences) that is associated with the
                                  diagnosis 'E' trailer. **Medicare requires a POA for
                                  'E' codes in the regular diagnosis trailer but not
                                  for 'E' codes in the 'E' diagnosis trailer. However,
                                  5010 has POA indicators as situational for 'E' codes
                                  in the 'E' code trailer, so a POA could be reported.

                                  DB2   ALIAS : CLM_POA_IND_CD
                                  SAS   ALIAS : POAINDCD
                                  STANDARD ALIAS : CLM_POA_DGNS_IND_CD

                                  LENGTH   : 1

                                  COMMENTS :
                                  Prior to Version 'J', tje POA indicators were stored in a
                                  10-byte field in the fixed portion of the claim. The field
                                  was named: CLM_POA_IND_CD.

                                  SOURCE   : CWF

                                  CODE TABLE   : CLM_POA_IND_TB

267. Claim Present on Admission (POA) Diagnosis E Group
                         24   2668   2691   GRP

The number of claim POA diagnosis E trailers is
determined by the claim POA diagnosis E code
count. This group contains those POA codes associated
with the diagnosis E codes.

STANDARD ALIAS : CLM_POA_DGNS_E_GRP

OCCURS MIN: 0 OCCURS MAX: 12

   DEPENDING ON : IP_CLM_POA_DGNS_E_CD_CNT

268. NCH POA Diagnosis E Trailer Indicator Code
                  1   2668   2668   CHAR

Effective with Version 'J', the code indicating
the presence of a POA Diagnosis E trailer.

NOTE: During the Version 'J' conversion, this
field was populated throughout history.

DB2   ALIAS : UNDEFINED
SAS   ALIAS : PETRLR
STANDARD ALIAS : NCH_POA_DGNS_E_TRLR_IND_CD

LENGTH   : 1

SOURCE   : NCH

CODE TABLE   : NCH_POA_DGNS_E_TRLR_IND_TB

269. Claim POA Diagnosis E Indicator Code
                  1   2669   2669   CHAR

Effective with Version 'J', the code used to identify
the present on admission (POA) indicator code
associated with the diagnosis E codes.

DB2   ALIAS : CLM_POA_IND_CD
SAS   ALIAS : POAEIND
STANDARD ALIAS : CLM_POA_DGNS_E_IND_CD

LENGTH   : 1

COMMENTS :
Prior to Version 'J', the POA indicators were stored in a
10-byte field in the fixed portion of the claim. The field

was named: CLM_POA_IND_CD.

                              SOURCE   : CWF

                              CODE TABLE   : CLM_POA_IND_TB

270. Claim Diagnosis Group
                    225   2692   2916   GRP

                              The number of claim diagnosis trailers is
                              determined by the claim diagnosis code
                              count. The principal diagnosis is the first occurrence.
                              The principal diagnosis is 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.

                              STANDARD ALIAS : CLM_DGNS_GRP

                              OCCURS MIN: 0 OCCURS MAX: 25

                                 DEPENDING ON : IP_CLM_DGNS_CD_J_CNT

271. NCH Diagnosis Trailer Indicator Code
                      1   2692   2692   CHAR

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

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

                              DB2   ALIAS : DGNS_TRLR_IND_CD
                              SAS   ALIAS : DGNSIND
                              STANDARD ALIAS : NCH_DGNS_TRLR_IND_CD

                              LENGTH   : 1

                              SOURCE   : NCH

                              CODE TABLE   : NCH_DGNS_TRLR_IND_TB

272. Claim Diagnosis Version Code

                          1   2693   2693   CHAR

                                   Effective with Version 'J', the code used to indicate if the
                                   diagnosis code is ICD-9 or ICD-10.

                                   NOTE: With 5010, the diagnosis and procedure codes have been
                                   expanded to accommodate ICD-10, even though ICD-10 is not
                                   scheduled for implementation until 10/2014.

                                   DB2   ALIAS : CLM_DGNS_VRSN_CD
                                   SAS   ALIAS : DVRSNCD
                                   STANDARD ALIAS : CLM_DGNS_VRSN_CD

                                   LENGTH   : 1

                                   CODE TABLE   : CLM_DGNS_VRSN_TB

273. Claim Diagnosis Code

                          7   2694   2700   CHAR

                                   The diagnosis code identifying the
                                   beneficiary's principal or other diagnosis
                                   (including E code).

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

                                   NOTE1: Effective with Version 'J', this field has been
                                   expanded from 5 bytes to 7 bytes to accommodate the
                                   future implementation of ICD-10.

                                   NOTE2: Effective with Version 'J', the diagnosis E
                                   codes are stored in a separate trailer (CLM_DGNS_E_GRP).

                                   DB2   ALIAS : CLM_DGNS_CD
                                   SAS   ALIAS : DGNS_CD
                                   STANDARD ALIAS : CLM_DGNS_CD

                                   LENGTH   : 7

                                   EDIT RULES :

274. Claim Diagnosis E Group

                    108   2917   3024   GRP

The number of claim diagnosis E trailers is determined
by the claim diagnosis E code count.
This group contains the diagnosis E codes and
the diagnosis E version code.

STANDARD ALIAS : CLM_DGNS_E_GRP

OCCURS MIN: 0 OCCURS MAX: 12

   DEPENDING ON : IP_CLM_DGNS_E_CD_CNT

275. NCH Diagnosis E Trailer Indicator Code

                    1   2917   2917   CHAR

Effective with Version 'J', the code indicating the
presence of a diagnosis E trailer.

NOTE: During the Version 'J' conversion, this field
was populated throughout history.

DB2   ALIAS : DGNS_E_TRLR_IND_CD
SAS   ALIAS : ETRLRIND
STANDARD ALIAS : NCH_DGNS_E_TRLR_IND_CD

LENGTH   : 1

SOURCE   : NCH

CODE TABLE   : NCH_DGNS_E_TRLR_IND_TB

276. Claim Diagnosis Version Code

                    1   2918   2918   CHAR

Effective with Version 'J', the code used to indicate if
the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have
been expanded to accomodate ICD-10, even though ICD-10 is
not scheduled for implementation until 10/2014.

DB2   ALIAS : UNDEFINED

```
                                        SAS       ALIAS : EVRSNCD
                                        STANDARD ALIAS : CLM_DGNS_E_VRSN_CD

                                        LENGTH         : 1

                                        CODE TABLE     : CLM_DGNS_VRSN_TB

277. Claim Diagnosis E Code
                        7    2919   2925   CHAR

                                        Effective with Version J, the code used to identify the
                                        external cause of injury, poisoning, or other adverse
                                        affect.

                                        NOTE:  Effective with Version 'J', this field has been
                                        expanded from 5 bytes to 7 bytes to accomodate the future
                                        implementation of ICD-10.

                                        During the Version 'J' conversion,  all 'E' codes in the
                                        diagnosis trailer were moved to the diagnosis 'E'
                                        trailer.

                                        With the implementation of Version 'J', diagnosis 'E'
                                        codes can also be found in the regular diagnosis trailer,
                                        reflected as secondary diagnosis codes.

                                        DB2       ALIAS : CLM_DGNS_E_CD
                                        SAS       ALIAS : EDGNSCD
                                        STANDARD ALIAS : CLM_DGNS_E_CD

                                        LENGTH         : 7

                                        SOURCE         : CWF

                                        EDIT RULES :
                                             ICD-9-CM

278. Claim Procedure Group
                        425   3025   3449   GRP


                                        The number of claim procedure trailers is determined
                                        by the claim procedure code count.
                                        Effective with Version 'J', up to 25 occurrences
                                        may be reported on a claim.
                                        Beginning 10/93, up to six
                                        occurrences (one principal; five others) may be
```

```
                                              reported.

                                              STANDARD ALIAS : CLM_PRCDR_GRP

                                              OCCURS MIN: 0 OCCURS MAX: 25

                                                  DEPENDING ON : IP_CLM_PRCDR_CD_J_CNT

279. NCH Procedure Trailer Indicator Code
                      1    3025   3025    CHAR

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

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

                                              DB2      ALIAS : NCH_PRCDR_TRLR_IND
                                              SAS      ALIAS : PRCDRIND
                                              STANDARD ALIAS : NCH_PRCDR_TRLR_IND_CD

                                              LENGTH         : 1

                                              SOURCE         : NCH

                                              CODE TABLE     : NCH_PRCDR_TRLR_IND_TB

280. Claim Procedure Version Code
                      1    3026   3026    CHAR

                                              Effective with Version 'J', the code used to indicate if
                                              the surgical procedure code is ICD-9 or ICD-10.

                                              NOTE:  With 5010, the diagnosis and procedure codes have
                                              been expanded to accommodate ICD-10, even though ICD-10
                                              is not scheduled for iomplementation until 10/2014.

                                              DB2      ALIAS : CLM_PRCDR_VRSN_CD
                                              SAS      ALIAS : PVRSNCD
                                              STANDARD ALIAS : CLM_PRCDR_VRSN_CD

                                              LENGTH         : 1

                                              CODE TABLE     : CLM_PRCDR_VRSN_TB

281. Claim Procedure Code
                      7    3027   3033    CHAR
```

The code that indicates the principal or other
procedure performed during the period covered by the
institutional claim.

NOTE:
Effective July 2004, ICD-9-CM procedure codes are no
longer being accepted on Outpatient claims. The
ICD-9-CM codes were named as the HIPPA standard code
set for inpatient hospital procedures. HCPCS/CPT codes
were named as the standard code set for physician services
and other health care services.

NOTE1: Effective with Version 'J', the number of procedure
code occurrences has expanded from 6 to 25.

DB2   ALIAS : CLM_PRCDR_CD
SAS   ALIAS : PRCDR_CD
STANDARD ALIAS : CLM_PRCDR_CD

LENGTH   : 7

DERIVATIONS :
DERIVED FROM:
NCH CLM_PRCDR_CD

IF FIELD CONTAINS 4 ALPHA-NUMERIC CHARACTERS OR
OR 3 ALPHA-NUMERIC CHARACTERS FOLLOWED BY A
SPACE, ASSUME CODE IS VALID
OTHERWISE
MOVE SPACES TO CLM_PRCDR_CD.

SOURCE   : CWF

EDIT RULES :
     ICD-9-CM

282. Claim Procedure Performed Date
                         8   3034   3041   NUM

On an institutional claim, the date on which
the principal or other procedure was performed.

DB2   ALIAS : CLM_PRCDR_PRFRM_DT
SAS   ALIAS : PRCDR_DT
STANDARD ALIAS : CLM_PRCDR_PRFRM_DT

```
                              LENGTH          : 8    SIGNED : N

                              SOURCE          : CWF

                              LIMITATIONS :

                                REFER TO :
                                 CLM_PRCDR_PRFRM_DT_LIM

                              EDIT RULES :
                                    YYYYMMDD

283. Claim Related Condition Group
                      90   3450   3539   GRP


                              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.

                              STANDARD ALIAS : CLM_RLT_COND_GRP

                              OCCURS MIN: 0 OCCURS MAX: 30

                                 DEPENDING ON : IP_CLM_RLT_COND_CD_CNT

284. NCH Condition Trailer Indicator Code
                       1   3450   3450   CHAR

                              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

                              LENGTH          : 1

                              SOURCE          : NCH

                              CODE TABLE      : NCH_COND_TRLR_IND_TB
```

285. Claim Related Condition Code
                              2   3451   3452   CHAR

                                   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
                                   TITLE   ALIAS : RELATED_CONDITION_CD

                                   LENGTH   : 2

                                   SOURCE   : CWF

                                   CODE TABLE   : CLM_RLT_COND_TB

286. Claim Related Occurrence Group
                            330   3540   3869   GRP

                                   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.

                                   STANDARD ALIAS : CLM_RLT_OCRNC_GRP

                                   OCCURS MIN: 0 OCCURS MAX: 30

                                      DEPENDING ON : IP_CLM_RLT_OCRNC_CD_CNT

287. NCH Occurrence Trailer Indicator Code
                              1   3540   3540   CHAR

                                   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

                                    LENGTH          : 1

                                    SOURCE          : NCH

                                    CODE TABLE      : NCH_OCRNC_TRLR_IND_TB

288. Claim Related Occurrence Code
                    2    3541    3542    CHAR

                                    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
                                    TITLE     ALIAS : OCCURRENCE_CD

                                    LENGTH          : 2

                                    SOURCE          : CWF

                                    CODE TABLE      : CLM_RLT_OCRNC_TB

289. Claim Related Occurrence Date
                    8    3543    3550    NUM

                                    The date associated with a significant event
                                    related to an institutional claim that may
                                    affect payer processing.

                                    DB2       ALIAS : CLM_RLT_OCRNC_DT
                                    SAS       ALIAS : OCRNCDT
                                    STANDARD ALIAS : CLM_RLT_OCRNC_DT
                                    TITLE     ALIAS : RLT_OCRNC_DT

                                    LENGTH          : 8     SIGNED : N

                                    SOURCE          : CWF

                                    EDIT RULES :
                                         YYYYMMDD
```

290. Claim Occurrence Span Group
                              190   3870   4059   GRP

                                     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.

                                     STANDARD ALIAS : CLM_OCRNC_SPAN_GRP

                                     OCCURS MIN: 0 OCCURS MAX: 10

                                        DEPENDING ON : IP_CLM_OCRNC_SPAN_CD_CNT

291. NCH Span Trailer Indicator Code
                                1   3870   3870   CHAR

                                     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

                                     LENGTH   : 1

                                     SOURCE   : NCH

                                     CODE TABLE   : NCH_SPAN_TRLR_IND_TB

292. Claim Occurrence Span Code
                                2   3871   3872   CHAR

                                     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

```
                                          TITLE    ALIAS : SPAN_CD

                                          LENGTH          : 2

                                          SOURCE          : CWF

                                          CODE TABLE      : CLM_OCRNC_SPAN_TB

293. Claim Occurrence Span From Date
                         8    3873   3880   NUM

                                          The from date of a period associated with
                                          an occurrence of a specific event relating to
                                          an institutional claim that may affect payer
                                          processing.

                                          DB2      ALIAS : OCRNC_SPAN_FROM_DT
                                          SAS      ALIAS : SPANFROM
                                          STANDARD ALIAS : CLM_OCRNC_SPAN_FROM_DT
                                          TITLE    ALIAS : SPAN_FROM_DT

                                          LENGTH          : 8    SIGNED : N

                                          SOURCE          : CWF

                                          EDIT RULES :
                                               YYYYMMDD

294. Claim Occurrence Span Through Date
                         8    3881   3888   NUM

                                          The thru date of a period associated with an
                                          occurrence of a specific event relating to an
                                          institutional claim that may affect payer
                                          processing.

                                          DB2      ALIAS : OCRNC_SPAN_THRU_DT
                                          SAS      ALIAS : SPANTHRU
                                          STANDARD ALIAS : CLM_OCRNC_SPAN_THRU_DT
                                          TITLE    ALIAS : SPAN_THRU_DT

                                          LENGTH          : 8    SIGNED : N

                                          SOURCE          : CWF

                                          EDIT RULES :
                                               YYYYMMDD
```

295. Claim Value Group

                    324   4060   4383   GRP

                            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.

                            STANDARD ALIAS : CLM_VAL_GRP

                            OCCURS MIN: 0 OCCURS MAX: 36

                               DEPENDING ON : IP_CLM_VAL_CD_CNT

296. NCH Value Trailer Indicator Code
                      1   4060   4060   CHAR

                            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

                            LENGTH   : 1

                            SOURCE   : NCH

                            CODE TABLE   : NCH_VAL_TRLR_IND_TB

297. Claim Value Code
                      2   4061   4062   CHAR

                            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

```
                                   TITLE    ALIAS : VALUE_CD

                                   LENGTH        : 2

                                   SOURCE        : CWF

                                   CODE TABLE    : CLM_VAL_TB

298. Claim Value Amount
                       6   4063   4068   PACK

                                   The amount related to the condition identified
                                   in the CLM_VAL_CD which was used by the
                                   intermediary to process the institutional
                                   claim.

                                   DB2      ALIAS : CLM_VAL_AMT
                                   SAS      ALIAS : VAL_AMT
                                   STANDARD ALIAS : CLM_VAL_AMT
                                   TITLE    ALIAS : VALUE_AMOUNT

                                   LENGTH        : 9.2    SIGNED : Y

                                   SOURCE        : CWF

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

299. Claim Revenue Center Group
                   27270   4384   31653   GRP


                                   STANDARD ALIAS : CLM_REV_CNTR_GRP

                                   OCCURS MIN: 0 OCCURS MAX: 45

                                      DEPENDING ON : IP_REV_CNTR_CD_I_CNT

300. NCH Revenue Center Trailer Indicator Code
                       1   4384   4384   CHAR

                                   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

                              LENGTH         : 1

                              SOURCE         : NCH

                              CODE TABLE     : NCH_REV_TRLR_IND_TB
```

301. Revenue Center Code

```
          4    4385   4388    CHAR
```

> 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.

```
                              DB2      ALIAS : REV_CNTR_CD
                              SAS      ALIAS : REV_CNTR
                              STANDARD ALIAS : REV_CNTR_CD
                              TITLE    ALIAS : REVENUE_CENTER_CD

                              LENGTH         : 4

                              SOURCE         : CWF

                              CODE TABLE     : REV_CNTR_TB
```

302. Revenue Center Date

```
          8    4389   4396    NUM
```

> 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 re-
presents 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.

DB2   ALIAS : REV_CNTR_DT
STANDARD ALIAS : REV_CNTR_DT
TITLE   ALIAS : REV_CNTR_DATE

LENGTH   : 8   SIGNED : N

SOURCE   : CWF

EDIT RULES :
     YYYYMMDD

303. Revenue Center 1st ANSI Code
                    5   4397   4401   CHAR

The first code used to identify the
detailed reason an adjustment was made
(e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those

lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: 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
TITLE    ALIAS : ANSI_CD

LENGTH         : 5

SOURCE         : CWF

CODE TABLE     : REV_CNTR_ANSI_TB
```

304. Revenue Center 2nd ANSI Code
                    5   4402   4406   CHAR

The second code used to identify the
detailed reason an adjustment was made
(e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: 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

                                LENGTH         : 5

                                SOURCE         : CWF

305. Revenue Center 3rd ANSI Code
                  5    4407   4411    CHAR

                                The third code used to identify the
                                detailed reason an adjustment was made
                                (e.g. reason for denial or reducing payment).

                                NOTE1:  This field is populated for those claims
                                that are required to process through Outpatient
                                PPS Pricer.  The type of bills (TOB) required to
                                process through are: 12X, 13X, 14X (except Maryland
                                providers, Indian Health Providers, hospitals located
                                in American Samoa, Guam and Saipan and Critical
                                Access Hospitals (CAH)); 76X; 75X and 34X if
                                certain HCPCS are on the bill; and any outpatient
                                type of bill with a condition code '07' and certain
                                HCPCS.  These claim types could have lines that are
                                not required to price under OPPS rules so those
                                lines would not have data in this field.

                                Additional exception:  Virgin Island hospitals and
                                hospitals that furnish only inpatient Part B services
                                with dates of service 1/1/02 and forward.

                                NOTE2:  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
```

LENGTH   : 5

SOURCE   : CWF

306. Revenue Center 4th ANSI Code
                    5   4412   4416   CHAR

The fourth code used to identify the
detailed reason an adjustment was made
(e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: 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

LENGTH   : 5

SOURCE   : CWF

307. Revenue Center APC/HIPPS Code
                    5   4417   4421   CHAR

Effective with Version 'I', this field was created
to house two pieces of data. The Ambulatory Payment

Classification (APC) code and the HIPPS code. The APC
is used to identify groupings of outpatient services. APC
codes are used to calculate payment for services under
OPPS. The APC is a four byte field. The HIPPS codes
are used to identify patient classifications for SNFPPS,
HHPPS and IRFPPS that will be used to calculate payment.
The HIPPS code is a five byte field.

NOTE1: The APC field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: Under SNFPPS, HHPPS & IRFPPS, HIPPS codes
are stored in the HCPCS field. **EXCEPTION: if a
HHPPS HIPPS code is downcoded/upcoded the downcoded/
upcoded HIPPS will be stored in this field.

NOTE3: 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
TITLE   ALIAS : APC_HIPPS

LENGTH   : 5

SOURCE   : CWF

CODE TABLE   : REV_CNTR_APC_TB

308. Revenue Center Healthcare Common Procedure Coding System Code

```
     5    4422   4426    CHAR

                        Healthcare 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
                        STANDARD ALIAS : REV_CNTR_HCPCS_CD
                        TITLE    ALIAS : HCPCS_CD

                        LENGTH        : 5

                        COMMENTS :
                        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),
                        '0023' (HH PPS), or '0024' (IRF 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
                        (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.

                        The HIPPS code (CMG Code) for IRF PPS identifies
                        the clinical characteristics of the beneficiary.
                        The HIPPS rate/CMG code (AXXYY - DXXYY) must contain
                        five digits.  The first position of the code is an
```

A, B, C, or 'D'. The HIPPS code beginning with an 'A' in front of the CMG is defined as without comorbidity. The 'B' in front of the CMG is defined as with comorbidity for Tier 1. The 'C' is defined as comorbidity for Tier 2 and 'D' is defined as comorbidity for Tier 3. The 'XX' in the HIPPS rate code is the Rehabilitation Impairment Code (RIC). The 'YY' is the sequential number system within the RIC.

For SNF PPS, HH PPS & IRF 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.

                                       LIMITATIONS :

                                         REFER TO :
                                          HHA_HCPCS_LIM

                                       CODE TABLE   : CLM_HIPPS_TB

309. Revenue Center HCPCS Initial Modifier Code
                         2   4427   4428   CHAR

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

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

                                       LENGTH   : 2

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

                                       SOURCE   : CWF

                                       EDIT RULES :
                                             Carrier Information File

310. Revenue Center HCPCS Second Modifier Code
                         2   4429   4430   CHAR

                                       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
                                       STANDARD ALIAS : REV_CNTR_HCPCS_2ND_MDFR_CD
                                       TITLE   ALIAS : SECOND_MODIFIER

                                       LENGTH   : 2

                                       COMMENTS :

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

SOURCE   : CWF

EDIT RULES :
        CARRIER INFORMATION FILE

311. Revenue Center HCPCS Third Modifier Code
                    2   4431   4432   CHAR

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
STANDARD ALIAS : REV_CNTR_HCPCS_3RD_MDFR_CD
TITLE   ALIAS : THIRD_MODIFIER

LENGTH   : 2

COMMENTS :
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

EDIT RULES :
        CARRIER INFORMATION FILE

312. Revenue Center HCPCS Fourth Modifier Code
                    2   4433   4434   CHAR

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
STANDARD ALIAS : REV_CNTR_HCPCS_4TH_MDFR_CD
TITLE   ALIAS : FOURTH_MODIFIER

```
                                        LENGTH          : 2

                                        COMMENTS :
                                        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

                                        EDIT RULES :
                                             CARRIER INFORMATION FILE

313. Revenue Center HCPCS Fifth Modifier Code
                    2    4435    4436    CHAR

                                        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

                                        LENGTH          : 2

                                        COMMENTS :
                                        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

                                        EDIT RULES :
                                             CARRIER INFORMATION FILE

314. Revenue Center Payment Method Indicator Code
                    2    4437    4438    CHAR

                                        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.

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be
populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion
OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated
on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the
dates of service.

NOTE3: Effective 10/2005, this field will no longer
represent the service indicator and the payment
indicator. This field will now house the 2-byte
payment indicator. The status indicator will be housed
in a new field named: REV_CNTR_STUS_IND_CD.

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

LENGTH   : 2

SOURCE   : CWF

CODE TABLE   : REV_CNTR_PMT_MTHD_IND_TB

315. Revenue Center Discount Indicator Code

                 1   4439   4439   CHAR

Effective with Version 'I', 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 dis-
counting the factor will be 1.0.**

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be
populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion
OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated
on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the
dates of service.

NOTE3: VALUES D, U & T REPRESENT THE FOLLOWING:
D = Discounting fraction (currently 0.5)
U = Number of units
T = Terminated procedure discount (currently 0.5)

```
                         DB2      ALIAS : REV_DSCNT_IND_CD
                         SAS      ALIAS : DSCNTIND
                         STANDARD ALIAS : REV_CNTR_DSCNT_IND_CD
                         TITLE    ALIAS : REV_CNTR_DSCNT_IND_CD

                         LENGTH        : 1

                         SOURCE        : CWF

                         CODE TABLE    : REV_CNTR_DSCNT_IND_TB
```

316. Revenue Center Packaging Indicator Code
```
                1    4440    4440    CHAR
```

Effective with Version 'I', the code used to
identify those services that are packaged/
bundled with another service.

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be
populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion
OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated
on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the
dates of service.

```
                                    DB2      ALIAS : REV_PACKG_IND_CD
                                    SAS      ALIAS : PACKGIND
                                    STANDARD ALIAS : REV_CNTR_PACKG_IND_CD
                                    TITLE    ALIAS : REV_CNTR_PACKG_IND

                                    LENGTH         : 1

                                    SOURCE         : CWF

                                    CODE TABLE     : REV_CNTR_PACKG_IND_TB
317. Revenue Center Pricing Indicator Code
                        2    4441    4442    CHAR

                                    Effective with Version 'I', the code used
                                    to identify if there was a deviation from
                                    the standard method of calculating payment
                                    amount.

                                    NOTE1:  This field is populated for those claims
                                    that are required to process through Outpatient
                                    PPS Pricer.  The type of bills (TOB) required to
                                    process through are: 12X, 13X, 14X (except Maryland
                                    providers, Indian Health Providers, hospitals located
                                    in American Samoa, Guam and Saipan and Critical
                                    Access Hospitals (CAH)); 76X; 75X and 34X if
                                    certain HCPCS are on the bill; and any outpatient
                                    type of bill with a condition code '07' and certain
                                    HCPCS.  These claim types could have lines that are
                                    not required to price under OPPS rules so those
                                    lines would not have data in this field.

                                    Additional exception:  Virgin Island hospitals and
                                    hospitals that furnish only inpatient Part B services
                                    with dates of service 1/1/02 and forward.

                                    NOTE2:  It has been discovered that this field may be
                                    populated with data on claims with dates of service
                                    prior to 7/00 (implementation of Claim Line Expansion
                                    OPPS/HHPPS).  The original understanding of the new
                                    revenue center fields was that data would be populated
                                    on claims with dates of service 7/00 and forward.  Data
                                    has been found in claims with dates of service prior to
                                    7/00 because the Standard Systems have processed any
                                    claim coming in 7/00 and after, meeting the above criteria,
                                    through the Outpatient Code Editor (OCE) regardless of the
                                    dates of service.
```

```
                              DB2      ALIAS : REV_PRICNG_IND_CD
                              SAS      ALIAS : PRICNG
                              STANDARD ALIAS : REV_CNTR_PRICNG_IND_CD
                              TITLE    ALIAS : REV_CNTR_PRICNG_IND

                              LENGTH         : 2

                              SOURCE         : CWF

                              CODE TABLE     : REV_CNTR_PRICNG_IND_TB
```

318. Revenue Center Obligation to Accept As Full (OTAF) Payment Code
```
                     1   4443   4443   CHAR
```

Effective with Version 'j' the code used
to indicate that the provider was obligated
to accept as full payment the amount re-
ceived from the primary (or secondary) payer.

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be
populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion
OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated
on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the

```
                                              dates of service.

                              DB2     ALIAS : REV_OTAF_IND_CD
                              SAS     ALIAS : OTAF
                              STANDARD ALIAS : REV_CNTR_OTAF_IND_CD

                              LENGTH        : 1

                              SOURCE        : CWF

                              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.

319. Revenue Center IDE, NDC, UPC Number
                         24    4444   4467    CHAR

                              Effective with Version H, the exemption number
                              assigned by the Food and Drug Administration (FDA)
                              to an investigational device after a manufacturer
                              has been approved by FDA to conduct a clinical
                              trial on that device.   HCFA established a new
                              policy of covering certain IDE's which was
                              implemented in claims processing on 10/1/96
                              (which is NCH weekly process 10/4/96) for service
                              dates beginning 10/1/95.  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 con-
                              version IDE's were moved from the dummy '0624'
                              trailer to this dedicated field.

                              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 pro-
                                          cess 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


                                          LENGTH         : 24


                                          SOURCE         : CWF


                                          LIMITATIONS :


                                            REFER TO :
                                            REV_CNTR_IDE_NDC_UPC_LIM

320. Revenue Center NDC Quantity Qualifier Code
                  2   4468   4469     CHAR


                                          Effective with Version 'J', the code used to indicate the
                                          unit of measurement for the drug that was administered.


                                          DB2       ALIAS : NDC_QTY_QLFR_CD
                                          SAS       ALIAS : QTYQLFR
                                          STANDARD ALIAS : REV_CNTR_NDC_QTY_QLFR_CD


                                          LENGTH         : 2


                                          CODE TABLE     : REV_CNTR_NDC_QTY_QLFR_TB

321. Revenue Center NDC Quantity
                  6   4470   4475     PACK


                                          Effective with Version 'J', the quantity dispensed
                                          for the drug reflected on the revenue center line item.


                                          DB2       ALIAS : NDC_QTY_NUM
                                          SAS       ALIAS : NDCQTY
                                          STANDARD ALIAS : REV_CNTR_NDC_QTY


                                          LENGTH         : 7.3    SIGNED : Y
```

322. Revenue Center Unit Count

                  4   4476   4479   PACK

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.

DB2   ALIAS : REV_CNTR_UNIT_CNT
SAS   ALIAS : REV_UNIT
STANDARD ALIAS : REV_CNTR_UNIT_CNT
TITLE   ALIAS : UNITS

LENGTH   : 7   SIGNED : Y

SOURCE   : CWF

323. Revenue Center Rate Amount

                  6   4480   4485   PACK

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.

NOTE1: For SNF PPS claims (when revenue center
code equals '0022'), CMS 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, CMS 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'), CMS 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.

NOTE4: For IRF PPS claims (when revenue center
code equals '0024'), CMS has developed a PRICER
to compute the rate based on the HIPPS/CMG
(HIPPS code, stored in revenue center HCPCS code
field).

DB2   ALIAS : REV_CNTR_RATE_AMT
SAS   ALIAS : REV_RATE
STANDARD ALIAS : REV_CNTR_RATE_AMT
TITLE   ALIAS : CHARGE_PER_UNIT

LENGTH   : 9.2   SIGNED : Y

COMMENTS :
Prior to Version H the size of this field was:
S9(7)V99.

SOURCE   : CWF

324. Revenue Center Blood Deductible Amount
                    6   4486   4491   PACK

Effective with Version 'I', the amount of money
for which the intermediary determined the
beneficiary is liable for the blood deductible
for the line item service.

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be
populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion
OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated
on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the
dates of service.

DB2   ALIAS : REV_BLOOD_DDCTBL
SAS   ALIAS : REVBLOOD
STANDARD ALIAS : REV_CNTR_BLOOD_DDCTBL_AMT
TITLE   ALIAS : BLOOD_DDCTBL_AMT

LENGTH   : 9.2   SIGNED : Y

SOURCE   : CWF

325. Revenue Center Cash Deductible Amount
                         6   4492   4497   PACK

Effective with Version 'I' the amount of cash
deductible the beneficiary paid for the line
item service.

NOTE1: This field is populated for those claims
that are required to process through Outpatient

PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be
populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion
OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated
on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the
dates of service.

```
DB2      ALIAS : REV_CASH_DDCTBL
SAS      ALIAS : REVDCTBL
STANDARD ALIAS : REV_CNTR_CASH_DDCTBL_AMT
TITLE    ALIAS : CASH_DDCTBL

LENGTH         : 9.2    SIGNED : Y

SOURCE         : CWF
```

326. Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount
                         6   4498   4503   PACK

Effective with Version 'I', the amount of
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 is populated for those claims

that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. The above claim types could have lines that
are not required to price under OPPS rules so those
lines would not have data in this field.

NOTE2: 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.

NOTE3: It has been discovered that this field may be
populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion
OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated
on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the
dates of service.

DB2   ALIAS : ADJSTD_COINSRNC
SAS   ALIAS : WAGEADJ
STANDARD ALIAS : REV_CNTR_WAGE_ADJSTD_COINS_AMT
TITLE   ALIAS : WAGE_ADJSTD_COINS

LENGTH   : 9.2   SIGNED : Y

SOURCE   : CWF

327. Revenue Center Reduced Coinsurance Amount
                          6   4504   4509   PACK

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: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: The reduced coinsurance amount cannot
be lower than 20% of the payment rate for the
APC line.

NOTE3: It has been discovered that this field may be
populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion
OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated
on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the
dates of service.

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

LENGTH   : 9.2   SIGNED : Y

SOURCE   : CWF

328. Revenue Center 1st Medicare Secondary Payer Paid Amount
                          6   4510   4515   PACK

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

                              NOTE1: This field is populated for those claims
                              that are required to process through Outpatient
                              PPS Pricer. The type of bills (TOB) required to
                              process through are: 12X, 13X, 14X (except Maryland
                              providers, Indian Health Providers, hospitals located
                              in American Samoa, Guam and Saipan and Critical
                              Access Hospitals (CAH)); 76X; 75X and 34X if
                              certain HCPCS are on the bill; and any outpatient
                              type of bill with a condition code '07' and certain
                              HCPCS. These claim types could have lines that are
                              not required to price under OPPS rules so those
                              lines would not have data in this field.

                              Additional exception: Virgin Island hospitals and
                              hospitals that furnish only inpatient Part B services
                              with dates of service 1/1/02 and forward.

                              NOTE2: It has been discovered that this field may be
                              populated with data on claims with dates of service
                              prior to 7/00 (implementation of Claim Line Expansion
                              OPPS/HHPPS). The original understanding of the new
                              revenue center fields was that data would be populated
                              on claims with dates of service 7/00 and forward. Data
                              has been found in claims with dates of service prior to
                              7/00 because the Standard Systems have processed any
                              claim coming in 7/00 and after, meeting the above criteria,
                              through the Outpatient Code Editor (OCE) regardless of the
                              dates of service.

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

                              LENGTH   : 9.2   SIGNED : Y

                              SOURCE   : CWF

329. Revenue Center 2nd Medicare Secondary Payer Paid Amount
                          6   4516   4521   PACK

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

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be
populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion
OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated
on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the
dates of service.

```
DB2      ALIAS : REV_MSP2_PD_AMT
SAS      ALIAS : REV_MSP2
STANDARD ALIAS : REV_CNTR_MSP2_PD_AMT
TITLE    ALIAS : MSP PAID AMOUNT

LENGTH         : 9.2    SIGNED : Y

SOURCE         : CWF
```

330. Revenue Center Provider Payment Amount
                        6   4522   4527   PACK

Effective with Version 'I', the amount paid

to the provider for the services reported
on the line item.

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to
the present, the OPPS revenue center fields are
being processed differently by FISS and APASS
(standard systems). For more information on OPPS
data problems for this time period see Limitations
Appendix. The following is how each system handles
this field:

FISS: populated correctly with provider payment
amount

APASS: provider payment amount plus interest on
1st revenue center line (CMM will instruct
APASS not to include interest)

Currently, the following FI numbers are under the APASS
system and all other FI numbers are under FISS. See
FI_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)
00430 -- Washington/Alaska (until 11/1/2003)
00310 -- North Carolina BC (until 12/1/2003)
00370 -- Rhode Island (until 2/1/2004)
00270 -- New Hampshire/Vermont (until 3/1/2004)
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be

populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion
OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated
on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the
dates of service.

```
DB2      ALIAS : REV_PRVDR_PMT_AMT
SAS      ALIAS : RPRVDPMT
STANDARD ALIAS : REV_CNTR_PRVDR_PMT_AMT
TITLE    ALIAS : REV_PRVDR_PMT

LENGTH         : 9.2    SIGNED : Y

SOURCE         : CWF
```

331. Revenue Center Beneficiary Payment Amount
```
                    6    4528    4533    PACK
```

Effective with Version I, the amount paid
to the beneficiary for the services reported
on the line item.

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be
populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion

OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated
on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the
dates of service.

```
DB2      ALIAS : REV_BENE_PMT_AMT
SAS      ALIAS : RBENEPMT
STANDARD ALIAS : REV_CNTR_BENE_PMT_AMT
TITLE    ALIAS : REV_BENE_PMT

LENGTH         : 9.2    SIGNED : Y

SOURCE         : CWF
```

332. Revenue Center Patient Responsibility Payment Amount
                                6   4534   4539   PACK

Effective with Version I, the amount paid
by the beneficiary to the provider for the
line item service.

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to
present, the OPPS revenue center fields are being
processed differently by FISS and APASS (standard
systems). For more information on OPPS data problems
for this time period see the Limitations Appendix. The

following is how each system is handling this field:

FISS: populating correctly (sum of coinsurance and
deductible)

APASS: not populating this field

Currently, the following FI numbers are under the APASS
system and all other FI numbers are under FISS. See
FI_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)
00430 -- Washington/Alaska (until 11/1/2003)
00310 -- North Carolina BC (until 12/1/2003)
00370 -- Rhode Island (until 2/1/2004)
00270 -- New Hampshire/Vermont (until 3/1/2004)
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be
populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion
OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated
on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the
dates of service.

DB2   ALIAS : REV_PTNT_RESP_AMT
SAS   ALIAS : PTNTRESP
STANDARD ALIAS : REV_CNTR_PTNT_RESP_PMT_AMT
TITLE   ALIAS : REV_PTNT_RESP

LENGTH   : 9.2   SIGNED : Y

SOURCE   : CWF

333. Revenue Center Payment Amount
                        6   4540   4545   PACK

Effective with Version 'I', the line item
Medicare payment amount for the specific
revenue center.

NOTE1: This field is populated for those claims

that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to
present, the OPPS revenue center fields are being
processed differently by FISS and APASS (standard
systems). For more information on OPPS data problems
for this time period see the Limitations Appendix. The
following is how each system is handling this field:

FISS: this field contains provider reimbursement.

APASS: provider payment amount plus coinsurance and
deductible (should not include coinsurance and
deductible). Users should rely on provider
payment amount field for the trust fund
payment.

Currently, the following FI numbers are under the APASS
system and all other FI numbers are under FISS. See
FI_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)
00430 -- Washington/Alaska (until 11/1/2003)
00310 -- North Carolina BC (until 12/1/2003)
00370 -- Rhode Island (until 2/1/2004)
00270 -- New Hampshire/Vermont (until 3/1/2004)
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be
populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion
OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated

on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the
dates of service.

```
DB2      ALIAS : REV_CNTR_PMT_AMT
SAS      ALIAS : REVPMT
STANDARD ALIAS : REV_CNTR_PMT_AMT

LENGTH         : 9.2    SIGNED : Y

SOURCE         : CWF

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

334. Revenue Center Total Charge Amount

```
              6    4546    4551    PACK
```

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 Inpatient Rehabilitation Facility (IFR) PPS, when
                            the revenue center code = '0024', the total charges will
                            be zero.  For accommodation revenue codes (010X - 021X),
                            total charges must equal the rate times the units.

                            (6)  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).

                            DB2      ALIAS : REV_TOT_CHRG_AMT
                            SAS      ALIAS : REV_CHRG
                            STANDARD ALIAS : REV_CNTR_TOT_CHRG_AMT
                            TITLE    ALIAS : REVENUE_CENTER_CHARGES

                            LENGTH        : 9.2    SIGNED : Y

                            COMMENTS :
                            Prior to Version H the size of this field was:
                            S9(7)V99.

                            SOURCE        : CWF

                            LIMITATIONS :

                              REFER TO :
                               MLTPL_REV_CNTR_0001_CD_LIM
                               REV_CNTR_TOT_CHRG_AMT_LIM

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

335. Revenue Center Non-Covered Charge Amount
                       6    4552    4557    PACK

                            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.

                            DB2      ALIAS : REV_NCVR_CHRG_AMT
                            SAS      ALIAS : REV_NCVR
                            STANDARD ALIAS : REV_CNTR_NCVR_CHRG_AMT
                            TITLE    ALIAS : REV_CENTER_NONCOVERED_CHARGES
```

```
                                 LENGTH          : 9.2    SIGNED : Y

                                 SOURCE          : CWF

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

336. Revenue Center Deductible Coinsurance Code
                  1    4558    4558    CHAR

                                 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

                                 LENGTH          : 1

                                 SOURCE          : CWF

                                 CODE TABLE      : REV_CNTR_DDCTBL_COINSRNC_TB

337. Revenue Center Consolidated Billing Code
                  1    4559    4559    CHAR

                                 Effective 1/1/2004 with the implementation of NCH/NMUD
                                 CR#1, this code is reflected on outpatient claims only
                                 to identify those line item services (i.e. therapy
                                 and nonroutine supply services) that are subject
                                 to SNF and Home Health consolidated billing. If the
                                 line item service was paid by an intermediary prior
                                 to the submission of the SNF or home health claim
                                 an adjustment for the outpatient claim will be submitted
                                 identifying those services that are subject to
                                 consolidated billing.

                                 NOTE1:  Prior to 10/2005 (implementation of NCH/NMUD
                                 CR#2), this data was stored in position 175 (FILLER)
                                 in the revenue center trailer.

                                 NOTE2:  Effective July 2005, this data will no longer
                                 be coming into the NCH.  This process is being handled
                                 in the new CWF override processing.

                                 DB2      ALIAS : CNSLDTD_BLG_CD
```

```
                               SAS      ALIAS : RCNSLDTD
                               STANDARD ALIAS : REV_CNTR_CNSLDTD_BLG_CD

                               LENGTH         : 1

                               SOURCE         : CWF

                               CODE TABLE     : REV_CNTR_CNSLDTD_BLG_TB
```

338. Revenue Center Status Indicator Code
```
                    2   4560   4561   CHAR
```

Effective 10/3/2005 with the implementation of NCH/NMUD
CR#2, the code used to identify the status of the
line item service. This field along with the
payment method indicator field is used to identify
how the service was priced for payment.

NOTE1: This 2-byte indicator is being added due to
an expansion of a field that currently exist on the
revenue center trailer. The status indicator is
currently the 1st position of the Revenue Center
Payment Method Indicator Code. The payment method
indicator code is being split into two 2-byte
fields (payment indicator and status indicator). The
expanded payment indicator will continue to be stored
in the existing payment method indicator field. The
split of the current payment method indicator field
is due to the expansion of both pieces of date from
1-byte to 2-bytes.

NOTE2: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services.

```
                                 DB2      ALIAS : REV_STUS_IND_CD
                                 SAS      ALIAS : RSTUSIND
                                 STANDARD ALIAS : REV_CNTR_STUS_IND_CD

                                 LENGTH         : 2

                                 SOURCE         : CWF

                                 CODE TABLE     : REV_CNTR_STUS_IND_TB
```

339. Revenue Center Duplicate Claim Check Indicator Code
```
                 1    4562    4562    CHAR

                                 Effective 1/1/2009 with the implementation of NCH/NMUD
                                 CR#4, the code used to identify an item or service that
                                 appeared to be a duuplicate but has been reviewed by an
                                 FI or MAC and appropriately approved for payment.

                                 DB2      ALIAS : DUP_CLM_CHK_IND_CD
                                 SAS      ALIAS : DUP-CHK
                                 STANDARD ALIAS : REV_CNTR_DUP_CLM_CHK_IND_CD

                                 LENGTH         : 1

                                 CODE TABLE     : REV_CNTR_DUP_CLM_CHK_IND_TB
```

340. Revenue Center APC Buffer Code
```
                 2    4563    4564    CHAR

                                 APC - Ambulatory Payment Classification
                                 Effective 1/1/2009 with the implementation of CR#4, the
                                 code used to identify related line items that make up a
                                 composite APC group.  This field is only applicable to
                                 outpatient PPS claims.

                                 DB2      ALIAS : REV_CNTR_BUFR_CD
                                 SAS      ALIAS : APCBUFR
                                 STANDARD ALIAS : REV_CNTR_APC_BUFR_CD

                                 LENGTH         : 2

                                 CODE TABLE     : REV_CNTR_APC_BUFR_TB
```

341. Revenue Center Rendering Physician NPI Num
```
                 10   4565    4574    CHAR

                                 Effective with Version 'J', the NPI of the rendering
```

```
                                         physician who performed the service.

                                         DB2      ALIAS : RNDRNG_NPI_NUM
                                         SAS      ALIAS : REVNPI
                                         STANDARD ALIAS : REV_CNTR_RNDRNG_PHYSN_NPI_NUM

                                         LENGTH        : 10

                                         LIMITATIONS :

                                           REFER TO :
                                           REV_RNDRNG_PHYSN_NPI_NUM_LIM

342. Revenue Center Rendering Physician Surname
                     6    4575   4580    CHAR

                                         Effective with Version 'J', the 6 position last name
                                         of the rendering physician who performed the service.

                                         DB2      ALIAS : RNDRNG_SRNM_NAME
                                         SAS      ALIAS : REVSRNM
                                         STANDARD ALIAS : REV_CNTR_RNDRNG_SRNM_NAME

                                         LENGTH        : 6

343. Revenue Center Paperwork (PWK) Code
                     2    4581   4582    CHAR

                                         Effective with CR#6, the code used to indicate a provider
                                         has submitted an electronic claim that requires additional
                                         documentation.

                                         DB2      ALIAS : REV_CNTR_PWK_CD
                                         STANDARD ALIAS : REV_CNTR_PWK_CD

                                         LENGTH        : 2

                                         CODE TABLE    : REV_CNTR_PWK_TB

344. Rendering Physician Specialty Code
                     2    4583   4584    CHAR

                                         Effective with CR#7, the code used to identify the
                                         CMS specialty code corresponding to the rendering
                                         physician at the revenue center line.

                                         NOTE:  Medicare needs to identify primary physicians/
```

```
                             practitioners of service not only for use in standard
                             claims transactions but also for review, fraud detection,
                             and planning purposes.  In order to do this, CMS must
                             be able to determine the rendering physician/practitioner
                             for each service billed to Medicare and store this infor-
                             mation in our databases that serve as the source for data
                             analysis.

                             DB2       ALIAS : REV_CNTR_SPCLTY_CD
                             SAS       ALIAS : RSPCLTY
                             STANDARD ALIAS : REV_CNTR_PHYSN_SPCLTY_CD

                             LENGTH         : 2

                             COMMENTS :
                             (CMS CR7578)

                             LIMITATIONS :

                               REFER TO :
                               REV_CNTR_RNDRNG_SPCLTY_CD_LIM

                             CODE TABLE     : CMS_PRVDR_SPCLTY_TB

345. Revenue Center Therapy CAP Indicator 1 Code
                     1    4585    4585    CHAR

                             Effective with Version 'K', the field used to
                             identify whether the claim line is subject to a therapy cap.

                             DB2       ALIAS : REV_THRPY_CAP_1_CD
                             SAS       ALIAS : RTHRPY1
                             STANDARD ALIAS : REV_CNTR_THRPY_CAP_IND_1_CD

                             LENGTH         : 1

                             CODE TABLE     : REV_CNTR_THRPY_CAP_IND_CD_TB

346. Revenue Center Therapy CAP Indicator 2 Code
                     1    4586    4586    CHAR

                             Effective with Version 'K', the field used to
                             identify whether the claim line is subject to a therapy cap.

                             DB2       ALIAS : REV_THRPY_CAP_2_CD
                             SAS       ALIAS : RTHRPY2
                             STANDARD ALIAS : REV_CNTR_THRPY_CAP_IND_2_CD
```

LENGTH   : 1

CODE TABLE   : REV_CNTR_THRPY_CAP_IND_CD_TB

347. Revenue Center Therapy CAP Indicator 3 Code
                    1   4587   4587   CHAR

Effective with Version 'K', the field used to
identify whether the claim line is subject to a therapy cap.

DB2   ALIAS : REV_THRPY_CAP_3_CD
SAS   ALIAS : RTHRPY3
STANDARD ALIAS : REV_CNTR_THRPY_CAP_IND_3_CD

LENGTH   : 1

CODE TABLE   : REV_CNTR_THRPY_CAP_IND_CD_TB

348. Revenue Center Therapy CAP Indicator 4 Code
                    1   4588   4588   CHAR

Effective with Version 'K', the field used to
identify whether the claim line is subject to a therapy cap.

DB2   ALIAS : REV_THRPY_CAP_4_CD
SAS   ALIAS : RTHRPY4
STANDARD ALIAS : REV_CNTR_THRPY_CAP_IND_4_CD

LENGTH   : 1

CODE TABLE   : REV_CNTR_THRPY_CAP_IND_CD_TB

349. Revenue Center Therapy CAP Indicator 5 Code
                    1   4589   4589   CHAR

Effective with Version 'K', the field used to
identify whether the claim line is subject to a therapy cap.

DB2   ALIAS : REV_THRPY_CAP_5_CD
SAS   ALIAS : RTHRPY5
STANDARD ALIAS : REV_CNTR_THRPY_CAP_IND_5_CD

LENGTH   : 1

CODE TABLE   : REV_CNTR_THRPY_CAP_IND_CD_TB

350. Revenue Center FPS Model Number
                               2   4590   4591   CHAR

                               Effective with Version 'K', this field identifies an
                               FPS analytic model that identifies claims that may
                               be high risk for fraud based on specific information.

                               DB2   ALIAS : REV_FPS_MODEL_NUM
                               SAS   ALIAS : RMODEL
                               STANDARD ALIAS : REV_CNTR_FPS_MODEL_NUM

                               LENGTH   : 2

351. Revenue Center FPS Reason Code
                               3   4592   4594   CHAR

                               Effective with Version 'K', this field identifies the
                               reason codes used to explain why a claim was not
                               paid or how the claim was paid. These codes also
                               show the reason for any claim financial adjustment
                               such as denial, reductions or increases in payment.

                               DB2   ALIAS : REV-FPS-RSN-CD
                               SAS   ALIAS : RFPSRSN
                               STANDARD ALIAS : REV_CNTR_FPS_RSN_CD

                               LENGTH   : 3

                               CODE TABLE   : CLM_ADJ_RSN_TB

352. Revenue Center FPS Remark Code
                               5   4595   4599   CHAR

                               Effective with Version 'K', the codes used to
                               convey information about remittance processing or
                               to provide a supplemental explanation for an
                               adjustment already described by a Claim
                               Adjustment Reason Code.

                               DB2   ALIAS : REV_FPS_RMRK_CD
                               SAS   ALIAS : RFPSRMRK
                               STANDARD ALIAS : REV_CNTR_FPS_RMRK_CD

                               LENGTH   : 5

                               CODE TABLE   : CLM_RMTNC_ADVC_TB

353. Revenue Center FPS MSN 1 Code
                         5   4600   4604   CHAR

                                Effective with Version 'K', the field used to
                                identify the Medicare Secondary Notice Code.

                                DB2   ALIAS : REV_FPS_MSN_1_CD
                                SAS   ALIAS : RFPSMSN1
                                STANDARD ALIAS : REV_CNTR_FPS_MSN_1_CD

                                LENGTH   : 5

                                CODE TABLE   : CLM_FPS_MSN_CD_TB

354. Revenue Center FPS MSN 2 Code
                         5   4605   4609   CHAR

                                Effective with Version 'K', the field used to
                                identify the Medicare Secondary Notice Code.

                                DB2   ALIAS : REV_FPS_MSN_2_CD
                                SAS   ALIAS : RFPSMSN2
                                STANDARD ALIAS : REV_CNTR_FPS_MSN_2_CD

                                LENGTH   : 5

                                CODE TABLE   : CLM_FPS_MSN_CD_TB

355. Revenue Center Patient/Initial Visit Add-On Payment Amount
                         6   4610   4615   PACK

                                Effective with CR#9 (October 2014 release), this field represents
                                a base rate increase factor of 1.3516 for new patient initial
                                preventive physical examination (IPPE) and annual wellness
                                visit.

                                NOTE: This field only applies to Outpatient claims.

                                DB2   ALIAS : REV_ADD_ON_AMT
                                SAS   ALIAS : ADDONAMT
                                STANDARD ALIAS : REV_CNTR_PTNT_ADD_ON_PMT_AMT

                                LENGTH   : 9.2   SIGNED : Y

356. Revenue Center Prior Authorization Indicator Code
                         4   4616   4619   CHAR

Effective with CR#9 (October 2014 release), this indicator is assigned by CMS for each prior authorization program to define the applicable line of busines (i.e. Part A, Part B, DME, Home Health and Hospice).

NOTE: This field applies to all institutional claim.

```
DB2        ALIAS : REV_AUTHRZTN_CD
SAS        ALIAS : REVPRIOR
STANDARD ALIAS : REV_CNTR_PRIOR_AUTHRZTN_IND_CD

LENGTH         : 4

CODE TABLE     : REV_CNTR_PRIOR_AUTHRZTN_TB
```

357. Revenue Center Unique Tracking Number
                 14   4620   4633   CHAR

Effective with CR#9 (October 2014 release), this field represents the number assigned to each prior authorization request.

NOTE: This field applies to all institutional claims.

```
DB2        ALIAS : REV_UNIQ_TRKNG_NUM
SAS        ALIAS : REVTRKNG
STANDARD ALIAS : REV_CNTR_UNIQ_TRKNG_NUM

LENGTH         : 14

DERIVATIONS :
Position 1 - 2 = MAC Identifier (e.g. RR for Railroad,
OF = Jurisdiction F, 05 = Jurisdiction
5, etc.)
Position 3     = Line of Business (e.g. A = Part A,
B = Part B, D = DME & H = Home Health
Hospice)
Position 4- 14 = a unique sequence number assigned by
the Shared System
```

358. Revenue Center Representative Payee (RP) Indicator Code
                 1   4634   4634   CHAR

Effective with CR#11, this field will be used to designate by-passing of the prior authorization processing for claims with a representative payee when an 'R' is present in the field.

```
                               NOTE:  Data will not start coming in until April 2016.  This field
                               was added to the January 2016 release because our workload (FA fix)
                               will not allow us to implement another CR in April.


                               DB2       ALIAS : REV_CNTR_RP_IND_CD
                               SAS       ALIAS : RCRPIND
                               STANDARD ALIAS : REV_CNTR_RP_IND_CD


                               LENGTH         : 1


                               SOURCE         : CWF


                               CODE TABLE     : RP_IND_TB
```

359. Revenue Center Transitional Drug Add-On Payment Amount
```
                    6    4635   4640    PACK


                               Effective with CR#13 (January 2018 release), the amount for the
                               Transitional Drug Add-On Payment Adjustment (TDAPA) for ESRD
                               claims (72X) with injectable, intraveneous, and oral
                               calcimimetics when reported with an AX modifier.   These
                               services qualify for an add-on payment from the ESRD Pricer.


                               NOTE:  This field only applies to Outpatient claims.


                               DB2       ALIAS : TRNSTNL_DRUG_AMT
                               SAS       ALIAS : TDAPAAMT
                               STANDARD ALIAS : REV_CNTR_TRNSTNL_DRUG_AMT


                               LENGTH         : 7.4    SIGNED : Y


                               SOURCE         : CWF


                               EDIT RULES :
                                    $$$$$$$cccc
```

360. FILLER
```
              349    4641   4989    CHAR


                               DB2       ALIAS : H_FILLER_6
                               STANDARD ALIAS : FILLER


                               LENGTH         : 349
```

361. End of Record Code
```
              3    31654   31656    CHAR
```

Effective with Version 'I', the code used
to identify the end of a record/segment or
the end of the claim.

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

                 LENGTH   : 3

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

                 SOURCE   : NCH

                 CODE TABLE   : END_REC_TB

                 QUERY: RIFQQ11, RIFQQ21 ON DB2T
          ***********END OF MAIN REPORT FOR RECORD: FI_IP_SNF_CLM_REC***********

1

  TABLE OF CODES APPENDIX FOR RECORD: FI_IP_SNF_CLM_REC, STATUS: PROD, VERSION: 19068
  PRINTED: 07/10/2019, USER: A4KJ, DATA SOURCE: CA REPOSITORY ON DB2T

 BENE_CWF_LOC_TB   Beneficiary Common Working File Location Table

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

 BENE_IDENT_TB   Beneficiary Identification Code (BIC) Table

        Social Security Administration:

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

```
DD = Aged widow (4th claimant)
DG = Aged widow (5th claimant)
DH = Aged widower (3rd claimant)
DJ = Aged widower (4th claimant)
DK = Aged widower (5th claimant)
DL = Remarried widow (4th claimant)
DM = Surviving divorced husband (2nd
     claimant)
DN = Remarried widow (5th claimant)
DP = Remarried widower (2nd claimant)
DQ = Remarried widower (3rd claimant)
DR = Remarried widower (4th claimant)
DS = Surviving divorced husband (3rd
     claimant)
DT = Remarried widower (5th claimant)
DV = Surviving divorced wife (3rd claimant)
DW = Surviving divorced wife (4th claimant)
DX = Surviving divorced husband (4th
     claimant)
DY = Surviving divorced wife (5th claimant)
DZ = Surviving divorced husband (5th
     claimant)
E  = Mother (widow) (1st claimant)
E1 = Surviving divorced mother (1st
     claimant)
E2 = Mother (widow) (2nd claimant)
E3 = Surviving divorced mother (2nd
     claimant)
E4 = Father (widower) (1st claimant)
E5 = Surviving divorced father (widower)
     (1st claimant)
E6 = Father (widower) (2nd claimant)
E7 = Mother (widow) (3rd claimant)
E8 = Mother (widow) (4th claimant)
E9 = Surviving divorced father (widower)
     (2nd claimant)
EA = Mother (widow) (5th claimant)
EB = Surviving divorced mother (3rd
     claimant)
EC = Surviving divorced mother (4th
     claimant)
ED = Surviving divorced mother (5th
     claimant
EF = Father (widower) (3rd claimant)
EG = Father (widower) (4th claimant)
EH = Father (widower) (5th claimant)
EJ = Surviving divorced father (3rd
```

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              claimant)
EK = Surviving divorced father (4th
     claimant)
EM = Surviving divorced father (5th
     claimant)
F1 = Father
F2 = Mother
F3 = Stepfather
F4 = Stepmother
F5 = Adopting father
F6 = Adopting mother
F7 = Second alleged father
F8 = Second alleged mother
J1 = Primary prouty entitled to HIB
     (less than 3 Q.C.) (general fund)
J2 = Primary prouty entitled to HIB
     (over 2 Q.C.) (RSI trust fund)
J3 = Primary prouty not entitled to HIB
     (less than 3 Q.C.) (general fund)
J4 = Primary prouty not entitled to HIB
     (over 2 Q.C.) (RSI trust fund)
K1 = Prouty wife entitled to HIB (less than
     3 Q.C.) (general fund) (1st claimant)
K2 = Prouty wife entitled to HIB (over 2
     Q.C.) (RSI trust fund) (1st claimant)
K3 = Prouty wife not entitled to HIB (less
     than 3 Q.C.) (general fund) (1st
     claimant)
K4 = Prouty wife not entitled to HIB (over
     2 Q.C.) (RSI trust fund) (1st
     claimant)
K5 = Prouty wife entitled to HIB (less than
     3 Q.C.) (general fund) (2nd claimant)
K6 = Prouty wife entitled to HIB (over 2
     Q.C.) (RSI trust fund) (2nd claimant)
K7 = Prouty wife not entitled to HIB (less
     than 3 Q.C.) (general fund) (2nd
     claimant)
K8 = Prouty wife not entitled to HIB (over
     2 Q.C.) (RSI trust fund) (2nd
     claimant)
K9 = Prouty wife entitled to HIB (less than
     3 Q.C.) (general fund) (3rd claimant)
KA = Prouty wife entitled to HIB (over 2
     Q.C.) (RSI trust fund) (3rd claimant)
KB = Prouty wife not entitled to HIB (less
     than 3 Q.C.) (general fund) (3rd
```

```
           claimant)
KC = Prouty wife not entitled to HIB (over
     2 Q.C.) (RSI trust fund) (3rd
     claimant)
KD = Prouty wife entitled to HIB (less than
     3 Q.C.) (general fund) (4th claimant)
KE = Prouty wife entitled to HIB (over 2 Q.C
     (4th claimant)
KF = Prouty wife not entitled to HIB (less
     than 3 Q.C.)(4th claimant)
KG = Prouty wife not entitled to HIB (over
     2 Q.C.)(4th claimant)
KH = Prouty wife entitled to HIB (less than
     3 Q.C.)(5th claimant)
KJ = Prouty wife entitled to HIB (over 2
     Q.C.) (5th claimant)
KL = Prouty wife not entitled to HIB (less
     than 3 Q.C.)(5th claimant)
KM = Prouty wife not entitled to HIB (over
     2 Q.C.) (5th claimant)
M  = Uninsured-not qualified for deemed HIB
M1 = Uninsured-qualified but refused HIB
T  = Uninsured-entitled to HIB under deemed
     or renal provisions
TA = MQGE (primary claimant)
TB = MQGE aged spouse (first claimant)
TC = MQGE disabled adult child (first claimant)
TD = MQGE aged widow(er) (first claimant)
TE = MQGE young widow(er) (first claimant)
TF = MQGE parent (male)
TG = MQGE aged spouse (second claimant)
TH = MQGE aged spouse (third claimant)
TJ = MQGE aged spouse (fourth claimant)
TK = MQGE aged spouse (fifth claimant)
TL = MQGE aged widow(er) (second claimant)
TM = MQGE aged widow(er) (third claimant)
TN = MQGE aged widow(er) (fourth claimant)
TP = MQGE aged widow(er) (fifth claimant)
TQ = MQGE parent (female)
TR = MQGE young widow(er) (second claimant)
TS = MQGE young widow(er) (third claimant)
TT = MQGE young widow(er) (fourth claimant)
TU = MQGE young widow(er) (fifth claimant)
TV = MQGE disabled widow(er) fifth claimant
TW = MQGE disabled widow(er) first claimant
TX = MQGE disabled widow(er) second claimant
TY = MQGE disabled widow(er) third claimant
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TZ = MQGE disabled widow(er) fourth claimant
T2-T9 = Disabled child (second to ninth
        claimant)
W  = Disabled widow, age 50 or over (1st
     claimant)
W1 = Disabled widower, age 50 or over (1st
     claimant)
W2 = Disabled widow (2nd claimant)
W3 = Disabled widower (2nd claimant)
W4 = Disabled widow (3rd claimant)
W5 = Disabled widower (3rd claimant)
W6 = Disabled surviving divorced wife (1st
     claimant)
W7 = Disabled surviving divorced wife (2nd
     claimant)
W8 = Disabled surviving divorced wife (3rd
     claimant)
W9 = Disabled widow (4th claimant)
WB = Disabled widower (4th claimant)
WC = Disabled surviving divorced wife (4th
     claimant)
WF = Disabled widow (5th claimant)
WG = Disabled widower (5th claimant)
WJ = Disabled surviving divorced wife (5th
     claimant)
WR = Disabled surviving divorced husband
     (1st claimant)
WT = Disabled surviving divorced husband
     (2nd claimant)

Railroad Retirement Board:

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

10 = Retirement - employee or annuitant
80 = RR pensioner (age or disability)
14 = Spouse of RR employee or annuitant
     (husband or wife)
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     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)
```

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BENE_MDCR_STUS_TB                        CWF Beneficiary Medicare Status Table

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

```
BENE_PRMRY_PYR_TB                        Beneficiary Primary Payer Table

     A = Working aged bene/spouse with employer
         group health plan (EGHP)
     B = End stage renal disease (ESRD) beneficiary
         in the 18 month coordination period with
         an employer group health plan
     C = Conditional payment by Medicare; future
         reimbursement expected
     D = Automobile no-fault (eff. 4/97; Prior
         to 3/94, also included any liability
         insurance)
     E = Workers' compensation
     F = Public Health Service or other federal
         agency (other than Dept. of Veterans
         Affairs)
     G = Working disabled bene (under age 65
         with LGHP)
```

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     H = Black Lung
     I = Dept. of Veterans Affairs
     J = Any liability insurance
         (eff. 3/94 - 3/97)
     L = Any liability insurance (eff. 4/97)
         (eff. 12/90 for carrier claims and 10/93
         for FI claims; obsoleted for all claim
         types 7/1/96)

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

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

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

                 ***Prior to 12/90***

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

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




BENE_RACE_TB                          Beneficiary Race Table


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

```
BENE_SEX_IDENT_TB                          Beneficiary Sex Identification Table

        1 = Male
        2 = Female
        0 = Unknown



CLM_ADJ_RSN_TB                             Claim Adjustment Reason Code

        1    = Deductible Amount
               Start: 01/01/1995
        2    = Coinsurance Amount
               Start: 01/01/1995
        3    = Co-payment Amount
               Start: 01/01/1995
        4    = The procedure code is inconsistent with the
               modifier used or a required modifier is
               missing. Note: Refer to the 835 Healthcare
               Policy Identification Segment (loop 2110
               Service Payment Information REF), if
               present.
               Start: 01/01/1995
        5    = The procedure code/bill type is
               inconsistent with the place of service.
               Note: Refer to the 835 Healthcare Policy
               Identification Segment (loop 2110 Service
               Payment Information REF), if present.
               Start: 01/01/1995
        6    = The procedure/revenue code is inconsistent
               with the patient's age. Note: Refer to the
               835 Healthcare Policy Identification
               Segment (loop 2110 Service Payment
               Information REF), if present.
               Start: 01/01/1995
        7    = The procedure/revenue code is inconsistent
               with the patient's gender. Note: Refer to
               the 835 Healthcare Policy Identification
               Segment (loop 2110 Service Payment
               Information REF), if present.
               Start: 01/01/1995
        8    = The procedure code is inconsistent with the
               provider type/specialty (taxonomy). Note:
               Refer to the 835 Healthcare Policy
```

Identification Segment (loop 2110 Service
         Payment Information REF), if present.
         Start: 01/01/1995
9   = The diagnosis is inconsistent with the
         patient's age. Note: Refer to the 835
         Healthcare Policy Identification Segment
         (loop 2110 Service Payment Information REF),
         if present.
         Start: 01/01/1995
10   = The diagnosis is inconsistent with the
         patient's gender. Note: Refer to the 835
         Healthcare Policy Identification Segment
         (loop 2110 Service Payment Information REF),
         if present.
         Start: 01/01/1995
11   = The diagnosis is inconsistent with the
         procedure. Note: Refer to the 835
         Healthcare Policy Identification Segment
         (loop 2110 Service Payment Information REF),
         if present.
         Start: 01/01/1995
         Last Modified: 09/20/2009
12   = The diagnosis is inconsistent with the
         provider type. Note: Refer to the 835
         Healthcare Policy Identification Segment
         (loop 2110 Service Payment Information REF),
         if present.
         Start: 01/01/1995
13   = The date of death precedes the date of
         service.
         Start: 01/01/1995
14   = The date of birth follows the date of
         service.
         Start: 01/01/1995
15   = The authorization number is missing,
         invalid, or does not apply to the billed
         services or provider.
         Start: 01/01/1995
16   = Claim/service lacks information which is
         needed for adjudication. At least one
         Remark Code must be provided (may be
         comprised of either the NCPDP Reject
         Reason Code, or Remittance Advice Remark
         Code that is not an ALERT.)
         Start: 01/01/1995
17   = Requested information was not provided or
         was insufficient/incomplete. At least one

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      Remark Code must be provided (may be
      comprised of either the Remittance Advice
      Remark Code or NCPDP Reject Reason Code.)
      Start: 01/01/1995
      Stop: 07/01/2009
18  = Duplicate claim/service. This change
      effective 1/1/2013: Exact duplicate claim/
      service (Use only with Group Code OA)
      Start: 01/01/1995
19  = This is a work-related injury/illness and
      thus the liability of the Worker's
      Compensation Carrier.
      Start: 01/01/1995
20  = This injury/illness is covered by the
      liability carrier.
      Start: 01/01/1995
21  = This injury/illness is the liability of
      the no-fault carrier.
      Start: 01/01/1995
22  = This care may be covered by another payer
      per coordination of benefits.
      Start: 01/01/1995
23  = The impact of prior payer(s) adjudication
      including payments and/or adjustments.
      (Use only with Group Code OA)
      Start: 01/01/1995
24  = Charges are covered under a capitation
      agreement/managed care plan.
      Start: 01/01/1995
25  = Payment denied. Your Stop loss deductible
      has not been met.
      Start: 01/01/1995
      Stop: 04/01/2008
26  = Expenses incurred prior to coverage.
      Start: 01/01/1995
27  = Expenses incurred after coverage terminated
      Start: 01/01/1995
28  = Coverage not in effect at the time the
      service was provided.
      Start: 01/01/1995
      Stop: 10/16/2003
      Notes: Redundant to codes 26&27.
29  = The time limit for filing has expired.
      Start: 01/01/1995
30  = Payment adjusted because the patient has
      not met the required eligibility, spend
      down, waiting, or residency requirements.
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        Start: 01/01/1995
        Stop: 02/01/2006
31  = Patient cannot be identified as our insured
        Start: 01/01/1995
32  = Our records indicate that this dependent is
        not an eligible dependent as defined.
        Start: 01/01/1995
33  = Insured has no dependent coverage.
        Start: 01/01/1995
34  = Insured has no coverage for newborns.
        Start: 01/01/1995
35  = Lifetime benefit maximum has been reached.
        Start: 01/01/1995
36  = Balance does not exceed co-payment amount.
        Start: 01/01/1995
        Stop: 10/16/2003
37  = Balance does not exceed deductible.
        Start: 01/01/1995
        Stop: 10/16/2003
38  = Services not provided or authorized by
        designated (network/primary care) providers.
        Start: 01/01/1995
        Stop: 01/01/2013
39  = Services denied at the time authorization/
        pre-certification was requested.
        Start: 01/01/1995
40  = Charges do not meet qualifications for
        emergent/urgent care. Note: Refer to the
        835 Healthcare Policy Identification
        Segment (loop 2110 Service Payment
        Information REF), if present.
        Start: 01/01/1995
41  = Discount agreed to in Preferred Provider
        contract.
        Start: 01/01/1995
        Stop: 10/16/2003
42  = Charges exceed our fee schedule or maximum
        allowable amount. (Use CARC 45)
        Start: 01/01/1995
        Stop: 06/01/2007
43  = Gramm-Rudman reduction.
        Start: 01/01/1995
        Stop: 07/01/2006
44  = Prompt-pay discount.
        Start: 01/01/1995
45  = Charge exceeds fee schedule/maximum
        allowable or contracted/legislated fee
```

arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)
Start: 01/01/1995
46 = This (these) service(s) is (are) not covered.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 96.
47 = This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
Start: 01/01/1995
Stop: 02/01/2006
48 = This (these) procedure(s) is (are) not covered.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 96.
49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
51 = These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe /order/perform the service billed.
Start: 01/01/1995
Stop: 02/01/2006

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53  = Services by an immediate relative or a
      member of the same household are not
      covered.
      Start: 01/01/1995
54  = Multiple physicians/assistants are not
      covered in this case. Note: Refer to the
      835 Healthcare Policy Identification
      Segment (loop 2110 Service Payment
      Information REF), if present.
      Start: 01/01/1995
55  = Procedure/treatment is deemed experimental/
      investigational by the payer. Note: Refer
      to the 835 Healthcare Policy Identification
      Segment (loop 2110 Service Payment
      Information REF), if present.
      Start: 01/01/1995
56  = Procedure/treatment has not been deemed
      'proven to be effective' by the payer.
      Note: Refer to the 835 Healthcare Policy
      Identification Segment (loop 2110 Service
      Payment Information REF), if present.
      Start: 01/01/1995
57  = Payment denied/reduced because the payer
      deems the information submitted does not
      support this level of service, this many
      services, this length of service, this
      dosage, or this day's supply.
      Start: 01/01/1995
      Stop: 06/30/2007
      Notes: Split into codes 150, 151, 152, 153
      and 154.
58  = Treatment was deemed by the payer to have
      been rendered in an inappropriate or
      invalid place of service. Note: Refer to
      the 835 Healthcare Policy Identification
      Segment (loop 2110 Service Payment
      Information REF), if present.
      Start: 01/01/1995
59  = Processed based on multiple or concurrent
      procedure rules. (For example multiple
      surgery or diagnostic imaging, concurrent
      anesthesia.) Note: Refer to the 835
      Healthcare Policy Identification Segment
      (loop 2110 Service Payment Information REF),
      if present.
      Start: 01/01/1995
60  = Charges for outpatient services are not
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              covered when performed within a period of
              time prior to or after inpatient services.
              Start: 01/01/1995
61  = Penalty for failure to obtain second
              surgical opinion. Note: Refer to the 835
              Healthcare Policy Identification Segment
              (loop 2110 Service Payment Information REF),
              if present.
              Start: 01/01/1995
62  = Payment denied/reduced for absence of,
              or exceeded, pre-certification/
              authorization.
              Start: 01/01/1995
              Stop: 04/01/2007
63  = Correction to a prior claim.
              Start: 01/01/1995
              Stop: 10/16/2003
64  = Denial reversed per Medical Review.
              Start: 01/01/1995
              Stop: 10/16/2003
65  = Procedure code was incorrect. This payment
              reflects the correct code.
              Start: 01/01/1995
              Stop: 10/16/2003
66  = Blood Deductible.
              Start: 01/01/1995
67  = Lifetime reserve days. (Handled in QTY,
              QTY01=LA)
              Start: 01/01/1995
              Stop: 10/16/2003
68  = DRG weight. (Handled in CLP12)
              Start: 01/01/1995
              Stop: 10/16/2003
69  = Day outlier amount.
              Start: 01/01/1995
70  = Cost outlier - Adjustment to compensate for
              additional costs.
              Start: 01/01/1995
71  = Primary Payer amount.
              Start: 01/01/1995
              Stop: 06/30/2000
              Notes: Use code 23.
72  = Coinsurance day. (Handled in QTY, QTY01=CD)
              Start: 01/01/1995
              Stop: 10/16/2003
73  = Administrative days.
              Start: 01/01/1995
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         Stop: 10/16/2003
74   = Indirect Medical Education Adjustment.
       Start: 01/01/1995
75   = Direct Medical Education Adjustment.
       Start: 01/01/1995
76   = Disproportionate Share Adjustment.
       Start: 01/01/1995
77   = Covered days. (Handled in QTY, QTY01=CA)
       Start: 01/01/1995
       Stop: 10/16/2003
78   = Non-Covered days/Room charge adjustment.
       Start: 01/01/1995
79   = Cost Report days. (Handled in MIA15)
       Start: 01/01/1995
       Stop: 10/16/2003
80   = Outlier days. (Handled in QTY, QTY01=OU)
       Start: 01/01/1995
       Stop: 10/16/2003
81   = Discharges.
       Start: 01/01/1995
       Stop: 10/16/2003
82   = PIP days.
       Start: 01/01/1995
       Stop: 10/16/2003
83   = Total visits.
       Start: 01/01/1995
       Stop: 10/16/2003
84   = Capital Adjustment. (Handled in MIA)
       Start: 01/01/1995
       Stop: 10/16/2003
85   = Patient Interest Adjustment (Use Only Group
       code PR)
       Start: 01/01/1995
       Notes: Only use when the payment of
       interest is the responsibility of the
       patient.
86   = Statutory Adjustment.
       Start: 01/01/1995
       Stop: 10/16/2003
       Notes: Duplicative of code 45.
87   = Transfer amount.
       Start: 01/01/1995
       Stop: 01/01/2012
88   = Adjustment amount represents collection
       against receivable created in prior
       overpayment.
       Start: 01/01/1995
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           Stop: 06/30/2007
89  = Professional fees removed from charges.
      Start: 01/01/1995
90  = Ingredient cost adjustment. Note: To be
      used for pharmaceuticals only.
      Start: 01/01/1995
91  = Dispensing fee adjustment.
      Start: 01/01/1995
92  = Claim Paid in full.
      Start: 01/01/1995
      Stop: 10/16/2003
93  = No Claim level Adjustments.
      Start: 01/01/1995
      Stop: 10/16/2003
      Notes: As of 004010, CAS at the claim level
      is optional.
94  = Processed in Excess of charges.
      Start: 01/01/1995
95  = Plan procedures not followed.
      Start: 01/01/1995
96  = Non-covered charge(s). At least one Remark
      Code must be provided (may be comprised of
      either the NCPDP Reject Reason Code, or
      Remittance Advice Remark Code that is not
      an ALERT.) Note: Refer to the 835
      Healthcare Policy Identification Segment
      (loop 2110 Service Payment Information REF),
      if present.
      Start: 01/01/1995
97  = The benefit for this service is included in
      the payment/allowance for another service/
      procedure that has already been adjudicated.
      Note: Refer to the 835 Healthcare Policy
      Identification Segment (loop 2110 Service
      Payment Information REF), if present.
      Start: 01/01/1995
98  = The hospital must file the Medicare claim
      for this inpatient non-physician service.
      Start: 01/01/1995
      Stop: 10/16/2003
99  = Medicare Secondary Payer Adjustment Amount.
      Start: 01/01/1995
      Stop: 10/16/2003
100 = Payment made to patient/insured/responsible
      party/employer.
      Start: 01/01/1995
101 = Predetermination: anticipated payment upon
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            completion of services or claim
            adjudication.
            Start: 01/01/1995
102 = Major Medical Adjustment.
            Start: 01/01/1995
103 = Provider promotional discount (e.g., Senior
            citizen discount).
            Start: 01/01/1995
104 = Managed care withholding.
            Start: 01/01/1995
105 = Tax withholding.
            Start: 01/01/1995
106 = Patient payment option/election not in
            effect.
            Start: 01/01/1995
107 = The related or qualifying claim/service was
            not identified on this claim. Note: Refer
            to the 835 Healthcare Policy Identification
            Segment (loop 2110 Service Payment
            Information REF), if present.
            Start: 01/01/1995
108 = Rent/purchase guidelines were not met.
            Note: Refer to the 835 Healthcare Policy
            Identification Segment (loop 2110 Service
            Payment Information REF), if present.
            Start: 01/01/1995
109 = Claim/service not covered by this payer/
            contractor. You must send the claim/service
            to the correct payer/contractor.
            Start: 01/01/1995
110 = Billing date predates service date.
            Start: 01/01/1995
111 = Not covered unless the provider accepts
            assignment.
            Start: 01/01/1995
112 = Service not furnished directly to the
            patient and/or not documented.
            Start: 01/01/1995
113 = Payment denied because service/procedure
            was provided outside the United States or
            as a result of war.
            Start: 01/01/1995
            Stop: 06/30/2007
            Notes: Use Codes 157, 158 or 159.
114 = Procedure/product not approved by the Food
            and Drug Administration.
            Start: 01/01/1995
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115 = Procedure postponed, canceled, or delayed.
      Start: 01/01/1995
116 = The advance indemnification notice signed
      by the patient did not comply with
      requirements.
      Start: 01/01/1995
117 = Transportation is only covered to the
      closest facility that can provide the
      necessary care.
      Start: 01/01/1995
118 = ESRD network support adjustment.
      Start: 01/01/1995
119 = Benefit maximum for this time period or
      occurrence has been reached.
      Start: 01/01/1995
120 = Patient is covered by a managed care plan.
      Start: 01/01/1995
      Stop: 06/30/2007
      Notes: Use code 24.
121 = Indemnification adjustment - compensation
      for outstanding member responsibility.
      Start: 01/01/1995
122 = Psychiatric reduction.
      Start: 01/01/1995
123 = Payer refund due to overpayment.
      Start: 01/01/1995
      Stop: 06/30/2007
      Notes: Refer to implementation guide for
      proper handling of reversals.
124 = Payer refund amount - not our patient.
      Start: 01/01/1995
      Stop: 06/30/2007
      Notes: Refer to implementation guide for
      proper handling of reversals.
125 =  Submission/billing error(s). At least one
      Remark Code must be provided (may be
      comprised of either the NCPDP Reject Reason
      Code, or Remittance Advice Remark Code that
      is not an ALERT.)
      Start: 01/01/1995
126 = Deductible -- Major Medical
      Start: 02/28/1997
      Stop: 04/01/2008
      Notes: Use Group Code PR and code 1.
127 = Coinsurance -- Major Medical
      Start: 02/28/1997
      Stop: 04/01/2008
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        Notes: Use Group Code PR and code 2.
128 = Newborn's services are covered in the
      mother's Allowance.
      Start: 02/28/1997
129 = Prior processing information appears
      incorrect. At least one Remark Code must
      be provided (may be comprised of either the
      NCPDP Reject Reason Code, or Remittance
      Advice Remark Code that is not an ALERT.)
      Start: 02/28/1997
130 = Claim submission fee.
      Start: 02/28/1997
131 = Claim specific negotiated discount.
      Start: 02/28/1997
132 = Prearranged demonstration project
      adjustment.
      Start: 02/28/1997
133 = The disposition of the claim/service is
      pending further review. This change
      effective 1/1/2013: The disposition of the
      claim/service is pending further review.
      (Use only with Group Code OA)
      Start: 02/28/1997
134 = Technical fees removed from charges.
      Start: 10/31/1998
135 = Interim bills cannot be processed.
      Start: 10/31/1998
136 = Failure to follow prior payer's coverage
      rules. (Use Group Code OA). This change
      effective 7/1/2013: Failure to follow prior
      payer's coverage rules. (Use only with
      Group Code OA)
      Start: 10/31/1998
137 = Regulatory Surcharges, Assessments,
      Allowances or Health Related Taxes.
      Start: 02/28/1999
138 = Appeal procedures not followed or time
      limits not met.
      Start: 06/30/1999
139 = Contracted funding agreement - Subscriber
      is employed by the provider of services.
      Start: 06/30/1999
140 = Patient/Insured health identification
      number and name do not match.
      Start: 06/30/1999
141 = Claim spans eligible and ineligible periods
      of coverage.
```

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              Start: 06/30/1999
              Stop: 07/01/2012
142 = Monthly Medicaid patient liability amount.
              Start: 06/30/2000
143 = Portion of payment deferred.
              Start: 02/28/2001
144 = Incentive adjustment, e.g. preferred
              product/service.
              Start: 06/30/2001
145 = Premium payment withholding
              Start: 06/30/2002
              Stop: 04/01/2008
              Notes: Use Group Code CO and code 45.
146 = Diagnosis was invalid for the date(s) of
              service reported.
              Start: 06/30/2002
147 = Provider contracted/negotiated rate expired
              or not on file.
              Start: 06/30/2002
148 = Information from another provider was not
              provided or was insufficient/incomplete.
              At least one Remark Code must be provided
              (may be comprised of either the NCPDP
              Reject Reason Code, or Remittance Advice
              Remark Code that is not an ALERT.)
              Start: 06/30/2002
149 = Lifetime benefit maximum has been reached
              for this service/benefit category.
              Start: 10/31/2002
150 = Payer deems the information submitted does
              not support this level of service.
              Start: 10/31/2002
151 = Payment adjusted because the payer deems
              the information submitted does not support
              this many/frequency of services.
              Start: 10/31/2002
152 = Payer deems the information submitted does
              not support this length of service. Note:
              Refer to the 835 Healthcare Policy
              Identification Segment (loop 2110 Service
              Payment Information REF), if present.
              Start: 10/31/2002
153 = Payer deems the information submitted does
              not support this dosage.
              Start: 10/31/2002
154 = Payer deems the information submitted does
              not support this day's supply.
```

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          Start: 10/31/2002
155 = Patient refused the service/procedure.
          Start: 06/30/2003
156 = Flexible spending account payments. Note:
          Use code 187.
          Start: 09/30/2003
          Stop: 10/01/2009
157 = Service/procedure was provided as a result
          of an act of war.
          Start: 09/30/2003
158 = Service/procedure was provided outside of
          the United States.
          Start: 09/30/2003
159 = Service/procedure was provided as a result
          of terrorism.
          Start: 09/30/2003
160 = Injury/illness was the result of an
          activity that is a benefit exclusion.
          Start: 09/30/2003
161 = Provider performance bonus
          Start: 02/29/2004
162 = State-mandated Requirement for Property and
          Casualty, see Claim Payment Remarks Code
          for specific explanation.
          Start: 02/29/2004
163 = Attachment referenced on the claim was not
          received.
          Start: 06/30/2004
164 = Attachment referenced on the claim was not
          received in a timely fashion.
          Start: 06/30/2004
165 = Referral absent or exceeded.
          Start: 10/31/2004
166 = These services were submitted after this
          payers responsibility for processing claims
          under this plan ended.
          Start: 02/28/2005
167 = This (these) diagnosis(es) is (are) not
          covered. Note: Refer to the 835 Healthcare
          Policy Identification Segment (loop 2110
          Payment Information REF), if present.
          Start: 06/30/2005
168 = Service(s) have been considered under the
          patient's medical plan. Benefits are not
          available under this dental plan.
          Start: 06/30/2005
169 = Alternate benefit has been provided.
```

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       Start: 06/30/2005
170 = Payment is denied when performed/billed by
      this type of provider. Note: Refer to the
      835 Healthcare Policy Identification
      Segment (loop 2110 Service Payment
      Information REF), if present.
      Start: 06/30/2005
171 = Payment is denied when performed/billed by
      this type of provider in this type of
      facility. Note: Refer to the 835 Healthcare
      Policy Identification Segment (loop 2110
      Service Payment Information REF), if
      present.
      Start: 06/30/2005
172 = Payment is adjusted when performed/billed
      by a provider of this specialty. Note:
      Refer to the 835 Healthcare Policy
      Identification Segment (loop 2110 Service
      Payment Information REF), if present.
      Start: 06/30/2005
173 = Service was not prescribed by a physician.
      This change effective 7/1/2013: Service/
      equipment was not prescribed by a
      physician.
      Start: 06/30/2005
174 = Service was not prescribed prior to
      delivery.
      Start: 06/30/2005
175 = Prescription is incomplete.
      Start: 06/30/2005
176 = Prescription is not current.
      Start: 06/30/2005
177 = Patient has not met the required
      eligibility requirements.
      Start: 06/30/2005
178 = Patient has not met the required spend
      down requirements.
      Start: 06/30/2005
179 = Patient has not met the required waiting
      requirements. Note: Refer to the 835
      Healthcare Policy Identification Segment
      (loop 2110 Service Payment Information REF)
      , if present.
      Start: 06/30/2005
180 = Patient has not met the required residency
      requirements.
      Start: 06/30/2005
```

181 = Procedure code was invalid on the date of
      service.
      Start: 06/30/2005
182 = Procedure modifier was invalid on the date
      of service.
      Start: 06/30/2005
183 = The referring provider is not eligible to
      refer the service billed. Note: Refer to
      the 835 Healthcare Policy Identification
      Segment (loop 2110 Service Payment
      Information REF), if present.
      Start: 06/30/2005
184 = The prescribing/ordering provider is not
      eligible to prescribe/order the service
      billed. Note: Refer to the 835 Healthcare
      Policy Identification Segment (loop 2110
      Service Payment Information REF), if
      present.
      Start: 06/30/2005
185 = The rendering provider is not eligible to
      perform the service billed. Note: Refer
      to the 835 Healthcare Policy Identification
      Segment (loop 2110 Service Payment
      Information REF), if present.
      Start: 06/30/2005
      Last Modified: 09/20/2009
186 = Level of care change adjustment.
      Start: 06/30/2005
187 = Consumer Spending Account payments
      (includes but is not limited to Flexible
      Spending Account, Health Savings Account,
      Health Reimbursement Account, etc.)
      Start: 06/30/2005
188 = This product/procedure is only covered when
      used according to FDA recommendations.
      Start: 06/30/2005
189 = 'Not otherwise classified' or 'unlisted'
      procedure code (CPT/HCPCS) was billed when
      there is a specific procedure code for this
      procedure/service
      Start: 06/30/2005
190 = Payment is included in the allowance for a
      Skilled Nursing Facility (SNF) qualified
      stay.
      Start: 10/31/2005
191 = Not a work related injury/illness and thus
      not the liability of the workers'

compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF)
Start: 10/31/2005

192 = Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.
Start: 10/31/2005

193 = Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
Start: 02/28/2006

194 = Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.
Start: 02/28/2006

195 = Refund issued to an erroneous priority payer for this claim/service.
Start: 02/28/2006

196 = Claim/service denied based on prior payer's coverage determination.
Start: 06/30/2006
Stop: 02/01/2007
Notes: Use code 136.

197 = Precertification/authorization/notification absent.
Start: 10/31/2006

198 = Precertification/authorization exceeded.
Start: 10/31/2006

199 = Revenue code and Procedure code do not match.
Start: 10/31/2006

200 = Expenses incurred during lapse in coverage

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              Start: 10/31/2006
201 = Workers' Compensation case settled. Patient
      is responsible for amount of this claim/
      service through WC 'Medicare set aside
      arrangement' or other agreement. (Use group
      code PR). This change effective 7/1/2013:
      Workers Compensation case settled. Patient
      is responsible for amount of this claim/
      service through WC 'Medicare set aside
      arrangement' or other agreement. (Use only
      with Group Code PR)
      Start: 10/31/2006
202 = Non-covered personal comfort or convenience
      services.
      Start: 02/28/2007
203 = Discontinued or reduced service.
      Start: 02/28/2007
204 = This service/equipment/drug is not covered
      under the patient's current benefit plan
      Start: 02/28/2007
205 = Pharmacy discount card processing fee
      Start: 07/09/2007
206 = National Provider Identifier - missing.
      Start: 07/09/2007
207 = National Provider identifier - Invalid
      format
      Start: 07/09/2007
208 = National Provider Identifier - Not matched.
      Start: 07/09/2007
209 = Per regulatory or other agreement. The
      provider cannot collect this amount from
      the patient. However, this amount may be
      billed to subsequent payer. Refund to
      patient if collected. (Use Group code OA)
      This change effective 7/1/2013: Per
      regulatory or other agreement. The provider.
      cannot collect this amount from the patient
      However, this amount may be billed to
      subsequent payer. Refund to patient if
      collected. (Use only with Group code OA)
      Start: 07/09/2007
210 = Payment adjusted because pre-certification/
      authorization not received in a timely fashion
      Start: 07/09/2007
211 = National Drug Codes (NDC) not eligible for
      rebate, are not covered.
      Start: 07/09/2007
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212 = Administrative surcharges are not covered
   Start: 11/05/2007
213 = Non-compliance with the physician self
   referral prohibition legislation or payer
   policy.
   Start: 01/27/2008
214 = Workers' Compensation claim adjudicated as
   non-compensable. This Payer not liable for
   claim or service/treatment. Note: If
   adjustment is at the Claim Level, the payer
   must send and the provider should refer to
   the 835 Insurance Policy Number Segment
   (Loop 2100 Other Claim Related Information
   REF qualifier 'IG') for the jurisdictional
   regulation. If adjustment is at the Line
   Level, the payer must send and the provider
   should refer to the 835 Healthcare Policy
   Identification Segment (loop 2110 Service
   Payment information REF). To be used for
   Workers' Compensation only
   Start: 01/27/2008
215 = Based on subrogation of a third party
   settlement
   Start: 01/27/2008
216 = Based on the findings of a review
   organization
   Start: 01/27/2008
217 = Based on payer reasonable and customary
   fees. No maximum allowable defined by
   legislated fee arrangement. (Note: To be
   used for Property and Casualty only)
   Start: 01/27/2008
218 = Based on entitlement to benefits. Note:
   If adjustment is at the Claim Level, the
   payer must send and the provider should
   refer to the 835 Insurance Policy Number
   Segment (Loop 2100 Other Claim Related
   Information REF qualifier 'IG') for the
   jurisdictional regulation. If adjustment is
   at the Line Level, the payer must send and
   the provider should refer to the 835
   Healthcare Policy Identification Segment
   (loop 2110 Service Payment information REF)
   To be used for Workers' Compensation only
   Start: 01/27/2008
219 = Based on extent of injury. Note: If
   adjustment is at the Claim Level, the payer

must send and the provider should refer to
the 835 Insurance Policy Number Segment
(Loop 2100 Other Claim Related Information
REF qualifier 'IG') for the jurisdictional
regulation. If adjustment is at the Line
Level, the payer must send and the provider
should refer to the 835 Healthcare Policy
Identification Segment (loop 2110 Service
Payment information REF).
Start: 01/27/2008
220 = The applicable fee schedule/fee database
does not contain the billed code. Please
resubmit a bill with the appropriate fee
schedule/fee database code(s) that best
describe the service(s) provided and
supporting documentation if required.
(Note: To be used for Property and Casualty
only)
Start: 01/27/2008
221 = Workers' Compensation claim is under
investigation. Note: If adjustment is at
the Claim Level, the payer must send and
the provider should refer to the 835
Insurance Policy Number Segment (Loop 2100
Other Claim Related Information REF
qualifier 'IG') for the jurisdictional
regulation. If adjustment is at the Line
Level, the payer must send and the provider
should refer to the 835 Healthcare Policy
Identification Segment (loop 2110 Service
Payment information REF). This change
effective 7/1/2013: Claim is under
investigation. Note: If adjustment is at
the Claim Level, the payer must send and
the provider should refer to the 835
Insurance Policy Number Segment (Loop 2100
Other Claim Related Information REF
qualifier 'IG') for the jurisdictional
regulation. If adjustment is at the Line
Level, the payer must send and the provider
should refer to the 835 Healthcare Policy
Identification Segment (loop 2110 Service
Payment information REF). (Note: To be used
by Property & Casualty only)
Start: 01/27/2008
222 = Exceeds the contracted maximum number of
hours/days/units by this provider for this

period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 06/01/2008

223 = Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
Start: 06/01/2008

224 = Patient identification compromised by identity theft. Identity verification required for processing this and future claims.
Start: 06/01/2008

225 = Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)
Start: 06/01/2008

226 = Information requested from the Billing/ Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 7/1/2013: Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/ incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Start: 09/21/2008

227 = Information requested from the patient/ insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Start: 09/21/2008

228 = Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication
Start: 09/21/2008

229 = Partial charge amount not considered by
      Medicare due to the initial claim Type of
      Bill being 12X. Note: This code can only
      be used in the 837 transaction to convey
      Coordination of Benefits information when
      the secondary payer's cost avoidance policy
      allows providers to bypass claim submission
      to a prior payer. Use Group Code PR. This
      change effective 7/1/2013: Partial charge
      amount not considered by Medicare due to
      the initial claim Type of Bill being 12X.
      Note: This code can only be used in the
      837 transaction to convey Coordination of
      Benefits information when the secondary
      payer's cost avoidance policy allows
      providers to bypass claim submission to a
      prior payer. (Use only with Group Code PR)
      Start: 01/25/2009
230 = No available or correlating CPT/HCPCS code
      to describe this service. Note: Used only
      by Property and Casualty.
      Start: 01/25/2009
231 = Mutually exclusive procedures cannot be
      done in the same day/setting. Note: Refer
      to the 835 Healthcare Policy Identification
      Segment (loop 2110 Service Payment
      Information REF), if present.
      Start: 07/01/2009
232 = Institutional Transfer Amount. Note -
      Applies to institutional claims only and
      explains the DRG amount difference when the
      patient care crosses multiple institutions.
      Start: 11/01/2009
233 = Services/charges related to the treatment
      of a hospital-acquired condition or
      preventable medical error.
      Start: 01/24/2010
234 = This procedure is not paid separately. At
      least one Remark Code must be provided
      (may be comprised of either the NCPDP
      Reject Reason Code, or Remittance Advice
      Remark Code that is not an ALERT.)
      Start: 01/24/2010
235 = Sales Tax
      Start: 06/06/2010
236 = This procedure or procedure/modifier
      combination is not compatible with another

procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative. This change effective 7/1/2013: This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.
Start: 01/30/2011

237 = Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Start: 06/05/2011

238 = Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR). This change effective 7/1/2013: Claim spans eligible and ineligible periods of coverage , this is the reduction for the ineligible period. (Use only with Group Code PR)
Start: 03/01/2012

239 = Claim spans eligible and ineligible periods of coverage. Rebill separate claims.
Start: 03/01/2012

240 = The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 06/03/2012

241 = Low Income Subsidy (LIS) Co-payment Amount
Start: 06/03/2012

242 = Services not provided by network/primary care providers.
Start: 06/03/2012

243 = Services not authorized by network/primary care providers.
Start: 06/03/2012

244 = Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.

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        Start: 09/30/2012
245 = Provider performance program withhold.
        Start: 09/30/2012
246 = This non-payable code is for required
        reporting only.
        Start: 09/30/2012
247 = Deductible for Professional service
        rendered in an Institutional setting and
        billed on an Institutional claim.
        Start: 09/30/2012
        Notes: For Medicare Bundled Payment use
        only, under the Patient Protection and
        Affordable Care Act (PPACA).
248 = Coinsurance for Professional service
        rendered in an Institutional setting and
        billed on an Institutional claim.
        Start: 09/30/2012
        Notes: For Medicare Bundled Payment use
        only, under the Patient Protection and
        Affordable Care Act (PPACA).
249 = This claim has been identified as a
        readmission. (Use only with Group Code CO)
        Start: 09/30/2012
250 = The attachment content received is
        inconsistent with the expected content.
        Start: 09/30/2012
251 = The attachment content received did not
        contain the content required to process
        this claim or service.
        Start: 09/30/2012
252 = An attachment is required to adjudicate
        this claim/service. At least one Remark
        Code must be provided (may be comprised of
        either the NCPDP Reject Reason Code, or
        Remittance Advice Remark Code that is not
        an ALERT).
        Start: 09/30/2012
A0  = Patient refund amount.
        Start: 01/01/1995
A1  = Claim/Service denied. At least one Remark
        Code must be provided (may be comprised of
        either the NCPDP Reject Reason Code, or
        Remittance Advice Remark Code that is not
        an ALERT.)
        Start: 01/01/1995
A2  = Contractual adjustment.
        Start: 01/01/1995
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        Stop: 01/01/2008
        Notes: Use Code 45 with Group Code 'CO' or
        use another appropriate specific adjustment
        code.
A3   = Medicare Secondary Payer liability met.
        Start: 01/01/1995
        Stop: 10/16/2003
A4   = Medicare Claim PPS Capital Day Outlier
        Amount.
        Start: 01/01/1995
        Stop: 04/01/2008
A5   = Medicare Claim PPS Capital Cost Outlier
        Amount.
        Start: 01/01/1995
A6   = Prior hospitalization or 30 day transfer
        requirement not met.
        Start: 01/01/1995
A7   = Presumptive Payment Adjustment
        Start: 01/01/1995
A8   = Ungroupable DRG.
        Start: 01/01/1995
B1   = Non-covered visits.
        Start: 01/01/1995
B2   = Covered visits.
        Start: 01/01/1995
        Stop: 10/16/2003
B3   = Covered charges.
        Start: 01/01/1995
        Stop: 10/16/2003
B4   = Late filing penalty.
        Start: 01/01/1995
B5   = Coverage/program guidelines were not met
        or were exceeded.
        Start: 01/01/1995
B6   = This payment is adjusted when performed/
        billed by this type of provider, by this
        type of provider in this type of facility,
        or by a provider of this specialty.
        Start: 01/01/1995
        Stop: 02/01/2006
B7   = This provider was not certified/eligible
        to be paid for this procedure/service on
        this date of service. Note: Refer to the
        835 Healthcare Policy Identification
        Segment (loop 2110 Service Payment
        Information REF), if present.
        Start: 01/01/1995
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B8  = Alternative services were available, and
      should have been utilized. Note: Refer to
      the 835 Healthcare Policy Identification
      Segment (loop 2110 Service Payment
      Information REF), if present.
      Start: 01/01/1995
B9  = Patient is enrolled in a Hospice.
      Start: 01/01/1995
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.
      Start: 01/01/1995
B11 = The claim/service has been transferred to
      the proper payer/processor for processing.
      Claim/service not covered by this payer/
      processor.
      Start: 01/01/1995
B12 = Services not documented in patients'
      medical records.
      Start: 01/01/1995
B13 = Previously paid. Payment for this claim/
      service may have been provided in a
      previous payment.
      Start: 01/01/1995
B14 = Only one visit or consultation per
      physician per day is covered.
      Start: 01/01/1995
B15 = This service/procedure requires that a
      qualifying service/procedure be received
      and covered. The qualifying other service/
      procedure has not been received/adjudicated
      . Note: Refer to the 835 Healthcare Policy
      Identification Segment (loop 2110 Service
      Payment Information REF), if present.
      Start: 01/01/1995
B16 = 'New Patient' qualifications were not met.
      Start: 01/01/1995
B17 = Payment 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.
      Start: 01/01/1995
      Stop: 02/01/2006
B18 = This procedure code and modifier were
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invalid on the date of service.
Start: 01/01/1995
Stop: 03/01/2009
B19 = Claim/service adjusted because of the
finding of a Review Organization.
Start: 01/01/1995
Stop: 10/16/2003
B20 = Procedure/service was partially or fully
furnished by another provider.
Start: 01/01/1995
B21 = The charges were reduced because the
service/care was partially furnished by
another physician.
Start: 01/01/1995
Stop: 10/16/2003
B22 = This payment is adjusted based on the
diagnosis.
Start: 01/01/1995
B23 = Procedure billed is not authorized per
your Clinical Laboratory Improvement
Amendment (CLIA) proficiency test.
Start: 01/01/1995
D1 = Claim/service denied. Level of subluxation
is missing or inadequate.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if
necessary.
D2 = Claim lacks the name, strength, or dosage
of the drug furnished.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if
necessary.
D3 = Claim/service denied because information to
indicate if the patient owns the equipment
that requires the part or supply was
missing.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if
necessary.
D4 = Claim/service does not indicate the period
of time for which this will be needed.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if

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            necessary.
D5  = Claim/service denied. Claim lacks
      individual lab codes included in the test.
      Start: 01/01/1995
      Stop: 10/16/2003
      Notes: Use code 16 and remark codes if
      necessary.
D6  = Claim/service denied. Claim did not include
      patient's medical record for the service.
      Start: 01/01/1995
      Stop: 10/16/2003
      Notes: Use code 16 and remark codes if
      necessary.
D7  = Claim/service denied. Claim lacks date of
      patient's most recent physician visit.
      Start: 01/01/1995
      Stop: 10/16/2003
      Notes: Use code 16 and remark codes if
      necessary.
D8  = Claim/service denied. Claim lacks
      indicator that 'x-ray is available for
      review.'
      Start: 01/01/1995
      Stop: 10/16/2003
      Notes: Use code 16 and remark codes if
      necessary.
D9  = Claim/service denied. Claim lacks invoice
      or statement certifying the actual cost
      of the lens, less discounts or the type of
      intraocular lens used.
      Start: 01/01/1995
      Stop: 10/16/2003
      Notes: Use code 16 and remark codes if
      necessary.
D10 = Claim/service denied. Completed physician
      financial relationship form not on file.
      Start: 01/01/1995
      Stop: 10/16/2003
      Notes: Use code 17.
D11 = Claim lacks completed pacemaker
      registration form.
      Start: 01/01/1995
      Stop: 10/16/2003
      Notes: Use code 17.
D12 = Claim/service denied. Claim does not
      identify who performed the purchased
      diagnostic test or the amount you were
```

```
          charged for the test.
          Start: 01/01/1995
          Stop: 10/16/2003
          Notes: Use code 17.
D13 = Claim/service denied. Performed by a
      facility/supplier in which the ordering/
      referring physician has a financial
      interest.
      Start: 01/01/1995
      Stop: 10/16/2003
      Notes: Use code 17.
D14 = Claim lacks indication that plan of
      treatment is on file.
      Start: 01/01/1995
      Stop: 10/16/2003
      Notes: Use code 17.
D15 = Claim lacks indication that service was
      supervised or evaluated by a physician.
      Start: 01/01/1995
      Stop: 10/16/2003
      Notes: Use code 17.
D16 = Claim lacks prior payer payment information
      Start: 01/01/1995
      Stop: 06/30/2007
      Notes: Use code 16 with appropriate claim
      payment remark code [N4].
D17 = Claim/Service has invalid non-covered days.
      Start: 01/01/1995
      Stop: 06/30/2007
      Notes: Use code 16 with appropriate claim
      payment remark code.
D18 = Claim/Service has missing diagnosis
      information.
      Start: 01/01/1995
      Stop: 06/30/2007
      Notes: Use code 16 with appropriate claim
      payment remark code.
D19 = Claim/Service lacks Physician/Operative or
      other supporting documentation
      Start: 01/01/1995
      Stop: 06/30/2007
      Notes: Use code 16 with appropriate claim
      payment remark code.
D20 = Claim/Service missing service/product
      information.
      Start: 01/01/1995
      Stop: 06/30/2007
```

```
        Notes: Use code 16 with appropriate claim
        payment remark code.
D21 = This (these) diagnosis(es) is (are) missing
        or are invalid
        Start: 01/01/1995
        Stop: 06/30/2007
D22 = Reimbursement was adjusted for the reasons
        to be provided in separate correspondence.
        (Note: To be used for Workers' Compensation
        only) - Temporary code to be added for time
        frame only until 01/01/2009. Another code
        to be established and/or for 06/2008
        meeting for a revised code to replace or
        strategy to use another existing code
        Start: 01/27/2008
        Stop: 01/01/2009
D23 = This dual eligible patient is covered by
        Medicare Part D per Medicare Retro-
        Eligibility. At least one Remark Code must
        be provided (may be comprised of either the
        NCPDP Reject Reason Code, or Remittance
        Advice Remark Code that is not an ALERT.)
        Start: 11/01/2009
        Stop: 01/01/2012
W1  = Workers' compensation jurisdictional fee
        schedule adjustment. Note: If adjustment
        is at the Claim Level, the payer must send
        and the provider should refer to the 835
        Class of Contract Code Identification
        Segment (Loop 2100 Other Claim Related
        Information REF). If adjustment is at the
        Line Level, the payer must send and the
        provider should refer to the 835 Healthcare
        Policy Identification Segment (loop 2110
        Service Payment information REF).
        Start: 02/29/2000
W2  = Payment reduced or denied based on workers'
        compensation jurisdictional regulations or
        payment policies, use only if no other code
        is applicable. Note: If adjustment is at
        the Claim Level, the payer must send and
        the provider should refer to the 835
        Insurance Policy Number Segment (Loop 2100
        Other Claim Related Information REF
        qualifier 'IG') for the jurisdictional
        regulation. If adjustment is at the Line
        Level, the payer must send and the provider
```

should refer to the 835 Healthcare Policy
Identification Segment (loop 2110 Service
Payment information REF). To be used for
Workers' Compensation only.
Start: 10/17/2010
W3 = The Benefit for this Service is included
in the payment/allowance for another
service/procedure that has been performed
on the same day. Note: Refer to the 835
Healthcare Policy Identification Segment
(loop 2110 Service Payment Information REF),
if present. For use by Property and
Casualty only.
Start: 09/30/2012
W4 = Workers' Compensation Medical Treatment
Guideline Adjustment.
Start: 09/30/2012
Y1 = Payment denied based on Medical Payments
Coverage (MPC) or Personal Injury
Protection (PIP) Benefits jurisdictional
regulations or payment policies, use only
if no other code is applicable. Note: If
adjustment is at the Claim Level, the payer
must send and the provider should refer to
the 835 Insurance Policy Number Segment
(Loop 2100 Other Claim Related Information
REF qualifier 'IG') for the jurisdictional
regulation. If adjustment is at the Line
Level, the payer must send and the provider
should refer to the 835 Healthcare Policy
Identification Segment (loop 2110 Service
Payment information REF). To be used for
P&C Auto only.
Start: 09/30/2012
Y2 = Payment adjusted based on Medical Payments
Coverage (MPC) or Personal Injury
Protection (PIP) Benefits jurisdictional
regulations or payment policies, use only
if no other code is applicable. Note: If
adjustment is at the Claim Level, the payer
must send and the provider should refer to
the 835 Insurance Policy Number Segment
(Loop 2100 Other Claim Related Information
REF qualifier 'IG') for the jurisdictional
regulation. If adjustment is at the Line
Level, the payer must send and the provider
should refer to the 835 Healthcare Policy

```
                 Identification Segment (loop 2110 Service
                 Payment information REF). To be used for
                 P&C Auto only.
                 Start: 09/30/2012
        Y3  = Medical Payments Coverage (MPC) or Personal
                 Injury Protection (PIP) Benefits
                 jurisdictional fee schedule adjustment.
                 Note: If adjustment is at the Claim Level,
                 the payer must send and the provider should
                 refer to the 835 Class of Contract Code
                 Identification Segment (Loop 2100 Other
                 Claim Related Information REF). If
                 adjustment is at the Line Level, the payer
                 must send and the provider should refer to
                 the 835 Healthcare Policy Identification
                 Segment (loop 2110 Service Payment
                 information REF). To be used for P&C Auto
                 only.
                 Start: 09/30/2012
```

CLM_ADMTG_DGNS_VRSN_TB   Claim Admitting Diagnosis Version Code Table

```
    Valid Values:
    9 = ICD-9
    0 = ICD-10
```

CLM_BENE_ID_TYPE_TB   Claim Beneficiary Identifier Type Table

```
    M = MBI
    H = HICN
```

CLM_BILL_TYPE_TB   Claim Bill Type Table

```
    11 = Hospital-inpatient (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-Laboratory Services Provided to
         Non-patients
    15 = Hospital-intermediate care - level I (obsolete)
```

```
16 = Hospital-intermediate care - level II (obsolete)
17 = Hospital-intermediate care - level III (obsolete)
18 = Hospital-swing beds
19 = 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) - (obsolete)
25 = SNF-intermediate care - level I (obsolete)
26 = SNF-intermediate care - level II (obsolete)
27 = SNF-intermediate care - level III (obsolete)
28 = SNF-swing beds
29 = SNF-reserved for national assignment
31 = HHA-inpatient (including Part A) (obsolete)
32 = HHA-Home Health Services under a Plan of Treatment
     (name revised 10/2013)
33 = HHA-outpatient (plan of treatment under Part A,
     including DME under Part A) (term. 10/2013)
34 = HHA-other (for medical and surgical services not
     under a plan of treatment) (obsolete)
35 = HHA-intermediate care - level I (obsolete)
36 = HHA-intermediate care - level II (obsolete)
37 = HHA-intermediate care - level III (obsolete)
38 = HHA-swing beds (obsolete)
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) - (obsolete)
45 = RNHCI hospital-intermediate care - level I (obsolete)
46 = RNHCI hospital-intermediate care - level II (obsolete)
47 = RNHCI hospital-intermediate care - level III (obsolete)
48 = RNHCI hospital-swing beds (obsolete)
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) - OBSOLETE; prior to 7/00
     Christian Science (CS)
53 = RNHCI extended care-outpatient (HHA-A also) (eff. 7/00);
     OBSOLETE - prior to 7/00 referenced CS
54 = RNHCI extended care-other (Part B)(eff. 7/00)- OBSOLETE;
     prior to 7/00 referenced CS
```

```
55 = RNHCI extended care-intermediate care - level I (eff. 7/00)
     OBSOLETE - prior to 7/00 referenced CS
56 = RNHCI extended care-intermediate care - level II (eff. 7/00)
     OBSOLETE - prior to 7/00 referenced CS
57 = RNHCI extended care-intermediate care - level III (eff. 7/00)
     OBSOLETE - prior to 7/00 referenced CS
58 = RNHCI extended care-swing beds (eff. 7/00)- OBSOLETE
     prior to 7/00 referenced CS
59 = RNHCI extended care-reserved for national assignment
     (eff. 7/00) - OBSOLETE; prior to 7/00 referenced CS
61 = Intermediate care-inpatient (including Part A)
     OBSOLETE
62 = Intermediate care-inpatient or home health visits (Part B only)
     OBSOLETE
63 = Intermediate care-outpatient (HHA-A also) - OBSOLETE
64 = Intermediate care-other (Part B)- OBSOLETE
65 = Intermediate care-intermediate care - level I
66 = Intermediate care-intermediate care - level II
67 = Intermediate care-intermediate care - level III - OBSOLETE
68 = Intermediate care-swing beds - OBSOLETE
69 = Reserved for national assignment
71 = Clinic-rural health
72 = Clinic-hospital based or independent renal dialysis facility
73 = Clinic-Freestanding
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-Federally Qualified Health Center (FQHC)
     eff. 4/2010
78 = Clinic-reserved for national assignment
79 = Clinic-other
81 = Hospice (non-hospital based)
82 = Hospice (hospital based)
83 = Ambulatory Aurgical Center
     (Discontinued for Hospitals Subject to Outpatient PPS;
      hospitals must use 13X for ASC claims submitted for OPPS
      payment -- eff. 7/00)
84 = Freestanding Birthing Center
85 = Critical Access Hospital (eff. 10/94)
86 = Residential Facility (eff. 4/1/2010)
87 = Reserved for national assignment
88 = Reserved for national assignment
89 = Special facility or ASC surgery-other
91 = Reserved for national assignment
92 = Reserved for national assignment
93 = Reserved for national assignment
```

```
        94 = Reserved for national assignment
        95 = Reserved for national assignment
        96 = Reserved for national assignment
        97 = Reserved for national assignment
        98 = Reserved for national assignment
        99 = Reserved for national assignment
```

CLM_CARE_IMPRVMT_MODEL_TB   Claim Care Improvement Model Table


```
        61 = CLAIM CARE IMPROVEMENT MODEL 1
        62 = CLAIM CARE IMPROVEMENT MODEL 2
        63 = CLAIM CARE IMPROVEMENT MODEL 3
        64 = CLAIM CARE IMPROVEMENT MODEL 4
```


CLM_DGNS_VRSN_TB   Claim Diagnosis Version Code Table

```
        Valid Values:
        9 = ICD-9
        0 = ICD-10
```


CLM_DISP_TB   Claim Disposition Table

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

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


CLM_EHR_PGM_RDCTN_IND_TB   Claim Electronic Health Records (EHR) Program Reduction Indicator Table

```
    Y = hospital is subject to a reduction under the EHR
        program
```

```
       Blank


CLM_EXCPTD_NEXCPTD_TRTMT_TB            Claim Excepted/Nonexcepted Treatment Table

     0 = No Entry
     1 = Excepted
     2 = Nonexcepted



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
         (discontinued effective 10/1/05)
     6 = Intermediate care
     7 = Clinic or hospital-based renal dialysis facility
     8 = Special facility or ASC surgery
     9 = Reserved



CLM_FPS_MSN_CD_TB                      Claim FPS MSN Code Table

     Section 1 Ambulance
     1.1   = Payment for transportation is allowed
             only to the closest facility that can
             provide the necessary care.
     1.10  = Air ambulance is not covered since you
             were not taken to the airport by
             ambulance.
     1.11  = The information provided does not support
             the need for an air ambulance.
             The approved amount is based on ground
             ambulance.
     1.2   = Payment is denied because the ambulance
             company is not approved by Medicare.
     1.3   = Ambulance service to a funeral home is
             not covered.
```

```
1.4   = Transportation in a vehicle other than
        an ambulance is not covered.
1.5   = Transportation to a facility to be closer
        to home or family is not covered.
1.6   = This service is included in the allowance
        for the ambulance transportation.
1.7   = Ambulance services to or from a doctor's
        office are not covered.
1.8   = This service is denied because you
        refused to be transported.
1.9   = Payment for ambulance services does not
        include mileage when you were not in the
        ambulance.


Section 10 Foot Care
10.1  = Shoes are only covered as part of a leg
        brace.


Section 11 Transfer of Claims or Parts of Claims
11.1  = Your claim has been forwarded to the
        correct Medicare contractor for
        processing. You will receive a notice
        from them.
11.10 = We have identified you as a Railroad
        Retirement Board (RRB) Medicare
        beneficiary. You must send your claim
        for these services for processing to the
        RRB carrier Palmetto GBA, at PO Box
        10066, Augusta, GA 30999.
11.11 = This claim/service is not payable under
        our claims jurisdiction. We have notified
        your provider to send your claim for
        these services to the United Mine
        Workers of America for processing.
11.2  = This information is being sent to
        Medicaid. They will review it to see if
        additional benefits can be paid.
11.3  = Our records show that you are enrolled in
        a Medicare health plan. Your provider
        must bill this service to the plan.
11.4  = Our records show that you are enrolled in
        a Medicare health plan. Your claim was
        sent to the plan for processing.
11.5  = This claim will need to be submitted to
        (another carrier, a Durable Medical
        Equipment Medicare Administrative
        Contractor (DME MAC), or Medicaid agency)
```

```
11.6  = We have asked your provider to submit
        this claim to the proper Medicare
        Administrative Contractor (MAC). That
        MAC is (name and address).
        NOTE: Due to different systems'
        capabilities, DMACs may omit the final
        sentence in this message, "That MAC is
        (name and address)," whenever this
        message is used. Part A and Part B MACs
        are expected to use the complete message.
        This instruction also applies to the
        Spanish translation of the message.
11.7  = This claim/service is not payable under
        our claims jurisdiction area. We have
        notified your provider that they must
        forward the claim/service to the correct
        carrier for processing.
11.8  = This claim will need to be submitted to
        the Region B Durable Medical Equipment
        Regional Carrier.
11.9  = This claim/service is not payable under
        our claims jurisdiction. We have
        notified your provider to send your
        claim for these services to the Railroad
        Retirement Board Medicare carrier.

Section 12 Hearing Aids
12.1  = Hearing aids are not covered.

Section 13 Skilled Nursing Facility
13.1  = No qualifying hospital stay dates were
        shown for this skilled nursing facility
        stay.
13.10 = Medicare Part B doesn't pay for items or
        services provided by this type of
        healthcare provider since our records
        show that you were receiving Medicare
        Part A benefits in a skilled nursing
        facility on this date.
13.11 = You have ___ days(s) remaining of your
        total 100 days of skilled nursing
        facility benefits for this benefit period
13.12 = Medicare Part B doesn't pay separately
        for this item/service. Payment for this
        item/service should be included in
        another Medicare benefit. The hospital/
        nursing facility must bill for this
```

Medicare service.

13.2 = Skilled nursing facility benefits are
       only available after a hospital stay of
       at least 3 days.
13.3 = Information provided does not support the
       need for skilled nursing facility care.
13.4 = Information provided does not support the
       need for continued care in a skilled
       nursing facility.
13.5 = You were not admitted to the skilled
       nursing facility within 30 days of your
       hospital discharge.
13.6 = Rural primary care skilled nursing
       facility benefits are only available
       after a hospital stay of at least 2 days.
13.7 = Normally, care is not covered when
       provided in a bed that is not certified
       by Medicare. However, since you received
       covered care, we have decided that you
       will not have to pay the facility for
       anything more than Medicare coinsurance
       and noncovered items.
13.8 = The skilled nursing facility should file
       a claim for Medicare benefits because
       you were an inpatient.
13.9 = Medicare Part B does not pay for this
       item or service since our records show
       that you were in a skilled nursing
       facility on this date.

Section 14 Laboratory
14.1 = The laboratory is not approved for this
        type of test.
14.10 = Medicare does not allow a separate
        payment for EKG readings.
14.11 = A travel allowance is paid only when a
        covered specimen collection fee is billed
14.12 = Payment for transportation can only be
        made if an X-ray or EKG is performed.
14.13 = The laboratory was not approved for this
        test on the date it was performed.
14.2 = Medicare approved less for this
        individual test because it can be done
        as part of a complete group of tests.
14.3 = Services or items not approved by the
        Food and Drug Administration are not
        covered.

```
14.4  = Payment denied because the claim did not
        show who performed the test and/or the
        amount charged.
14.5  = Payment denied because the claim did not
        show if the test was purchased by the
        physician or if the physician performed
        the test.
14.6  = This test must be billed by the
        laboratory that did the work.
14.7  = This service is paid at 100% of the
        Medicare approved amount.
14.8  = Payment cannot be made because the
        physician has a financial relationship
        with the laboratory.
14.9  = Medicare cannot pay for this service for
        the diagnosis shown on the claim.

Section  Medical Necessity
15.1  = The information provided does not support
        the need for this many services or items.
15.10 = Medicare does not pay for more than one
        assistant surgeon for this procedure.
15.11 = Medicare does not pay for an assistant
        surgeon for this procedure/surgery.
15.12 = Medicare does not pay for two surgeons
        for this procedure.
15.13 = Medicare does not pay for team surgeons
        for this procedure.
15.14 = Medicare does not pay for acupuncture.
15.15 = Payment has been reduced because
        information provided does not support the
        need for this item as billed.
15.16 = Your claim was reviewed by our medical
        staff.
15.17 = We have approved this service at a
        reduced level.
15.18 = Medicare does not cover this service at
        home.
15.19 = Local Coverage Determinations (LCDs) help
        Medicare decide what is covered. An LCD
        was used for your claim. You can compare
        your case to the LCD, and send
        information from your doctor if you
        think it could change our decision.
        Call 1-800-MEDICARE (1-800-633-4227) for
        a copy of the LCD.
15.2  = The information provided does not support
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                   the need for this equipment.
15.20 = The following policies were used when we
            made this decision: _____
15.21 = The information provided does not support
            the need for this many services or items
            in this period of time but you do not
            have to pay this amount.
15.22 = The information provided does not support
            the need for this many services or items
            in this period of time so Medicare will
            not pay for this item or service.
15.3  = The information provided does not support
            the need for the special features of this
            equipment.
15.4  = The information provided does not support
            the need for this service or item.
15.5  = The information provided does not support
            the need for similar services by more
            than one doctor during the same time
            period.
15.6  = The information provided does not support
            the need for this many services or items
            within this period of time.
15.7  = The information provided does not support
            the need for more than one visit a day.
15.8  = The information provided does not support
            the level of service as shown on the
            claim.
15.9  = The Quality Improvement Organization did
            not approve this service.
15.96 = Medicare does not pay for this
            investigational device(s).
15.97 = Medicare cannot pay for this
            investigational device because the
            approved period for the investigational
            device in the FDA clinical trial has not
            begun.
15.98 = Medicare cannot pay for this
            investigational device because the
            approved period for the investigational
            device in the FDA clinical trial has
            expired.
15.99 = Medicare does not pay for this many
            services on the same day. You cannot be
            billed for this service.


Section 16 Miscellaneous
```

```
16.1  = The service cannot be approved because
        the date on the claim shows it was billed
        before it was provided.
16.10 = Medicare does not pay for this item or
        service.
16.11 = Payment was reduced for late filing.  You
        cannot be billed for the reduction.
16.12 = Outpatient mental health services are
        paid at 50% of the approved charges.
16.13 = The code(s) your provider used is/are not
        valid for the date of service billed.
16.14 = The attached check replaces your previous
        check (#____) dated (_____).
16.15 = The attached check replaces your previous
        check.
16.16 = As requested, this is a duplicate copy of
        your Medicare Summary Notice.
        See "Message Expiration Date" and
        "Message Notes" columns ------->
16.17 = Medicare only pays for these services if
        you get them with total parenteral
        nutrition.
16.18 = Medicare won't pay for services provided
        before certified parenteral/enteral
        nutrition therapy started.
16.19 = The amount Medicare pays for a
        parenteral/enteral nutrition supply is
        based on the level of care you need
        (based on your diagnosis).
16.2  = This service cannot be paid when provided
        in this location/facility.
16.20 = The approved payment for calories/grams
        is the most Medicare may allow for the
        diagnosis stated.
16.21 = The procedure code was changed to reflect
        the actual service rendered.
16.22 = Medicare does not pay for services when
        no charge is indicated.
16.23 = This check is for the amount you overpaid
16.24 = Services provided aboard a ship are
        covered only when the ship is of United
        States registry and is in United States
        waters. In addition, the service must be
        provided by a doctor licensed to practice
        in the United States.
16.25 = Medicare does not pay for this much
        equipment, or this many services or
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                      supplies.
16.26 = Medicare does not pay for services or
        items related to a procedure that has not
        been approved or billed.
16.27 = This service is not covered since our
        records show you were in the hospital at
        this time.
16.28 = Medicare does not pay for services or
        equipment that you have not received.
16.29 = Payment is included in another service
        you have received.
16.3  = The claim did not show that this service
        or item was prescribed by your doctor.
16.30 = Services billed separately on this claim
        have been combined under this procedure.
16.31 = You are responsible to pay the primary
        physician care the agreed monthly charge.
16.32 = Medicare does not pay separately for this
        service.
16.33 = Your payment includes interest because
        Medicare exceeded processing time limits.
16.34 = You should not be billed for this service
        . You are only responsible for any
        deductible and coinsurance amounts listed
        in the "You May Be Billed" column.
        This message should be revised to read
        "Maximum You May Be Billed" (in place of
        "You May Be Billed") when your MAC
        implements the new MSN design.
        See "Message Implementation Date" and
        "Message Notes."
16.35 = You do not have to pay this amount.
16.36 = If you have already paid it, you are
        entitled to a refund from this provider.
16.37 = Please see the back of this notice.
        See "Message Expiration Date" and
        "Message Notes" columns
16.38 = Charges are not incurred for leave of
        absence days.
16.39 = Only one provider can be paid for this
        service per calendar month. Payment has
        already been made to another provider for
        this service.
16.4  = This service requires prior approval by
        the Quality Improvement Organization.
16.40 = Only one inpatient service per day is
        allowed.
```

16.41 = Payment is being denied because you refused to request reimbursement under your Medicare benefits.
16.42 = The provider's determination of noncoverage is correct.
16.43 = This service cannot be approved without a treatment plan and supervision of a doctor.
16.44 = Routine care is not covered.
16.45 = You cannot be billed separately for this item or service. You do not have to pay this amount.
16.46 = Medicare payment limits do not affect a Native American's right to free care at Indian Health Institutions.
16.47 = When deductible is applied to outpatient psychiatric services, you may be billed for up to the approved amount. The "You May Be Billed" column will tell you the correct amount to pay your provider. This message should be revised to read "Maximum You May Be Billed" (in place of "You May Be Billed" when your MAC implements the new MSN design.
16.48 = Medicare does not pay for this item or service for this condition.
16.49 = This claim/service is not covered because alternative services were available, and should have been utilized.
16.5 = This service cannot be approved without a treatment plan by a physical or occupational therapist.
16.50 = The doctor or supplier may not bill more than the Medicare allowed amount.
16.51 = This service is not covered prior to July 1, 2001.
16.52 = This service was denied because coverage for this service is provided only after a documented failed trial of pelvic muscle exercise training.
16.53 = The amount Medicare paid the provider for this claim is ($_____).
16.54 = This service is not covered prior to January 1, 2002.
16.55 = The provider billed this charge as non-covered.
16.56 = Claim denied because information from the

Social Security Administration indicates that you have been deported.

16.57 = Medicare Part B does not pay for this item or service since our records show that you were in a Medicare health plan on this date. Your provider must bill this service to the Medicare health plan.

16.58 = The provider billed this charge as non-covered. You do not have to pay this amount.

16.59 = Medicare doesn't pay for missed appointments.

16.6 = This item or service cannot be paid unless the provider accepts assignment.

16.60 = Want to see your MSN right away? Access your Original Medicare claims directly at www.MyMedicare.gov, usually within 24 hours after Medicare processes the claim. You can also order duplicate MSNs, track your preventive services, and print an "On the Go" report to share with your provider.

16.61 = Outpatient mental health services are paid at 55% of the approved amount.

16.62 = Outpatient mental health services are paid at 60% of the approved amount

16.63 = Outpatient mental health services are paid at 65% of the approved amount.

16.64 = IMPORTANT: Starting in March 2010, Medicare will begin to mail Part A and Part B MSNs in the same envelope when possible.

16.66 = Medicare doesn't pay for DMEPOS items or services when provided by a hospital or physician if there is no matching date of discharge or date of service.

16.67 = Medicare doesn't pay for services or items when provided by a hospital when there is no matching date of discharge.

16.7 = Your provider must complete and submit your claim.

16.71 = Your provider must complete and submit your claim.

16.72 = This claim was denied because it was Submitted with a non-affirmative prior authorization request.

16.73 = This claim has received a payment

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                 reduction because it did not first go
                 through the prior authorization process.
16.74 = This claim is denied because there is no
                 record of a prior authorization request
                 to support this record.
16.76 = This service/item was not covered because
                 you have exceeded the lifetime limit for
                 getting this service/item.
16.77 = This service/item was not covered because
                 it was not provided as part of a
                 qualifying trial/study.
16.8  = Payment is included in another service
                 received on the same day.
16.9  = This allowance has been reduced by the
                 amount previously paid for a related
                 procedure.
16.98 = The amount you paid to the provider for
                 this claim was more than the required
                 payment. You should be receiving a refund
                 of $_____ from your provider, which is
                 the difference between what you paid and
                 what you should have paid.
16.99 = The amount owed you is $_____.
                 Medicare no longer routinely issues
                 payment under $1 This amount due will be
                 included on a future check issued to you.
                 If you want this money issued immediately
                 , please contact us at the address and
                 phone number shown at the bottom of this
                 page.

Section 17 Non Physician Services
17.1  = Services performed by a private duty
                 nurse are not covered.
17.10 = The allowance has been reduced because
                 the anesthesiologist medically directed
                 concurrent procedures.
17.11 = This item or service cannot be paid as
                 billed.
17.12 = This service is not covered when provided
                 by an independent therapist.
17.13 = Each year, Medicare pays for a limited
                 amount of physical therapy and speech-
                 language pathology services and a
                 separate amount of occupational therapy
                 services. Medically necessary therapy
                 over these limits is covered when
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approved by Medicare.
17.14 = Charges for maintenance therapy are not covered.
17.15 = This service cannot be paid unless certified by your physician every (___) days.
17.16 = The hospital should file a claim for Medicare benefits because these services were performed in a hospital setting.
17.17 = Medicare already paid for an initial visit for this service with this physician, another physician in his group practice, or a provider. Your doctor or provider must use a different code to bill for subsequent visits.
17.18 = ($) has been applied during this calendar year (CCYY) towards the ($) limit on outpatient physical therapy and speech-language pathology benefits.
17.19 = ($) has been applied during this calendar year (CCYY) towards the ($) limit on outpatient occupational therapy benefits.
17.2 = This anesthesia service must be billed by a doctor.
17.21 = The items or service was denied because Medicare can't pay for services ordered by or referred by this provider at this time" for this message number.
17.25 = Medicare does not pay for services of a nurse practitioner/clinical nurse specialist for this place and/or date of service.
17.3 = This service was denied because you did not receive it under the direct supervision of a doctor.
17.33 = Medicare does not pay for services by a noncertified nonphysician practitioner.
17.4 = Services performed by an audiologist are not covered except for diagnostic procedures.
17.5 = Your provider's employer must file this claim and agree to accept assignment.
17.6 = Full payment was not made for this service(s) because the yearly limit has been met.
17.7 = This service must be performed by a licensed clinical social worker.

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17.8  = Payment was denied because the maximum
          benefit allowance has been reached.
17.9  = Medicare (Part A/Part B) pays for this
          service. The provider must bill the
          correct Medicare contractor.


Section 18 Preventive Care
18.1  = Routine examinations and related services
          aren't covered.
18.10 = Expired
18.11 = Expired
18.12 = Screening mammograms are covered annually
          for women 40 years of age and older.
18.13 = This service isn't covered for people
          under 50 years old.
18.14 = Service is being denied because it has
          not been (12/24/48) months since your
          last (test/procedure) of this kind.
18.15 = Medicare only covers this procedure for
          people considered to be at high risk for
          colorectal cancer.
18.16 = This service is being denied because
          payment has already been made for a
          similar procedure within a set time frame
18.17 = Medicare pays for a screening Pap test
          and a screening pelvic examination once
          every 2 years unless high risk factors
          are present.
18.18 = Medicare does not pay for this service
          separately since payment of it is
          included in our allowance for other
          services you received on the same day.
18.19 = This service isn't covered until after
          your 50th birthday.
18.2  = This immunization and/or preventive care
          is not covered.
18.20 = Expired
18.21 =
18.22 = This service was denied because Medicare
          only allows the Welcome to Medicare
          preventive visit within the first 12
          months you have Part B coverage.
18.23 = You pay 25% of the Medicare-approved
          amount for this service.
18.24 = This service was denied. Medicare doesn't
          cover an Annual Wellness Visit within the
          first 12 months of your Medicare Part B
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                coverage. Medicare does cover a one-time
                Welcome to Medicare preventive visit with
                in the first 12 months.
18.25 = Your Annual Wellness Visit has been
                approved. You will qualify for another
                Annual Wellness Visit 12 months after the
                date of this visit.
18.26 = This service was denied because it
                occurred too soon after your last covered
                Annual Wellness Visit. Medicare only
                covers one Annual Wellness Visit within
                a 12 month period.
18.27 = This service was denied because it
                occurred too soon after your Initial
                Preventive Physical Exam.
18.3  = Screening mammography is not covered for
                women under 35 years of age.
18.4  = This service is being denied because it
                has not been (__) months since your last
                examination of this kind.
18.5  = Medicare will pay for another screening
                mammogram in 12 months.
18.6  = A screening mammography is covered only
                once for women age 35 - 39.
18.7  = Screening pap tests are covered only once
                every 24 months unless high risk factors
                are present.
18.8  = Deleted during EOMB-MSN transition.
18.9  = Deleted during EOMB-MSN transition.
18.94 = Medicare pays for screening Pap smear
                and/or screening pelvic examination
                (including a clinical breast examination)
                only once every 2 years unless high risk
                factors are present.


Section 19 Hospital Based Physician Services
19.1  = Services of a hospital-based specialist
                are not covered unless there is an
                agreement between the hospital and the
                specialist.
19.2  = Payment was reduced because this service
                was performed in a hospital outpatient
                setting rather than a provider's office.
19.3  = Only one hospital visit or consultation
                per provider is allowed per day.


Section 2 Blood
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2.1  = The first three pints of blood used in
        each year are not covered.
2.2  = Charges for replaced blood are not covered

Section 20 Benefit Limits
20.1  = You have used all of your benefit days
        for this period.
20.10 = This service was denied because Medicare
        only pays up to 10 hours of diabetes
        education training during the initial
        12-month period. Our records show you
        have already obtained 10 hours of
        training.
20.11 = This service was denied because Medicare
        pays for two hours of follow-up diabetes
        education training during a calendar year
        . Our records show you have already
        obtained two hours of training for this
        calendar year.
20.12 = This service was denied because Medicare
        only covers this service once a lifetime.
20.13 = This service was denied because Medicare
        only pays up to three hours of medical
        nutrition therapy during a calendar year.
        Our records show you have already
        received three hours of medical nutrition
        therapy.
20.14 = This service was denied because Medicare
        only pays two hours of follow-up for
        medical nutrition therapy during a
        calendar year. Our records show you have
        already received two hours of follow-up
        services for this calendar year.
20.2  = You have reached your limit of 190 days
        of psychiatric hospital services.
20.3  = You have reached your limit of 60
        lifetime reserve days.
20.4  = (__) of the Benefit Days Used were
        charged to your Lifetime Reserve Day
        benefit.
20.5  = These services cannot be paid because
        your benefits are exhausted at this time.
20.6  = Days used has been reduced by the primary
        group insurer's payment.
20.7  = You have (___) day(s) remaining of your
        190-day psychiatric limit.
20.8  = Days are being subtracted from your total
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                inpatient hospital benefits for this
                benefit period.
20.9   = Services after (mm/dd/yy) cannot be paid
                because your benefits were exhausted.
20.91 = This service was denied. Medicare covers
                a one-time initial preventative physical
                exam (Welcome to Medicare physical exam)
                if you get it within the first 12 months
                of the effective date of your Medicare
                Part B coverage.

Section 21 Restrictions to Coverage
21.1   = Services performed by an immediate
                relative or a member of the same
                household are not covered.
21.10 = A surgical assistant is not covered for
                this place and/or date of service.
21.11 = This service was not covered by Medicare
                at the time you received it.
21.12 = This hospital service was not covered
                because the attending physician was not
                eligible to receive Medicare benefits at
                the time the service was performed.
21.13 = This surgery was not covered because the
                attending physician was not eligible to
                receive Medicare benefits at the time the
                service was performed.
21.14 = Medicare cannot pay for this
                investigational device because the FDA
                clinical trial period has not begun.
21.15 = Medicare cannot pay for this
                investigational device because the FDA
                clinical trial period has ended.
21.16 = Medicare does not pay for this
                investigational device.
21.17 = Your provider submitted noncovered
                charges. You are responsible for paying
                these charges.
21.18 = This item or service is not covered when
                performed or ordered by this provider.
21.19 = This provider decided to dropout of
                Medicare. No payment can be made for
                this service. You are responsible for
                this charge. Under Federal law, your
                doctor cannot charge you more than the
                limiting charge amount.
21.2   = The provider of this service is not
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                     eligible to receive Medicare payments.
21.20 = This provider decided to dropout of
        Medicare. No payment can be made for
        this service. You are responsible for
        this charge.
21.21 = This service was denied because Medicare
        only covers this service under certain
        circumstances.
21.22 = Medicare does not pay for this service
        because it is considered investigational
        and/or experimental in these
        circumstances.
21.23 = Your claim is being denied because the
        physician noted on the claim has been
        deceased for more than 15 months.
21.24 = This service is not covered for patients
        over age 60.
21.25 = This service was denied because Medicare
        only covers this service in certain
        settings.
21.26 = Claim denied because services were
        provided by an Opt-Out physician or
        practitioner. No Medicare payment may be
        made.
21.27 = Services provided by a Medicare
        sanctioned/excluded provider. No
        Medicare payment may be made.
21.3  = This provider was not covered by
        Medicare when you received this service.
21.30 = The provider decided to drop out of
        Medicare. No payment can be made for this
        service. You are responsible for this
        charge.
21.31 = This service was not covered by Medicare
        at the time you recieved it.
21.32 = This service was denied because Medicare
        only covers this service under certain
        circumstances.
21.4  = Services provided outside the United
        States are not covered. See your
        Medicare Handbook for services received
        in Canada and Mexico.
21.5  = Services needed as a result of war are
        not covered.
21.6  = This item or service is not covered when
        performed, referred or ordered by this
        provider.
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21.7  = This service should be included on your
         inpatient bill.
21.8  = Services performed using equipment that
         has not been approved by the Food and
         Drug Administration are not covered.
21.9  = Payment cannot be made for unauthorized
         service outside the managed care plan.


Section 22 Split Claims
22.1  = Your claim was separated for processing.
         The remaining services may appear on a
         separate notice.


Section 23 Surgery
23.1  = The cost of care before and after the
         surgery or procedure is included in the
         approved amount for that service.
23.10 = Payment has been reduced because this
         procedure was terminated before
         anesthesia was started.
23.11 = Payment cannot be made because the
         surgery was canceled or postponed.
23.12 = Payment has been reduced because the
         surgery was canceled after you were
         prepared for surgery.
23.13 = Because you were prepared for surgery and
         anesthesia was started, full payment is
         being made even though the surgery was
         canceled.
23.14 = The assistant surgeon must file a
         separate claim for this service.
23.15 = The approved amount is less because the
         payment is divided between two doctors.
23.16 = An additional amount is not allowed for
         this service when it is performed on both
         the left and right sides of the body.
23.17 = Medicare won't cover these services
         because they are not considered medically
         necessary.
23.2  = Cosmetic surgery and related services are
         not covered.
23.3  = Medicare does not pay for surgical
         supports except primary dressings for
         skin grafts.
23.4  = A separate charge is not allowed because
         this service is part of the major
         surgical procedure.
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23.5  = Payment has been reduced because a
        different doctor took care of you before
        and/or after the surgery.
23.6  = This surgery was reduced because it was
        performed with another surgery on the
        same day.
23.7  = Payment cannot be made for an assistant
        surgeon in a teaching hospital unless a
        resident doctor was not available.
23.8  = This service is not payable because it is
        part of the total maternity care charge.
23.9  = Payment has been reduced because the
        charges billed did not include post-
        operative care.


Section 24 'Help Stop Fraud' messages
24.1  = Protect your Medicare number as you would
        a credit card number.
24.10 = Always read the front and back of your
        Medicare Summary Notice.
24.11 = Beware of Medicare scams, such as offers
        of free milk or cheese for your Medicare
        number.
24.12 = Read your Medicare Summary Notice
        carefully for accuracy of dates, services
        , and amounts billed to Medicare.
24.13 = Be sure you understand anything you are
        asked to sign.
24.14 = Be sure any equipment or services you
        received were ordered by your doctor.
24.15 = Review your Medicare Summary Notice and
        report items and services that you did
        not receive to Medicare's Fraud Hotline
        at 1-866-417-2078.
        FLORIDA - SPECIFIC MESSAGE
24.16 = Report items and services that you did
        not receive to Medicare's Fraud Hotline
        at 1-866-417-2078.
        FLORIDA - SPECIFIC MESSAGE
24.19 = You may see some claims that have been
        adjusted. For an explanation see the
        General Information section
        See Expiration Date and Message Notes
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24.2  = Beware of telemarketers or advertisements
        offering free or discounted Medicare
        items and services.
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24.22 = You can make a difference!  Last year,
        tax-payers saved $4 billion-the largest
        sum ever recovered in a single year-
        thanks in large part to people who came
        forward and reported suspicious activity.
        See "Message Implementation Date" and
        "Message Notes" columns. ---->
24.3  = Beware of door-to-door solicitors
        offering free or discounted Medicare
        items or services.
24.4  = Only your physician can order medical
        equipment for you.
24.5  = Always review your Medicare Summary
        Notice for correct information about the
        items or services you received.
24.6  = Do not sell your Medicare number or
        Medicare Summary Notice.
24.7  = Do not accept free medical equipment you
        don't need.
24.8  = Beware of advertisements that read,
        "This item is approved by Medicare", or
        "No out-of-pocket expenses."
24.9  = Be informed - Read your Medicare Summary
        Notice.
        See "Message Expiration Date" and
        "Message Notes" columns ----->

Section 25 Time Limit for filing
25.1  = This claim was denied because it was
        filed after the time limit.
25.2  = You can be billed only 20% of the charges
        that would have been approved.
25.3  = The time limit for filing your claim has
        expired, therefore appeal rights are not
        applicable for this claim.

Section 26 Vision
26.1  = Eye refractions are not covered.
26.2  = Eyeglasses or contact lenses are only
        covered after cataract surgery or if the
        natural lens of your eye is missing.
26.3  = Only one pair of eyeglasses or contact
        lenses is covered after cataract surgery
        with lens implant.
26.4  = This service is not covered when
        performed by this provider.
26.5  = This service is covered only in
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conjunction with cataract surgery.
26.6 = Payment was reduced because the service
        was terminated early.

Section 27 Hospice
27.1 = This service is not covered because you
        are enrolled in a hospice.
27.10 = The documentation indicates that the
        service level of continuous home care
        wasn't reasonable and necessary.
        Therefore, payment will be adjusted to
        the routine home care rate.
27.11 = The provider has billed in error for the
        routine home care items or services
        received.
27.12 = The documentation indicates that your
        respite level of care exceeded five
        consecutive days. Therefore, payment
        for every day beyond the 5th day will be
        paid at the routine home care rate.
27.13 = According to Medicare hospice
        requirements, this service is not covered
        because the service was provided by a
        non-attending physician.
27.2 = Medicare will not pay for inpatient
        respite care when it exceeds five
        consecutive days at a time.
27.3 = The physician certification requesting
        hospice services was not received timely.
27.4 = The documentation received indicates that
        the general inpatient care level of
        services were not necessary for care
        related to the terminal illness.
        Therefore, payment will be adjusted to
        the routine home care rate.
27.5 = Payment for the day of discharge from the
        hospital will be made to the hospice
        agency at the routine home care rate.
27.6 = The documentation indicates the level of
        care was at the respite level not the
        general inpatient level of care.
        Therefore, payment will be adjusted to
        the routine home care rate.
27.7 = According to Medicare hospice
        requirements, the hospice election
        consent was not signed timely.
27.8 = The documentation submitted does not

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             support that your illness is terminal.
27.9   = The documentation indicates your
           inpatient level of care was not
           reasonable and necessary. Therefore,
           payment will be adjusted to the routine
           home care rate.
27.99 = Medicare allows your doctor to charge for
           developing a plan of treatment for your
           home health or hospice services.


Section 28 Mandatory
28.1   = Because you have Medicaid, your provider
           must agree to accept assignment.


Section 29 MSP
29.1   = Secondary payment cannot be made because
           the primary insurer information was
           either missing or incomplete.
29.10 = These services cannot be paid because you
           received them on or before you received
           a liability insurance payment for this
           injury or illness.
29.11 = Our records show that an automobile
           medical, liability, or no-fault insurance
           plan is primary for these services.
           Submit this claim to the primary payer.
29.12 = Our records show that these services may
           be covered under the Black Lung Program.
           Contact the U.S. Department of Labor,
           Federal Black Lung Program, P.O. Box 8302
           , London, KY 40742-8302
29.13 = Medicare does not pay for these services
           because they are payable by another
           government agency. Submit this claim to
           that agency.
29.14 = Medicare's secondary payment is ($_____)
           . This is the difference between the
           primary insurer's approved amount of
           ($_____) and the primary insurer's paid
           amount of ($_____).
29.15 = Medicare's secondary payment is ($_____)
           . This is the difference between
           Medicare's approved amount of ($_____)
           and the primary insurer's paid amount of
           ($_____).
29.16 = Your primary insurer approved and paid (
           $_____) on this claim. Therefore, no
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secondary payment will be made by
Medicare.

29.17 = Your provider agreed to accept ($_____)
as payment in full on this (claim/service
). Your primary insurer has already paid
($_____) so Medicare's payment is the
difference between the two amounts.

29.18 = The amount listed in the "You May Be
Billed" column assumes that your primary
insurer paid the provider. If your
primary insurer paid you, then you are
responsible to pay the provider the
amount your primary insurer paid to you
plus the amount in the "You May Be Billed
" column.
This message should be revised to read
"If your primary insurer paid you for
this claim, you are responsible to pay
that amount to your provider plus the
amount in the "Maximum You May Be Billed"
column."
See "Message Implementation Date" and
"Message Notes" columns.

29.19 = If your primary insurer paid your
provider for this claim, you now only
need to pay your provider the difference
between the amount charged and the amount
your primary insurer paid.

29.2 = No payment was made because your primary
insurer's payment satisfied the
provider's bill.

29.20 = If your primary insurer paid your
provider for this claim, you only need to
pay the difference between the amount
your provider agreed to accept and the
amount your primary insurer paid.

29.21 = If your primary insurer made payment on
this claim, you may be billed the
difference between the amount charged and
your primary insurer's payment.

29.22 = If your primary insurer paid the provider
, you need to pay the provider the
difference between the limiting charge
amount and the amount the primary
insurer paid your provider.

29.23 = No payment can be made because payment
was already made by either worker's

compensation or the Federal Black Lung
Program.

29.24 = No payment can be made because payment
was already made by another government
entity.

29.25 = Medicare paid all covered services not
paid by other insurer.

29.26 = The primary payer is _____.

29.27 = Your primary group's payment satisfied
Medicare deductible and coinsurance.

29.28 = Your responsibility on this claim has
been reduced by the amount paid by your
primary insurer.

29.29 = Your provider is allowed to collect a
total of ($_____) on this claim. Your
primary insurer paid ($_____) and
Medicare paid ($_____). You are
responsible for the unpaid portion of
($_____).

29.3 = Medicare benefits are reduced because
some of these expenses have been paid by
your primary insurer.

29.30 = ($_____) of the money approved by your
primary insurer has been credited to your
Medicare Part B (A) deductible. You do
not have to pay this amount.

29.31 = Resubmit this claim with the missing or
correct information.

29.32 = Medicare's secondary payment is ($_____)
. This is the difference between
Medicare's limiting charge amount of
($_____) and the primary insurer's paid
amount of ($_____).

29.33 = Your claim has been denied by Medicare
because you may have funds set aside from
your settlement to pay for your future
medical expenses and prescription drug
treatment related to your injury(ies).

29.34 = The claim for this item/service was
submitted by your complementary insurer
on your behalf.

29.35 = Per statute, Medicare only accepts claims
from your complementary insurer when
Medicare is the primary payer.

29.71 = Medicare benefits are being paid on the
condition that if you receive payment
from liability insurance, an automobile

medical insurance policy or plan, or any
other no-fault insurance, you must repay
Medicare.

29.4 = In the future, if you send claims to
Medicare for secondary payment, please
send them to (carrier MSP address).

29.5 = Our records show that Medicare is your
secondary payer. This claim must be sent
to your primary insurer first.

29.6 = Our records show that Medicare is your
secondary payer. Services provided
outside your prepaid health plan are not
covered. We will pay this time only
since you were not previously notified.

29.7 = Medicare cannot pay for this service
because it was furnished by a provider
who is not a member of your employer
prepaid health plan. Our records show
that you were informed of this rule.

29.8 = This claim is denied because the
service(s) may be covered by the worker's
compensation plan. Ask your provider to
submit a claim to that plan.

29.9 = Since your primary insurance benefits
have been exhausted, Medicare will be
primary on this accident related service.

Section 3 Chiropractic
3.1   = This service is covered only when recent
x-rays support the need for the service.

3.7   = Medicare does not pay for this unless a
sympton or sign of a problem is stated
on the claim.

3.18 = This represents an adjustment of a
previously processed claim. If an
underpayment was made, the attached
check pays the total claim allowed minus
the amount originally paid. If an
overpayment requiring a refund was made
and a refund has not already been
submitted, you will be contacted by
letter from the Medicare claims office.

Section 30 Reasonable Charge and Fee Schedule
30.1 = The approved amount is based on a special
payment method.

30.2 = The facility fee allowance is greater

than the billed amount.
30.3 = Your doctor did not accept assignment for
        this service. Under Federal law, your
        doctor cannot charge more than ($_____)
        . If you have already paid more than
        this amount, you are entitled to a refund
        from the provider.
30.4 = A change in payment methods has resulted
        in a reduced or zero payment for this
        procedure.
30.41 = What Medicare pays for a service or item
        may be higher than the billed amount.
        This amount is correct. Medicare pays
        this provider less than the billed amount
        on other claims since payment rates are
        set in advance for certain services and
        averaged out over an entire year.
30.5 = This amount is the difference in billed
        amount and Medicare approved amount.

Section 31 Adjustments
31.1 = This is a adjustment to a previously
        processed claim and/or deductible record.
31.10 = This is an adjustment to a previously
        processed charge (s). This notice may
        not reflect the charges as they were
        originally submitted.
31.11 = The previous notice we sent stated that
        your doctor could not charge more than
        ($_____). This additional payment
        allows your doctor to bill you the full
        amount charged.
31.12 = The previous notice we sent stated the
        amount you could be charged for this
        service. This additional payment changed
        that amount. Your doctor cannot charge
        you more than ($_____).
31.13 = The Medicare paid amount has been reduced
        by ($_____) previously paid for this
        claim.
31.14 = This payment is the result of an
        Administrative Law Judge's decision.
31.15 = An adjustment was made based on a
        redetermination.
31.16 = An adjustment was made based on a
        reconsideration.
31.17 = This is an internal adjustment. No

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                action is required on your part.
31.18 = This adjustment has resulted in an
                overpayment to your provide/supplier.
                Your provider/supplier has been requested
                to repay $_____ to Medicare. You do
                not have to pay this amount.
31.19 = If you do not agree with the Medicare
                approved amount(s), you may ask for a
                reconsideration. You must request a
                reconsideration within 180 days of the
                date of receipt of this notice. You may
                present any new evidence which could
                affect your decision. Call us at the
                number in the Customer Service block if
                you need more information about the
                reconsideration process.
                This message should be revised to read,
                "If you disagree with the Medicare-
                approved amount, you may ask for a
                redetermination within 120 days of
                receipt of this notice. Call
                1-800-MEDICARE if you need information
                on the redetermination process." when
                your MAC implements the new MSN design.
                See "Message Implementation Date" and
                "Message Notes" colums. ----->
31.2  = A payment adjustment was made based on a
                telephone review.
31.3  = This notice is being sent to you as the
                result of a reopening request.
31.4  = This notice is being sent to you as the
                result of a fair hearing request.
31.5  = If you do not agree with the Medicare
                approved amount(s) and $100 or more is
                in dispute (less deductible and
                coinsurance), you may ask for a hearing.
                You must request a hearing within 6
                months of the date of this notice. To
                meet the limit you may combine amounts
                on other claims that have been reviewed.
                At the hearing, you may present any new
                evidence which could affect the decision.
                Call us at the number in the Customer
                Service block if you need more
                information about the hearing process.
31.6  = A payment adjustment was made based on a
                Quality Improvement Organization request.
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31.7  = This claim was previously processed under
        an incorrect Medicare claim number or
        name. Our records have been corrected.
31.8  = This claim was adjusted to reflect the
        correct provider.
31.9  = This claim was adjusted because there
        was an error in billing.
31.95 = Per our telephone call, no payment can be
        made on your review request. The approved
        amount is the total allowance we can make
        for this service.
31.96 = Per our telephone call, no payment can be
        made on your review request. Medicare
        does not separately pay for these charges
        because the cost of related care before
        and after the surgery/procedure is part
        of the approved amount for the surgery/
        procedure.
31.97 = Per our telephone call, no payment can be
        made on your review request. Medicare
        does not pay for this many services
        within this period of time.
31.98 = Per our telephone call, no payment can be
        made on your review request. Medicare
        does not pay for routine foot care.
31.99 = As a result of the Hearing Officer's
        decision, no additional payment can be
        made.

Section  Overpayments/Offsets
32.1  = ($_____) of this payment has been
        withheld to recover a previous
        overpayment.
32.2  = You should not be billed separately by
        your physician(s) for services provided
        during this inpatient stay.
32.3  = Medicare has paid $_____ for hospital
        and doctor services. You shouldn't be
        billed separately by your doctor(s) for
        services you got during this inpatient
        stay.

Section 33 Ambulatory Surgical Centers
33.1  = The ambulatory surgical center must bill
        for this service.

Section 34 Patient Paid/Split Payments
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34.1 = Of the total ($_____) paid on this claim, we are paying you ($_____) because you paid your provider more than your 20% coinsurance on Medicare approved services. The remaining ($_____) was paid to the provider.

34.2 = The amount in the "You May Be Billed" column has been reduced by the amount you paid the provider at the time the services were rendered.
This message should be revised to read "Maximum You May Be Billed" (in place of "You May Be Billed") when your MAC implements the new MSN design.
See "Message Implementation Date" and "Message Notes" columns. ------>

34.3 = After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider.

34.4 = We are paying you ($_____) because the amount you paid the provider was more than you may be billed for Medicare approved charges.

34.5 = The amount owed you is ($_____).
Medicare does not routinely issue checks for amounts under $1.00. This amount due will be included in your next check.
If you want this money issued immediately, please contact us at the address or phone number in the Customer Service Information box.
The last sentence of this message should be revised to read, "If you want this money issued immediately, please call 1-800-MEDICARE (1-800-633-4227)." when your MAC implements the new MSN design.
See "Message Implementation Date" and Message Notes" columns.

34.6 = Your check includes ($_____) which was withheld on a prior claim.

34.7 = This check includes an amount less than $1.00 that was withheld on a prior claim.

34.8 = The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of

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                  ($_____) from your provider, which is
                  the difference between what you paid and
                  what you should have paid.
34.9   =  If you already paid the supplier/provider
                  , the supplier/provider must refund any
                  amount that exceeds the Medicare approved
                  amount.

Section 35 Supplemental Coverage/Medigap
35.1   =  This information is being sent to your
                  private insurer(s). Send any questions
                  regarding your benefits to them.
35.2   =  We have sent your claim to your Medigap
                  insurer. Send any questions regarding
                  your benefits to them.
35.3   =  A copy of this notice will not be
                  forwarded to your Medigap insurer because
                  the Medigap information submitted on the
                  claim was incomplete or invalid. Please
                  submit a copy of this notice to your
                  Medigap insurer.
35.4   =  A copy of this notice will not be
                  forwarded to your Medigap insurer because
                  your provider does not participate in the
                  Medicare program. Please submit a copy
                  of this notice to your Medigap insurer.
35.5   =  We did not send this claim to your
                  private insurer. They have indicated no
                  additional payment can be made. Send any
                  questions regarding your benefits to them
35.6   =  Your supplemental policy is not a Medigap
                  policy under Federal and State law or
                  regulation. It is your responsibility to
                  file a claim directly with your insurer.
35.7   =  Please do not submit this notice to them
                  (add-on to other messages as appropriate).

Section 36 Limitation of Liability
36.1   =  Our records show that you were informed
                  in writing, before receiving the service
                  that Medicare would not pay. You are
                  liable for this charge. If you do not
                  agree with this statement, you may ask
                  for a review.
36.2   =  You didn't know this service isn't
                  covered so you don't have to pay. If you
                  paid and do not receive a refund from
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              your provider, you have 6 months to send
              a copy of this notice, your provider's
              bill, and proof that you paid to the
              address on the last page of this notice.
              Future services of this type won't be
              paid.
36.3   = Your provider was told that you're owed
              a refund for this service. If you don't
              get a refund within 30 days of getting
              this notice, send a copy of this notice
              to the address on the last page. Refunds
              may be delayed if your provider appeals
              this decision.
36.4   = You are getting a refund because your
              provider didn't tell you in writing that
              Medicare wouldn't pay for this service.
              In the future, you will have to pay for
              the service.
36.5   = You are getting a refund because your
              provider didn't tell you in writing that
              Medicare would approve a reduced level/
              amount of services. In the future, you
              will have to pay for the service.
36.6   = Medicare is paying this claim, this time
              only, because it appears that neither you
              nor the provider knew that the service(s)
              would be denied. You will have to pay for
              future services of this type.
36.7   = This code is for informational/reporting
              purposes only. You should not be charged
              for this code. If there is a charge, you
              do not have to pay the amount.


Section 37 Deductible/Coinsurance
37.1   = This approved amount has been applied
              toward your deductible.
37.10 = You have now met ($_____) of your
              ($_____) Part A deductible for this
              benefit period.
37.11 = You have met the Part B deductible for
              (year).
37.12 = You have met the Part A deductible for
              this benefit period.
37.13 = You have met the blood deductible for
              (year).
37.14 = You have met ($_____) pint(s) of your
              blood deductible for (year).
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37.15 = After your deductible and coinsurance
        were applied, the amount Medicare paid
        was reduced due to Federal, State and
        local rules.
37.16 = You have now met $_____ of your
        $_____ Part B deductible for calendar
        year ____.
37.17 = The "Maximum You May Be Billed" column
        includes $_____ for your Part B
        deductible, $_____ for your Part B
        coinsurance, $_____ for your Part A
        deductible, and $_____ for your Part A
        coinsurance and/or lifetime reserve
        coinsurance.
        *If your MAC will implement the new MSN
        design AFTER 07/01/13, use the following
        language for this message from 07/01/13
        until your MAC DOES implement the new MSN
        design: The "You May Be Billed" column
        includes $_____ for your Part B
        deductible, $_____ for your Part B
        coinsurance, $_____ for your Part A
        deductible, and $_____ for your Part A
        coinsurance and/or lifetime reserve
        coinsurance.
37.2  = ($_____) of this approved amount has
        been applied toward your deductible.
37.3  = ($_____) was applied to your inpatient
        deductible.
37.4  = ($_____) was applied to your inpatient
        coinsurance.
37.5  = ($_____) was applied to your skilled
        nursing facility coinsurance.
37.6  = ($_____) was applied to your blood
        deductible.
37.7  = Part B cash deductible does not apply to
        these services.
37.8  = This coinsurance amount reflects the
        amount that you are required to pay for
        outpatient mental health treatment
        services under the Medicare program.
37.9  = You have now met ($_____) of your
        ($_____) Part B deductible for (year).

Section 38 General Information
38.1  = Discontinued 2002
38.10 = Compare the services you receive with
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those that appear on your Medicare
Summary Notice. If you have questions,
call your doctor or provider. If you feel
further investigation is needed due to
possible fraud or abuse, call the phone
number in the Customer Service
Information Box.
The last sentence of this message should
be revised to read, "If you feel further
investigation is needed due to possible
fraud or abuse, call 1-800-MEDICARE
(1-800-633-4227)." when your MAC
implements the new MSN design.
See "Message Implementation Date" and
Message Notes" columns. ----->
38.11 = Preventive Messages:

January - Cervical Health

January is cervical health month. The
Pap test is the most effective way to
screen for cervical cancer. Medicare
helps pay for screening Pap tests every
two years. For more information on Pap
tests, call your Medicare carrier.

January - National Glaucoma Awareness
Month (Optional)
Glaucoma may cause blindness. Medicare
helps pay for a yearly dilated eye exam
for people at high risk for Glaucoma.
African-Americans over 50 and people with
diabetes or a family history of glaucoma
are at higher risk. Talk to your doctor
to learn if this exam is right for you.

February - General Preventive Services
Medicare helps pay for many preventive
services including flu and pneumococcal
shots, tests for cancer, diabetes
monitoring supplies and others. Call
1-800-MEDICARE (1-800-633-4227) for more
information.

March - National Colorectal Cancer
Awareness Month
Colorectal cancer is the second leading

cancer killer in the United States.
Medicare helps pay for colorectal cancer
screening tests. Talk to your doctor
about screening options that are right
for you.

April - General Preventive Services
Medicare helps pay for many preventive
services including flu and pneumococcal
shots, tests for cancer, diabetes
monitoring supplies and others. Call
1-800-MEDICARE (1-800-633-4227) for more
information.

May - National Osteoporosis Month
Do you know how strong your bones are?
Medicare helps pay for bone mass
measurement tests to measure the strength
of bones for people at risk of
osteoporosis. Talk to your doctor to
learn if this test is right for you.

May - Breast Cancer Awareness (to
coordinate with Mother's Day) - Optional
Early detection is the best protection
from breast cancer. Get a mammogram.
Not just once, but for a lifetime.
Medicare helps pay for screening
mammograms.

June - General Preventive Services
Message:
Medicare helps pay for many preventive
services including flu and pneumococcal
shots, tests for cancer, diabetes
monitoring supplies and others. Call
1-800-MEDICARE (1-800-633-4227) for more
information.

July- Glaucoma Awareness
Glaucoma may cause blindness. Medicare
helps pay for a yearly dilated eye exam
for people at high risk for Glaucoma.
African-American people over 50, and
people with diabetes or a family history
of glaucoma are at higher risk. Talk to
your doctor to learn if this exam is

right for you.

August - National Immunization Awareness
Month (Contractors may elect to print
this message during a different month of
their choosing, but the message about
the pneumococcal shot must be printed one
month of each year.)
Get a pneumococcal shot. You may only
need it once in a lifetime. Contact your
health care provider about getting this
shot. You pay nothing if your health
care provider accepts Medicare assignment

September - Cold and Flu Campaign
During this flu season, get your flu shot
. Contact your health care provider for
the flu shot. Get the flu shot, not the
flu. You pay nothing if your health care
provider accepts Medicare assignment.

September - Prostate Cancer Awareness
Month - Optional
Prostate cancer is the second leading
cause of cancer deaths in men. Medicare
covers prostate screening tests once
every 12 months for men with Medicare who
are over age 50.

October - Breast Cancer Awareness Month
Early detection is your best protection.
Schedule your mammogram today, and
remember that Medicare helps pay for
screening mammograms.

October - Continuation of Cold/Flu
Campaign (optional)
If you have not received your flu shot,
it is not too late. Please contact your
health care provider about getting the
flu shot.

November - American Diabetes Month
Medicare covers expanded benefits to help
control diabetes

Section 38 General Information

38.12 = If you appeal this drug claim
        determination, send it to the Medicare
        contractor who processed your doctor's
        claim for giving you the drug.
38.13 = If you aren't due a payment check from
        Medicare, your Medicare Summary Notices
        (MSN) will now be mailed to you on a
        quarterly basis. You will no longer get
        a monthly statement in the mail for these
        types of MSNs. You will now get a
        statement every 90 days summarizing all
        of your Medicare claims. Your provider
        may send you a bill that you may need to
        pay before you get your MSN. When you
        get your MSN, look to see if you paid
        more than the MSN says is due. If you
        paid more, call your provider about a
        refund. If you have any questions about
        the bill from your provider, you should
        call your provider.
38.14 = Have limited income? Social Security
        can help with prescription drug costs.
        For more information on Extra Help with
        prescription drug costs and how to apply,
        visit www.socialsecurity.gov on the web
        or call 1-800-772-1213. TTY users should
        call 1-800-325-0778.
38.15 = If the coinsurance amount you paid is
        more than the amount shown on your notice
        , you are entitled to a refund. Please
        contact your provider.
38.18 = ALERT: Coverage by Medicare will be
        limited for outpatient physical therapy
        (PT), speech-language pathology (SLP),
        and occupational therapy (OT) services
        for services received on January 1, 2006
        through December 31, 2007. The limits are
        $1,740 in 2006 and $1780 in 2007 for PT
        and SLP combined and $1,740 in 2006 and
        $1780 in 2007 for OT. Medicare pays up
        to 80 percent of the limits after the
        deductible has been met. These limits
        don't apply to certain therapy approved
        by Medicare or to therapy you get at
        hospital outpatient departments, unless
        you are a resident of and occupy a
        Medicare-certified bed in a skilled

nursing facility. If you have questions, please call 1-800-MEDICARE.

You have the right to request an itemized statement which details each Medicare item or service which you have received from your physician, hospital, or any other health supplier or health professional. Please contact them directly, in writing, if you would like an itemized statement.

Beneficiaries needing or receiving home health care may qualify for the new Home Health Independence Demonstration and have the freedom to leave home more often while remaining eligible for Medicare home health services. To qualify, you must meet several criteria, have a permanent disabling condition, and live in Colorado, Massachusetts, or Missouri. For more information, ask your home health agency about the "Home Health Independence Demonstration"; call 1(800) MEDICARE (1-800-633-4227); or visit our website at: www.cms.hhs.gov/researchers/demos/homehealthindependence.asp

38.18 = ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2007. The limits are $1,740 in 2006 and $1780 in 2007 for PT and SLP combined and $1,740 in 2006 and $1780 in 2007 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE.

38.19 = Medicare Open Enrollment is from October 15 to December 7. This is when you can compare and change your health and drug plan coverage. If you're happy with your

current plan, you don't have to do anything. Call 1-800-MEDICARE (1 800-633-4227) for more information.

38.2   = Discontinued

38.20 = You have the right to request an itemized statement which details each Medicare item or service you have received from a physician, hospital, or any other healthcare provider or supplier. Contact your provider to get an itemized statement.

38.22 = Planning to retire? Does your current insurance pay before Medicare pays? Call Medicare within the 6 months before you retire to update your records. Make sure your health care bills get paid correctly

38.23 = Save tax dollars by getting your "Medicare & You" handbook electronically. Visit www.mymedicare.gov to sign up.

38.24 = Please have your complete Medicare number with you when you call so your record can be located. To protect your privacy, this MSN doesn't include your entire number.

38.25 = This item or service is being denied. Medicare won't pay for a Medical Nutrition Therapy service and Diabetes Self Management Training item or service performed on the same date for the same person with Medicare.

38.26 = Your claims may have been adjusted since Medicare changed how it pays for certain services in 2010. You can compare claims that have been changed to previous statements you received in the past. Your provider may owe you a refund or you may have to pay more coinsurance. Call your provider or 1-800-MEDICARE.

38.27 = Get a pneumococcal shot. You may only need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment

38.28 = Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.

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38.3   = If you change your address, contact the
         Social Security Administration by calling
         1-800-772-1213.
38.31  = To report a change of address, call
         Social Security at 1-800-772-1213. TTY
         users should call 1-800-325-0778.
38.32  = Welcome to your new Medicare Summary
         Notice! It has clear language, larger
         print, and a personal summary of your
         claims and deductibles. This improved
         notice better explains how to get help
         with your questions, report fraud, or
         file an appeal. It also includes
         important information from Medicare!
38.4   = You're at high risk for complications
         from the flu and it's very important
         that you get vaccinated. Please contact
         your healthcare provider about getting
         the flu vaccine.
38.5   = If you haven't gotten your flu vaccine,
         it isn't too late. Please contact your
         health care provider about getting the
         vaccine.
38.6   = January is cervical cancer prevention
         month.
38.7   = The Pap test is the most effective way
         to screen for cervical cancer.
38.8   = Medicare helps pay for screening Pap
         tests once every two years.
38.9   = Colorectal cancer is the second leading
         cancer killer in the United States.
         Medicare helps pay for screening tests
         that can find polyps before they become
         cancerous and find cancer early when
         treatment may work best. Medicare helps
         pay for screening tests. Talk to your
         doctor about the screening options that
         are right for you.

Section 4 End-Stage Renal Disease (ESRD)
4.1    = This charge is more than Medicare pays
         for maintenance treatment of renal
         disease.
4.10   = No more than ($_____) can be paid for
         these supplies each month.
4.11   = The amount listed in the "You May Be
         Billed" column is based on the Medicare
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approved amount. You are not responsible
for the difference between the amount
charged and the approved amount.
This message should be revised to read
"Maximum You May Be Billed" (in place of
"You May Be Billed") when your MAC
implements the new MSN design.

4.12 = This service has been denied/rejected
        since payment was made to your End Stage
        Renal Disease (ESRD) dialysis facility.

4.18 = Medicare cannot pay more than $_____ each
        month for these supplies. The provider
        cannot bill you for the supplies over
        this limit.

4.2   = This service is covered up to (insert
        appropriate number) months after
        transplant and release from the
        hospital.

4.3   = Prescriptions for immunosuppressive drugs
        are limited to a 30-day supply.

4.4   = Only one supplier per month may be paid
        for these supplies/services.

4.5   = Medicare pays the professional part of
        this charge to the hospital.

4.6   = Payment has been reduced by the number
        of days you were not in the usual place
        of treatment.

4.7   = Payment for all equipment and supplies
        is made through your dialysis center.
        They will bill Medicare for these
        services.

4.8   = This service cannot be paid because you
        did not choose an option for your
        dialysis equipment and supplies.

4.9   = Payment was reduced or denied because the
        monthly maximum allowance for this home
        dialysis equipment and supplies has been
        reached.

Section 41 Home Health Messages

41.1 = Medicare will only pay for this service
        when it is provided in addition to other
        services.

41.10 = Patients eligible to receive home health
        benefits from another government agency
        are not eligible to receive Medicare
        benefits for the same service.

41.11 = The doctor's orders for home health
        services were incomplete.
41.12 = According to the medical record, the
        provider has billed in error for these
        items/services.
41.13 = The provider has billed for services/
        items not documented in your record.
41.14 = This service/item was billed incorrectly.
41.15 = The information provided indicates that
        you are able to perform personal care
        activities on your own.
41.16 = To receive Medicare payment, you must
        have a signed doctor's order before you
        receive the services.
41.2 = This service must be performed by a nurse
        who has the required psychiatric nurse
        credentials.
41.3 = The medical information did not support
        the need for continued services.
41.4 = Medicare considers this item to be
        inappropriate for home use.
41.5 = Medicare does not pay for comfort or
        convenience items.
41.6 = This item was not furnished under a plan
        of care established by your physician.
41.7 = This item is not considered by Medicare
        to be a prosthetic and/or orthotic device
41.8 = The information provided indicates that
        your illness or injury doesn't restrict
        your ability to leave your home, except
        with the assistance of another individual
        or the aid of a supportive device (such
        as crutches, a cane, a wheelchair, or a
        walker).
41.9 = Services exceeded those ordered by your
        physician.

Section 42 Religious Nonmedical Health Care
Institutions
42.1 = You received medical care at a facility
        other than a religious nonmedical health
        care institution but that care did not
        revoke your election to receive benefits
        for religious nonmedical health care.
42.2 = Since you received medical care at a
        facility other than a religious
        nonmedical health care institution,

benefits for religious nonmedical health
care services have been revoked for these
services unless you file a new election.

42.3 = This service is not covered since you did
not elect to receive religious
nonmedical health care services instead
of regular Medicare services.

42.4 = This service is not covered because you
received medical health care services
which revoked your election to religious
nonmedical health care services.

42.5 = This service is not covered because you
requested in writing that your election
to religious nonmedical health care
services be revoked.

Section 5 Number/Name/Enrollment

5.1 = Our records show that you do not have
Medicare entitlement under the number
shown on this notice. If you do not
agree, please contact your local Social
Security office.

5.2 = The name or Medicare number was incorrect
or missing. Please check your Medicare
card. If the information on this notice
is different from your card, contact your
provider.

5.3 = Our records show that the date of death
was before the date of service.

5.4 = If you cash the enclosed check, you are
legally obligated to make payment for
these services. If you do not wish to
assume this obligation, please return
this check.

5.5 = Our records show you did not have Part A
(B) coverage when you received this
service. If you disagree, please contact
us at the customer service number shown
on this notice.

5.6 = The name or Medicare number was incorrect
or missing. Ask your provider to use the
name or number shown on this notice for
future claims.

5.7 = Medicare payment may not be made for the
item or service because on the date of
service you were not lawfully present in
the United States.

Section 6 Drugs
6.1   = This drug is covered only when Medicare
         pays for the transplant.
6.2   = Drugs not specifically classified as
         effective by the Food and Drug
         Administration are not covered.
6.3   = Payment cannot be made for oral drugs
         that do not have the same active
         ingredients as they would have if given
         by injection.
6.4   = Medicare does not pay for an oral
         anti-emetic drug that is not administered
         for use immediately before, at, or within
         48 hours after administration of a
         Medicare covered chemotherapy drug.
6.5   = Medicare cannot pay for this injection
         because one or more requirements for
         coverage were not met.

Section 43 Demonstration Project Messages
60.1   = In partnership with physicians in your
         area, _____ is participating in a
         Medicare demonstration project that uses
         a simplified payment method to combine
         all hospital and physician care related
         to your hospital service.
2/18/13= Even though this service is being paid
         in accordance with the rules and
         guidelines under the Competitive Bidding
         Demonstration, future claims may be
         denied when this item is provided to this
         patient by a non-demonstration supplier.
         If you would like more information
         egarding this project, you may contact
         1-888-289-0710.
60.11 = These services are covered by a
         demonstration project or payment model
         pilot. It will pay for all services
         related to this hospital stay. If you
         have already paid a provider for any of
         these services, you should receive a
         refund.
60.12 = Your co-payment under this demonstration
         is the lesser of 20% of the Medicare
         allowed amount or 20% of the allowed
         amount under your drug discount card.

60.13 = This claim is being processed under a
        demonstration project. Services cannot
        be covered because you do not reside in
        one of the demonstration areas.
60.14 = This claim is being processed under a
        demonstration project. Services cannot
        be covered because your doctor does not
        have a practice in one of the
        demonstration areas.
60.15 = Beginning April 1, 2005 through March 31,
        2007, Medicare will cover additional
        chiropractic services. For more
        information, talk to your chiropractor,
        call 1-800-MEDICARE, or go to
        http://www.cms.hhs.gov/researchers/demos
        /eccs/default.asp.
60.16 = This claim is being processed under a
        demonstration or payment model pilot.
        All hospital and doctor services related
        to your hospital stay have been combined
        into a single payment. You may have to
        pay any unmet deductible and coinsurance
        amounts.
60.2 = The total Medicare approved amount for
        your hospital service is ($_____).
        ($_____) is the Part A Medicare amount
        for hospital services and ($_____) is
        the Part B Medicare amount for physician
        services (of which Medicare pays 80
        percent). You are responsible for any
        deductible and coinsurance amounts
        represented.
60.3 = Medicare has paid ($_____) for hospital
        and physician services. Your Part A
        deductible is ($_____). Your Part A
        coinsurance is ($_____) Your Part B
        coinsurance is ($_____).
60.4 = This claim is being processed under a
        demonstration project.
60.5 = This claim is being processed under a
        demonstration project. If you would like
        more information about this project,
        please contact 1-888-289-0710.
60.6 = A claim has been submitted on your behalf
        indicating that you are participating in
        the Medicare Coordinated Care
        Demonstration project. However, our

```
               records indicate that you are not
               currently enrolled or your enrollment
               has not yet been approved for the
               demonstration.
60.7   = A claim has been submitted on your behalf
               indicating that you are participating in
               the Medicare Coordinated Care
               Demonstration project. However, our
               records indicate that either you have
               terminated your election to participate
               in the demonstration project or the dates
               of service are outside the demonstration
               participation dates.
60.8   = The approved amount is based on the
               maximum allowance for this item under the
               DMEPOS Competitive Bidding Demonstration.
60.9   = Our records indicate that this patient
               began using this service(s) prior to the
               current round of the DMEPOS Competitive
               Bidding Demonstration. Therefore, the
               approved amount is based on the allowance
               in effect prior to this round of bidding
               for this item.


Section 7 Duplicate Bills
7.1    = This is a duplicate of a charge already
               submitted.
7.15   = Medicare records show that payment for
               this service has already been made by
               another contractor.
7.2    = This is a duplicate of a claim processed
               by another contractor. You should
               receive a Medicare Summary Notice from
               them.
7.3    = This service/item is a duplicate of a
               previously processed service. You may
               only appeal the decision that this
               service/item is a duplicate. The appeals
               information on this notice only applies
               to the duplicate service issue.
7.4    = The claim for the billing fee was denied
               because it was submitted past the allowed
               time frame.
7.7    = Your physician has elected to participate
               in the Competitive Acquisition Program
               for these drugs. Claims for these drugs
               must be billed by the appropriate drug
```

vendor instead of your physician.

7.8 = Your physician has elected to participate
in the Competitive Acquisition Program
(CAP) for Medicare Part B drugs. Medicare
cannot pay for the administration of the
drug(s) being billed because these
drug(s) are not available from the CAP
vendor.

Section 8 Durable Medical Equipment (DME)

8.1 = Your supplier is responsible for the
servicing and repair of your rented
equipment.

8.2 = To receive Medicare payment, you must
have a doctor's prescription before you
rent or purchase this equipment.

8.10 = Payment is included in the approved
amount for other equipment.

8.11 = The purchase allowance has been reached.
If you continue to rent this piece of
equipment, the rental charges are your
responsibility.

8.12 = The approved charge is based on the
amount of oxygen prescribed by the doctor

8.13 = Monthly rental payments can be made for
up to 15 months from the first paid
rental month or until the equipment is
no longer needed, whichever comes first.

8.14 = Your equipment supplier must furnish and
service this item for as long as you
continue to need it. Medicare will pay
for maintenance and/or servicing for
every 6 month period after the end of
the 15th paid rental month.

8.15 = Maintenance and/or servicing of this item
is not covered until 6 months after the
end of the 15th paid rental month.

8.16 = Monthly allowance includes payment for
oxygen and supplies.

8.17 = Payment for this item is included in the
monthly rental payment amount.

8.18 = Payment is denied because the supplier
did not have a written order from your
doctor prior to delivery of this item.

8.19 = Sales tax is included in the approved
amount for this item.

8.2 = To receive Medicare payment, you must

```
             have a doctor's prescription before you
             rent or purchase this equipment.
8.20   = Medicare does not pay for this equipment
             or item.
8.21   = Medicare won't cover this item without a
             new, revised or renewed certificate of
             medical necessity.
8.22   = No further payment can be made because
             the cost of repairs has added up to the
             purchase price of this item.
8.23   = No payment can be made because the item
             has reached the 15-month limit.
             Separate payments can be made for
             maintenance or servicing every 6 months.
8.24   = The claim doesn't show that you own the
             equipment requiring these parts or
             supplies.
8.25   = Payment cannot be made until you tell
             your supplier whether you want to rent
             or buy this equipment.
8.26   = Payment is reduced by 25% beginning the
             4th month of rental.
8.27   = Payment is limited to 13 monthly rental
             payments because you have decided to
             purchase this equipment.
8.28   = Maintenance, servicing, replacement, or
             repair of this item is not covered.
8.29   = Payment is allowed only for the seat lift
             mechanism, not the entire chair.
8.3    = This equipment is not covered because its
             primary use is not for medical purposes.
8.30   = This item is not covered because the
             doctor did not complete the certificate
             of medical necessity.
8.31   = Payment is denied because blood gas tests
             cannot be performed by a durable medical
             equipment supplier.
8.32   = This item can only be rented for 2 months
             . If the item is still needed, it must
             be purchased.
8.33   = This is the next to last payment for this
             item.
8.34   = This is the last payment for this item.
8.35   = This item is not covered when oxygen is
             not being used.
8.36   = Payment is denied because the certificate
             of medical necessity on file was not in
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           effect for this date of service.
8.37   = An oxygen recertification form was sent
           to the physician.
8.38   = This item must be rented for 2 months
           before purchasing it.
8.39   = This is the 10th month of rental payment.
           Your supplier should offer you the choice
           of changing the rental to a purchase
           agreement.
8.4    = Payment can't be made for equipment
           that's the same or similar to equipment
           already being used.
8.40   = We have previously paid for the purchase
           of this item.
8.41   = Payment for the amount of oxygen supplied
           has been reduced or denied because the
           monthly limit has been reached.
8.42   = Standby equipment is not covered.
8.43   = Payment has been denied because this
           equipment cannot deliver the liters per
           minute prescribed by your doctor.
8.44   = Payment is based on a standard item
           because information did not support the
           need for a deluxe or more expensive item.
8.45   = Payment for electric wheelchairs is
           allowed only if the purchase decision is
           made in the first or tenth month of
           rental.
8.46   = Payment is included in the allowance for
           another item or service provided at the
           same time.
8.47   = Supplies or accessories used with
           noncovered equipment are not covered.
8.48   = Payment for this drug is denied because
           the need for the equipment has not been
           established.
8.49   = This allowance has been reduced because
           part of this item was paid on another
           claim.
8.5    = Rented equipment that is no longer needed
           or used is not covered.
8.50   = Medicare can't pay for this drug/
           equipment because our records show that
           your supplier isn't licensed to dispense
           prescription drugs, and, therefore, can't
           assure the safety and effectiveness of
           the drug/equipment.
```

8.51 = You are not liable for any additional charge as a result of receiving an upgraded item.

8.52 = You signed an Advanced Beneficiary Notice (ABN). You are responsible for the difference between the upgrade amount and the Medicare payment.

8.53 = This item or service was denied because the upgrade information was invalid.

8.54 = If a supplier knew that Medicare wouldn't pay and you paid, you might get a refund unless you signed a notice in advance. Refunds may be delayed if the provider appeals. Call your supplier if you don't hear anything within 30 days.

8.55 = Medicare will process your first claim but, from now on, you must use a Medicare-enrolled supplier and put the supplier ID number on your claim. For a list of Medicare-enrolled suppliers call 1-800-MEDICARE or visit www.medicare.gov/supplier

8.56 = Medicare can't process this claim because you were already notified that you must use a supplier who has a Medicare supplier identification number, and this supplier doesn't have one.

8.57 = Your equipment supplier must furnish and service this item for as long as you continue to need it. Medicare will pay for maintenance and/or servicing for every 3-month period after the end of the 15th paid rental month.

8.58 = No payment can be made because the item has reached the 15-month limit. Separate payments can be made for maintenance or servicing every 3 months.

8.59 = Durable Medical Equipment Regional Carriers only pay for Epoetin Alfa and Darbepoetin Alfa for Method II End Stage Renal Disease home dialysis patients.

8.6 = A partial payment has been made because the purchase allowance has been reached. No further rental payments can be made.

8.60 = Payment is denied because there is no hospital stay/surgery on file for implantation of the Durable Medical

Equipment (DME) or prosthetic device.

8.61 = This supplier isn't located in your competitive bidding area, but is required to accept the same price as a supplier in your area. This supplier may not charge you more than 20% of the bid price , plus any unmet deductibles.

8.62 = This supplier didn't win a contract for furnishing this item in the competitive bidding area where you received it. This supplier isn't allowed to charge you for this item unless you signed a written notice agreeing to pay before you got the item.

8.63 = This supplier isn't located in your competitive bidding area, but is located in a different competitive bidding area. This supplier won a contract under national competitive bidding in their area. They must accept the bid price from your area as payment in full, and may not charge you more than 20% of the bid price for your area, plus any unmet deductibles.

8.64 = Monthly payments can be made for 13 months, or until the equipment is no longer needed, whichever comes first. After the 13th month, your supplier must transfer title of this equipment to you.

8.65 = Medicare will pay for medically necessary maintenance and/or servicing as needed after the end of the 13th paid rental month.

8.66 = Medicare has paid for 36 months of rental for your oxygen equipment. Your supplier must transfer title of this equipment to you. No further rental payments will be made. We will continue to pay for delivery of oxygen contents, as appropriate, and necessary maintenance of your equipment.

8.67 = Medicare has already paid for 36 months of rental for your oxygen equipment. The supplier should have transferred the title for the equipment to you. The supplier may not collect any more money from you for this equipment, and must

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             provide you with a refund of any money
             you have already paid.
8.68   = Medicare will pay for you to rent oxygen
             for up to 36 months (or until you no
             longer need the equipment). After
             Medicare makes 36 payments, your supplier
             will transfer the title of the equipment
             to you, and you will own the equipment.
8.69   = Medicare will pay to maintain and service
             your oxygen equipment. This will start
             six months after the supplier transfers
             the title of the equipment to you.
8.7    = This equipment is covered only if rented.
8.70   = The Medicare-approved amount is based on
             the bid price for this item under the
             DMEPOS competitive bidding program.
8.71   = Our records show that you began using
             this item before the current round of
             competitive bidding and you decided to
             keep getting this item from your current
             supplier. The Medicare-approved amount
             is based on the bid price for this item.
8.72   = This item must be provided by a contract
             supplier under the DMEPOS competitive
             bidding program. You should not be billed
             for this item or service. You do not have
             to pay this amount. There are no Medicare
             appeal rights related to this item.
8.73   = The claim for this service was processed
             according to rules of the DMEPOS
             competitive bidding program.
8.74   = You signed an Advanced Beneficiary Notice
             (ABN) saying that you wanted to get this
             item from a non-winning supplier under
             the DMEPOS Competitive Bidding Program.
             Therefore, Medicare will not pay for this
             item. You must pay the supplier in full.
8.75   = Our records show that you began using
             this item before competitive bidding
             started for this item in your area.
             Because you decided to keep getting this
             item from your current supplier, this
             item will be paid at the standard payment
             amount and not at the bid price.
8.76   = This item or service is not covered
             because the claim shows that it was not
             given in a skilled nursing facility or a
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nursing facility. The claim for this item or service was processed according to the rules of the DMEPOS competitive bidding program.

8.78 = Medicare has paid for 36 months for your oxygen equipment. Your supplier is required to provide the oxygen equipment and related supplies, at no charge, for the remainder of the equipment's 5 year lifetime.

8.79 = Medicare has paid 36 months of rental for your oxygen equipment. The supplier may not collect any more money from you for this equipment, and must refund any money you have already paid.

8.8 = This equipment is covered only if purchased.

8.80 = Medicare will pay for rental of this equipment for 36 months (or until you no longer need the equipment). After 36 months, Medicare will continue to pay for delivery of liquid or gaseous contents, as long as it is still medically necessary.

8.81 = If the provider/supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment , you may be entitled to a refund of any amounts you paid. However, if the provider/supplier requests a review of this claim within 30 days, a refund is not required until we complete our review . If you paid for this service and do not hear anything about a refund within the next 30 days, contact your provider/ supplier.

8.9 = Payment has been reduced by the amount already paid for the rental of this equipment.

8.90 = You live in a Competitive Bidding Area. This is a Competitive Bidding item. The Medicare approved amount is based on the bid price for this item under the DMEPOS competitive bidding program.

8.91 = Our records show that you began using

this item before the DMEPOS Competitive Bidding program began and you decided to keep renting this item from your current supplier. The Medicare-approved amount is based on the bid price for this item for the area where you live.

8.92 = You live in a Competitive Bidding Area and this item must be provided by a Medicare-contract supplier under the DMEPOS competitive bidding program. Medicare won't pay for this item and you shouldn't be billed for this item or service. You don't have to pay this amount. Medicare appeal rights don't apply to this item.

8.93 = Medicare only pays 36 monthly payments for your oxygen. After 36 months, the supplier is still responsible for providing you with that equipment for 5 years. You shouldn't pay any more copayments.

8.95 = Our records show that you began using this item before the DMEPOS Competitive Bidding program started for this item in your area. Because you decided to keep renting this item from your current supplier, this item will be paid at the standard payment amount and not at the bid price.

8.96 = This item or service isn't covered because the claim shows that it wasn't provided in a skilled nursing facility or nursing facility. The claim for this item or service was processed according to the rules of the DMEPOS competitive bidding program.

8.97 = Starting January 1, 2011, you may have to use certain Medicare-contracted suppliers to get certain medical equipment and supplies. Visit www.medicare.gov or call 1-800-MEDICARE for details

Section 9 Failure to Furnish Information
9.1   = The information we requested was not received.
9.2   = This item or service was denied because information required to make payment was

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                      missing.
     9.3    = Please ask your provider to submit a new,
              complete claim to us.
     9.4    = This item or service was denied because
              information required to make payment was
              incorrect.
     9.5    = Our records show your doctor did not
              order this supply or amount of supplies.
     9.6    = Please ask your provider to resubmit this
              claim with a breakdown of the charges or
              services.
     9.7    = We have asked your provider to resubmit
              the claim with the missing or correct
              information.
     9.8    = The hospital has been asked to submit
              additional information, you should not be
              billed at this time.
     9.9    = This service is not covered unless the
              supplier/provider files an electronic
              media claim (EMC).

     Section 96 Jurisdiction-Specific
     96.10 = Go paperless, go green! If you live in
              CT or NY you can stop getting paper
              Medicare Summary Notices (MSNs) in the
              mail, and get Electronic MSNs (eMSNs)
              online instead. To sign up, go to
              www.mymedicare.gov or call 1-800-
              MEDICARE (1-800-633-4227).
              * See Message Notes ----------->

     Section 97 FISS Part A
     97.xx = The entire range of 97.xx messages
              have been blocked off for FISS/Part A
              usage.

     Section 99 Florida-Specific
     99.xx = The entire range of 99.xx messages have
              been blocked off for Florida usage.


CLM_FREQ_TB                              Claim Frequency Table


     0 = Non-payment/zero claims
     1 = Admit thru discharge claim
     2 = Interim - first claim
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3 = Interim - continuing claim (not valid for
    PPS claims)
4 = Interim - last claim (not valid for PPS claims)
5 = Late charge(s) only claim
6 = Reserved for national assignment; Adjustment of prior claim.
    Obsolete
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 election notice - used when hospice
    or Religious Nonmedical Health Care Institution
    is submitting the HCFA-1450 as an
    admission notice - hospice NOE only
    NOTE:  This value is not present in the NCH
    claims data because when they are used the
    transaction does not represent a claim.  This
    frequency code is used on hospice notices of
    election.  Their purpose is to create a hospice
    benefit period in CWF.  No paymentor utilization
    is reported on them.
B = Hospice/Medicare Coordinated Care Demonstration/
    RNCHI - Termination/Revocation Notice - hospice
    NOE only  (eff 9/93)
    NOTE:  This value is not present in the NCH
    claims data because when they are used the
    transaction does not represent a claim.  This
    frequency code is used on hospice notices of
    election.  Their purpose is to create a hospice
    benefit period in CWF.  No paymentor utilization
    is reported on them.
C = Hospice change of provider notice
    - hospice NOE only (eff 9/93)
    NOTE:  This value is not present in the NCH
    claims data because when they are used the
    transaction does not represent a claim.  This
    frequency code is used on hospice notices of
    election.  Their purpose is to create a hospice
    benefit period in CWF.  No paymentor utilization
D = Hospice/Medicare Coordinated Care Demonstration/
    RNHCI - void/cancel
    -  hospice NOE only  (eff 9/93)
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          NOTE:  This value is not present in the NCH
          claims data because when they are used the
          transaction does not represent a claim.  This
          frequency code is used on hospice notices of
          election.  Their purpose is to create a hospice
          benefit period in CWF.  No paymentor utilization
E = Hospice change of ownership
      - hospice NOE only  (eff 1/97)
      NOTE:  This value is not present in the NCH
      claims data because when they are used the
      transaction does not represent a claim.  This
      frequency code is used on hospice notices of
      election.  Their purpose is to create a hospice
      benefit period in CWF.  No paymentor utilization
F = Beneficiary initiated adjustment claim
      (eff 10/93)
G = CWF initiated adjustment claim (eff 10/93)
H = CMS initiated adjustment claim (eff 10/93)
I = Intermediary adjustment claim (other than PRO
      or provider) - used to identify a
      debit adjustment initiated by CMS or
      an intermediary (other than QIO or Provider)
      - 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 initiated adjustment (eff 10/93)
N = Reserved for national assignment
O = Nonpayment/Zero claims
P = Adjustment required by Quality Improvement
      Organization (QIO) -- formerly Peer Review
      Organization (PRO)
Q = Claim Submitted for Reconsideration Outside of
      Timely Limits
X = Replacement of Prior Abbreviated Encounter Submission
      (used by Medicare Advantage contractor or other plan
      required to submit encounter data);
      Special adjustment processing - used for QA editing (eff 8/92)
      Obsolete
Z = New Abbreviated Encounter Submission (TOB '11Z') used
      for MCO enrollee hospital discharges 7/1/97 - 12/31/98;
      not stored in the NCH.  Exception:  Problem in
      startup months may have resulted in this abbreviated
      UB-92 being erroneously stored in the NCH.
```

```
CLM_HAC_PGM_RDCTN_IND_TB                    Claim Hospital Acquired Condition (HAC) Program Reduction Indicator Table

     Y = hospital subject to a reduction under the HAC Reduction
         Program
     N = hospital is not subject to a reduction under the HAC
         Reduction Program




CLM_HIPPS_TB                                Claim SNF, HHA & IRF Health Insurance PPS Table

     ************************************************************
     Please refer to the CMS website for the latest information
     on the HIPPS Codes.  The URL is
     http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/
     ProspMedicareFeeSvcPmtGen/HIPPSCodes.html
     (paste into browser address bar without any spaces)
     ************************************************************




CLM_HRR_PRTCPNT_IND_TB                      Claim HRR Participant Indicator Code Table

     0 = Not participating
     1 = Participating and not equal to 1.0000
     2 = Participating and equal to 1.0000




CLM_IP_ADMSN_TYPE_TB                        Claim Inpatient Admission Type Table

     0 = Blank
     1 = Emergency - The patient required
         immediate medical intervention as a
         result of severe, life threatening, or
         potentially disabling conditions.
         Generally, the patient was admitted
         through the emergency room.
     2 = Urgent - The patient required immediate
         attention for the care and treatment
         of a physical or mental disorder.
         Generally, the patient was admitted to
         the first available and suitable
         accommodation.
     3 = Elective - The patient's condition
         permitted adequate time to schedule the
         availability of suitable accommodations.
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        4 = Newborn - Necessitates the use of
            special source of admission codes.
        5 = Trauma Center - visits to a trauma center/
            hospital as licensed or designated by the State
            or local government authority authorized to do
            so, or as verified by the American College of
            Surgeons and involving a trauma activation.
        6 THRU 8 =  Reserved
        9 =  Unknown - Information not available.
```

CLM_MASS_ADJSTMT_IND_CD_TB   Claim Mass Adjustment Indicator Code Table

```
    M = Mass Adjustment (MPFS)
    O = Mass Adjustment (Other)
```

CLM_MCO_PD_TB   Claim MCO Paid Switch Code Table

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

CLM_MDCD_INFO_TB   Claim Medicaid Information Table

```
    164 = Number of attachments submitted
    166 = Abortion/sterilization code
    167 = Child Health Assurance Program Referral Code
    168 = Civilian Health and Medical Program of the
          Uniformed Services Code
```

CLM_MDCR_NPMT_RSN_TB   Claim Medicare Non-Payment Reason Table

```
    Valid Values effective 1/2011 (2-byte values are replacing
    the character values)
     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
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        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)
00 = MSP cost avoided - COB Contractor
12 = MSP cost avoided - BCBS Voluntary Agreements
13 = MSP cost avoided - Office of Personnel Management
14 = MSP cost avoided - Workman's Compensation (WC) Datamatch
15 = MSP cost avoided - Workman's Compensation Insurer Voluntary
     Data Sharing Agreements (WC VDSA) (eff. 4/2006)
16 = MSP cost avoided - Liability Insurer VDSA (eff. 4/2006)
17 = MSP cost avoided - No-Fault Insurer VDSA (eff. 4/2006)
18 = MSP cost avoided - Pharmacy Benefit Manager Data
     Sharing Agreement (eff. 4/2006)
19 = MSP cost avoided - Worker's Compensation Medicare Set-Aside
     Arrangement
21 = MSP cost avoided - MIR Group Heqalth Plan (eff. 1/2009)
22 = MSP cost avoided - MIR non-Group Health Plan (eff. 1/2009)
25 = MSP cost avoided - Recovery Audit Contractor - California
```

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        (eff. 10/2005)
 26 = MSP cost avoided - Recovery Audit Contractor - Florida
        (eff. 10/2005)
 39 = MSP cost avoided - GHP Recovery
 41 = MSP cost avoided - NGHP Non-ORM
 42 = MSP cost avoided - NGHP ORM Recovery
 43 = MSP cost avoided - COBC/Medicare Part C/Medicare Advantage

 Prior to 1/2011, the character values below were used to
 represent the 2-byte values

 NOTE: Effective 4/1/02, the Medicare nonpayment reason
 code was expanded to a 2-byte field.  The NCH instituted
 a crosswalk from the 2-byte code to a 1-byte character
 code. Below are the character codes (found in NCH &
 NMUD). At some point, NMUD will carry the 2-byte code
 but NCH will continue to have the 1-byte character
 code.

 ! = MSP cost avoided - COB Contractor ('00' 2-byte code)
 @ = MSP cost avoided - BC/BS Voluntary Agreements
     ('12' 2-byte code)
 # = MSP cost avoided - Office of Personnel Management
     ('13' 2-byte code)
 $ = MSP cost avoided - Workman's Compensation (WC) Datamatch
     ('14' 2-byte code)
 * = MSP cost avoided - Workman's Compensation Insurer
     Voluntary Data Sharing Agreements (WC VDSA)
     ('15' 2-byte code) (eff. 4/2006)
 ( = MSP cost avoided - Liability Insurer VDSA
     ('16' 2-byte code) (eff. 4/2006)
 ) = MSP cost avoided - No-Fault Insurer VDSA
     ('17' 2-byte code) (eff. 4/2006)
 + = MSP cost avoided - Pharmacy Benefit Manager Data
     Sharing Agreement ('18' 2-byte code) (eff. 4/2006)
 < = MSP cost avoided - MIR Group Health Plan
     ('21' 2-byte code) (eff. 1/2009)
 > = MSP cost avoided - MIR non-Group Health Plan
     ('22' 2-byte code) (eff. 1/2009)
 % = MSP cost avoided - Recovery Audit Contractor -
     - California ('25' 2-byte code) (eff. 10/2005)
 & = MSP cost avoided - Recovery Audit Contractor -
     Florida ('26' 2-byte code) (eff. 10/2005)
```

```
    1 = claim is related readmission to a Model 4
    BPCI claim and shall pay IME, DSH, and
    Capital Only.

    2 = two Model 4 BPCI claims within 30 days of
    each other, first claim in episode shall process as
    it would in the absence of Model 4 BPCI.

    3 = two Model 4 BPCI claims within 30 days of
    each other, this is the second claim in the episode
    and paid as Model 4.


CLM_OCRNC_SPAN_TB                        Claim Occurrence Span Table

    70 = Qualifying Stay Dates for SNF Use
         Only - the from/through dates of at
         least a 3-day inpatient hospital stay
         that qualifies the resident for Medicare
         payment of SNF services billed.  Code
         can only be used by SNF for billing.
    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 (utilization charged) -
                  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 = Provider Liability (non-utilization) (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.
80 = Prior Same-SNF Stay Dates for Payment
                  Ban Purposes - the from/thru dates of a
                  prior same-SNF stay indicating a patient
                  resided in the SNF prior to, and if
                  applicable, during a payment ban period
                  up until their discharge to a hospital.
81 = Antepartum Days  (CR7716) - eff. 7/2/12
82 - 99 = Reserved for state assignment
M0 = QIO/UR approved stay dates - Eff 10/93,
                  the first and last days that were
                  approved where not all of the stay was
                  approved.
M1 = Provider Liability-No Utilization -- from/
                  thru dates of a period of noncovered care
                  that is denied due to lack of medical
                  necessity or custodial care for which the
                  provider is liable. (eff. 10/01)
M2 = Dates of Inpatient Respite Care -- from/thru
                  dates of a period of inpatient respite care
                  for hospice patients. (eff. 10/00)
```

```
        M3 = ICF Level of Care -- the from/through dates
             of a period of intermediate level of care
             during an inpatient hospital stay.
        M4 = Residential Level of Care - The from/through
             dates of a period of residential level of
             care during an inpatient hospital stay.


CLM_POA_IND_TB                            Claim Present on Admission (POA) Indicator Table

     Y = Diagnosis was present at the time of inpatient admission.
         CMS will pay the CC/MCC DRG for those selected HACs that
         are coded as 'Y' for the POA Indicator.

     N = Diagnosis was not present at the time of inpatient admission.
         CMS will not pay the CC/MCC DRG for those selected HACs that
         are coded as 'N' for the POA Indicator.

     U = Documentation is insufficient to determine if the
         condition was present at the time of inpatient admission.
         CMS will not pay the CC/MCC DRG for those selected HACs that
         are coded as 'U' for the POA Indicator.  NOTE: From 4/15/10 to
         12/31/10, the MQR process assigned a 'U' to those POAs that came
         in blank.  They did this because of the POA/DGNS issue.

     W = Clinically undetermined. Provider is unable to clinically determine
         whether condition was present at the time of inpatient admission.
         CMS will pay the CC/MCC DRG for those selected HACs that
         are coded as 'W' for the POA Indicator.
         NOTE:
         Inpatient claims received with a POA exempt ICD-9 code
         effective 10/1/11 are currently being returned to provider
         requesting a valid POA indicator.   CMS has created a
         workaround to resolve this issue by adding a POA indicator 'W'
         to the affected ICD-9 code instead of leaving it blank.

     1 = Unreported/not used - diagnosis codes exempt from POA reporting --
         This code is equivalent to a blank on the UB-04, however,
         it was determined that blanks are undesirable when submitting
         this data via the 4010A.
         CMS will not pay the CC/MCC DRG for those selected HACs that
         are coded as '1' for the POA Indicator. The '1' POA Indicator
         should not be applied to any codes on the HAC list.
         Obsolete eff. 1/3/11

     0 = This value was created by the NCH front-end system to replace
```

```
          a blank received in the POA field.

    Z = Denotes the end of the POA indicators (obsolete 1/2011).

    X = Denotes the end of the POA indicators in special
        data processing situations that may be identified
        by CMS in the future (obsolete 1/2011).

    Blank = identifies diagnosis codes that are exempt from the
        POA reporting requirements (replaces the '1'). NOTE:  NCH/NMUD
        will carry a '0' in place of a blank.


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)


CLM_PRCDR_VRSN_TB                       Claim Procedure Version Code Table

    Valid Values:
    9 = ICD-9
    0 = ICD-10


CLM_PRCR_RTRN_TB                        Claim Pricer Return Code Table

    *******Home Health Pricer Return Codes************
    *****TOB 32X or 33X, DOS 10/1/2000 and after******
```

```
Home Health Payment Return Codes:
00 = Final payment where no outlier applies
01 = Final payment where outlier applies
03 = Initial percentage payment, 0%
04 = Initial percentage payment, 50%
05 = Initial percentage payment, 60%
06 = LUPA payment only
07 = Final payment, SCIC
08 = Final payment, SCIC with outlier
09 = Final payment, PEP
11 = Final payment, PEP with outlier
12 = Final payment, SCIC within PEP
13 = FInal payment, SCIS within PEP with outlier


Home Health Error Return Codes:
10 = Invalid TOB
15 = Invalid PEP Days
16 = Invalid HRG Days, >60
20 = PEP indicator invalid
25 = Med review indicator invalid
30 = Invalid MSA code
35 = Invalid Initial Payment Indicator
40 = Dates < October 1, 2000 or invalid
70 = Invalid HRG Code
75 = No HRG present in 1st occurrence
80 = Invalid Revenue code
85 = No revenue code present on HH final claim/
     adjustment


*********Hospice Pricer Return Codes************
**************TOB 81X or 82X*******************


Hospice Payment Return Codes:
00 = Home rate returned


Hospice Error Return Codes:
10 = Bad units
20 = Bad units2 < 8
30 = Bad MSA code
40 = Bad hospice wage index from MSA file
50 = Bad bene wage index from MSA file
51 = Bad provider number


*************SNF Pricer Return Codes*********
******************TOB 21X******************


SNF Payment return codes:
```

```
00 = RUG III group rate returned

SNF Error return codes:
20 = Bad RUG code
30 = Bad MSA code
40 = Thru date < July 1, 1998 or invalid
50 = Invalid Federal blend for that year
60 = Invalid Federal blend
61 = Federal blend = 0 and SNF thru date < January
     1, 2000

****Inpatient Hospital Pricer Return Codes******
*****************TOB 11X**********************

Inpatient Hospital Payment return codes:
00 = Paid normal DRG payment
01 = Paid as a day outlier (Note: day outlier no longer
     being paid as of 10/1/97)
02 = Paid as a cost outlier
03 = Transfer paid on a per diem basis up to and
     including the ful DRG
05 = Transfer paid on a per diem basis up to and
     including the full DRG which also qualified
     for a cost outlier payment
06 = Provider refused cost outlier
10 = DRG is 209, 210, or 211 and post-acute transfer
12 = Post-acute transfer with specific DRGs.  The
     following DRG's: 14, 113, 236, 263, 264, 429,
     483
14 = Paid normal DRG payment with per diem days =
     or > GM ALOS
16 = Paid as a cost outlier with per diem days = or
     > GM ALOS

Inpatient Hospital Error return codes:
51 = No provider specific information found
52 = Invalid MSA# in provider file
53 = Waiver state - not calculated by PPS
54 = DRG < 001 or > 511, or = 214, 215, 221, 222, 438,
     456, 457, 458
55 = Discharge date < provider effective start date or
     discharge date < MSA effective start date for PPS
56 = Invalid length of stay
57 = Review code invalid (Not 00, 03, 06, 07, 09)
58 = Total charges not numeric
61 = Lifetime reserve days not numeric or BILL-LTR-DAYS
     > 60
```

```
62 = Invalid number of covere days
65 = PAY-CODE not = A, B or C on provider specific file
     for capital
67 = Cost outlier with LOS > covered days


************Outpatient PPS Pricer Return Codes******

Outpatient PPS Payment return codes:
01 = Line processed to payment
20 = Line processed but payment = 0 bene deductible
     = > adjusted payment


Outpatient PPS Error return codes:
30 = Missing, deleted or invalid APC
38 = Missing or invalid discount factor
40 = Invalid service indicator passed by the OCE
41 = Service indicator invalid for OPPS PRICER
42 = APC = '00000' or (packaging flag = 1 or 2)
43 = Payment indicator not = to 1 or 5 thru 9
44 = Service indicator = 'H' but payment indicator
     not = to 6
45 = Packaging flag not = to 0
46 = Line item denial/reject flag not = to 0
     or line item denial/reject flag = to 1 and (APC
     not = 0033 or 0034 or 0322 or 0323 or 0324 or 0325
     or 0373 or 0374)) or line item action flag not = to
     1
47 = Line item action flag = 2 or 3
48 = Payment adjustment flag not valid
49 = Site of service flag not = to 0 or (APC 0033 is not
     on the claim and service indicator = 'P' or APC =
     0322, 0325, 0373, 0374)
50 = Wage index not located
51 = Wage index equals zero
52 = Provider specific file wage index reclassification
     code invalid or missing
53 = Service from date not numeric or < 20000801
54 = Service from date < provider effective date
     or service from date > provider termination date


***Inpatient Rehab Facility (IRF) Pricer Return Codes***

IRF Payment return codes:
00 = Paid normal CMG payment without outlier
01 = Paid normal CMG payment with outlier
02 = Transfer paid on a per diem basis without outlier
03 = Transfer paid on a per diem basis with outlier
```

```
04 = Blended CMG payment -- 2/3 Federal PPS rate +
      1/3 provider specific rate -- without outlier
05 = Blended CMG payment -- 2/3 Federal PPS rate +
      1/3 provider specific rate -- with outlier
06 = Blended transfer payment -- 2/3 Federal PPS
      transfer rate + 1/3 provider specific rate --
      without outlier
07 = Blended transfer payment -- 2/3 Federal PPS
      transfer rate + 1/3 provider specific rate --
      with outlier
10 = Paid normal CMG payment with penalty without
      outlier
11 = Paid normal CMG payment with penalty with
      outlier
12 = Transfer paid on a per diem basis with penalty
      without outlier
13 = Transfer paid on a per diem basis with penalty
      with outlier
14 = Blended CMG payment -- 2/3 Federal PPS rate +
      1/3 provider specific rate -- with penalty
      without outlier
15 = Blended CMG payment -- 2/3 Federal PPS rate +
      1/3 provider specific rate -- with penalty
      with outlier
16 = Blended transfer payment -- 2/3 Federal PPS
      transfer rate + 1/3 provider specific rate --
      with penalty without outlier
17 = Blended transfer payment -- 2/3 Federal PPS
      transfer rate + 1/3 provider specific rate --
      with penalty with outlier

IRF Error return codes:
50 = Provider specific rate not numeric
51 = Provider record terminated
52 = Invalid wage index
53 = Waiver state - not calculated by PPS
54 = CMG on claim not found in table
55 = Discharge date < provider effective start
      date or discharge date < MSA effective start
      date for PPS
56 = Invalid length of stay
57 = Provider specific rate zero when blended payment
      requested
58 = Total covered charges not numeric
59 = Provider specific record not found
60 = MSA wage index record not found
61 = Lifetime reserve days not numeric or
```

```
          BILL-LTR-DAYS > 60
62 = Invalid number of covered days
65 = Operating cost-to-charge ratio not numeric
67 = Cost outlier with LOS > covered days or cost
     outlier threshold calculation
72 = Invalid blend indicator (not 3 or 4)
73 = Discharged before provider FY begin date
74 = Provider FY begin date not in 2002
```

Long Term Care Hospital (LTCH) Pricer Return Codes

```
LTCH Payment return codes:
00 = Normal DRG payment without outlier
01 = Normal DRG payment with outlier
02 = Short stay payment without outlier
03 = Short stay payment with outlier
04 = Blend year 1 - 80% facility rate plus 20%
     normal DRG payment without outlier
05 = Blend year 1 - 80% facility rate plus 20%
     normal DRG payment with outlier
06 = Blend year 1 - 80% facility rate plus 20%
     short stay payment without outlier
07 = Blend year 1 - 80% facility rate plus 20%
     short stay payment with outlier
08 = Blend year 2 - 60% facility rate plus 40%
     normal DRG payment without outlier
09 = Blend year 2 - 60% facility rate plus 40%
     normal DRG payment with outlier
10 = Blend year 2 - 60% facility rate plus 40%
     short stay payment without outlier
11 = Blend year 2 - 60% facility rate plus 40%
     short stay payment with outlier
12 = Blend year 3 - 40% facility rate plus 60%
     normal DRG payment without outlier
13 = Blend year 3 - 40% facility rate plus 60%
     normal DRG payment with outlier
14 = Blend year 3 - 40% facility rate plus 60%
     short stay payment without outlier
15 = Blend year 3 - 40% facility rate plus 60%
     short stay payment with outlier
16 = Blend year 4 - 20% facility rate plus 80%
     normal DRG payment without outlier
17 = Blend year 4 - 20% facility rate plus 80%
     normal DRG payment with outlier
18 = Blend year 4 - 20% facility rate plus 80%
     short stay payment without outlier
19 = Blend year 4 - 20% facility rate plus 80%
```

```
          short stay payment with outilier

LTCH Error return codes:
50 = Provider specific rate not numeric
51 = Provider record terminated
52 = Invalid wage index
53 = Waiver state - not calculated by PPS
54 = DRG on claim not found in table
55 = Discharge date < provider effective start date
     or discharge date < MSA effective start date
     for PPS
56 = Invalid length of stay
57 = Provider specific rate zero when blended payment
     requested
58 = Total covered charges not numeric
59 = Provider specific record not found
60 = MSA wage index record not found
61 = Lifetime reserve days not numeric or BILL-LTR-DAYS
     > 60
62 = Invalid number of covered days
65 = Operating cost-to-charge ratio not numeric
67 = Cost outlier with LOS > covered days or cost
     outlier threshold calculation
72 = Invalid blend indicator (not 1 thru 5)
73 = Discharged before provider FY begin date
74 = Provider FY begin date not in 2002

***End Stage Renal Disease (ESRD) Pricer Return Codes***

ESRD Payment return codes:
00 = ESRD PPS payment calculated
01 = ESRD facility rate > zero

ESRD Error return codes:
50 = ESRD facility rate not numeric
52 = Provider type not = '40' or '41'
53 = Special payment indicator not = '1'
     or blank
54 = Date of birth not numeric or = zero
55 = Patient weight not numeric or = zero
56 = Patient height not numeric or = zero
57 = Revenue center code not in range
58 = Condition code not = '73' or '74' or blank
60 = MSA wage adjusted rate record not found
98 = Claim through date before 4/1/2005 or not numeric
```

```
CLM_PRIOR_AUTHRZTN_TB                    Claim Prior Authorization Indicator Table

     A = Part A
     B = Part B
     D = DME
     H = Home Health and Hospice
     + 3 digit number


CLM_PRVDR_VLDTN_TB                       Claim Provider Validation Code Table

     RP = Rendering Provider
     OP = Operating Physician
     CP = Ordering/Referring Physician
     AP = Attending Physician
     FA = Facility


CLM_PTNT_RLTNSHP_TB                      Claim Patient Relationship Table

     01 = Spouse
     04 = Grandparent
     05 = Grandchild
     07 = Niece/Nephew
     10 = Foster child
     15 = Ward of the court
     17 = Step child
     18 = Patient is insured
     19 = Natural child/insured financial responsibility
     20 = Employee
     21 = Unknown
     22 = Handicapped dependent
     23 = Sponsored dependent
     24 = Minor dependent of a minor dependent
     32 = Mother
     33 = Father
     39 = Organ donor
     40 = Cadaver donor
     41 = Injured plaintiff
     43 = Natural child/insured does not have financial responsibility


CLM_PWK_TB                               Claim Paperwork Code Table
```

```
      P1 = one iteration is present
      P2 = two iterations are present
      P3 = three iterations are present
      P4 = four iterations are present
      P5 = five iterations are present
      P6 = six iterations are present
      P7 = seven iterations are present
      P8 = eight iterations are present
      P9 = nine iterations are present
      P0 = ten iterations are present
```

CLM_QUERY_TB   Claim Query Table

```
      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
```

CLM_RAC_ADJSTMT_TB   Recovery Audit Contractor (RAC) Adjustment Indicator Table

```
      R = RAC adjusted claim
      Spaces
```

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 = Information Only Bill - Health Maintenance
     Organization (HMO) enrollee - Medicare bene-
     ficiary 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 30 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. CMS
     will assign as needed. Providers will
     not report them.

13 = Payer code - Reserved for internal
     use only by third party payers. CMS
     will assign as needed. Providers will
     not report them.

14 = Payer code - Reserved for internal
     use only by third party payers. CMS
     will assign as needed. Providers will

```
         not report them.
15 = Payer code - reserved for internal
     use only by third party payers.  CMS
     will assign as needed.  Providers will
     not report them.  Prior to 3/07, clean
     claim (eff 10/92) OBSOLETE
16 = Payer code - reserved for internal
     use only by third party payers.   CMS
     will assign as needed.   Providers will
     not report them.  Prior to 3/07. SNF
     transition exemption - An exemption from
     the post-hospital requirement applies
     for this SNF stay for the qualifying
     stay dates are more than 30 days prior
     to the admission date. OBSOLETE
17 = Patient is homeless (eff. 3/07). Prior to
     3/07, code indicated Patient is over 100 years
     old - 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 = Patient is Non-U.S. resident
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
30 = Qualifying Clinical Trials - Non-research
     services provided to all patients, in-
     cluding managed care enrollees, enrolled
     in a Qualified Clinical Trial.
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 = Continuing Care Not Related to Inpatient
     Admission - continuing care not related
     to the condition or diagnosis for which
     the beneficiary received inpatient
     hospital services. (eff. 10/01)
43 = Continuing Care Not Provided Within
     Prescribed Postdischarge Window -
     continuing care was related to the
     inpatient admission but the prescribed
     care was not provided within the post-
     discharge window.(eff. 10/01)
44 = Inpatient Admission Changed to Outpatient -
     For use on outpatient claims only, when the
     physician ordered inpatient services, but
     upon internal review performed before the
     claim was initially submitted, the hospital
     determined the services did not meet its
     inpatient criteria. (eff. 4/1/04)
45 = Ambiguous Gender Category - claim indicates
     patient has ambiguous gender characteristics
     (e.g. transgendered or hermaphordite).
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 = Transfer from another Home Health Agency.
     (eff. 7/1/10)
48 = Psychiatric Residential Treatment Centers for
     Children and Adolescents (RTCs)
49 = Product Replacement within Product Lifecycle-
     replacement of a product earlier than the
     anticipated lifecycle due to an indication
     that the product is not functioning properly
     (eff. 4/2006)
50 = Product Replacement for Known Recall of
     a Product - Manufacturer or FDA has iden-
     tified the product for recall and therefore
```

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               replacement. (eff. 4/2006)
51 = Reserved for national assignment.
52 = Used to indicate a discharge due to the patient's
     unavailability/inability to receive hospice services
     from the hospice which has been responsible for
     the patient. (effective 7/2/12 - CR7677)
53 = Reserved for national assignment.
54 = No skilled HH visits in billing period (eff. 7/2016)
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
     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 = Non-primary ESRD facility - code indicates
     that ESRD beneficiary received non-scheduled
     or emergency dialysis services at a facility
     other than his/her primary ESRD dialysis
     facility.
60 = Operating cost day outlier - A hospital
     being paid under a prospective payment
     system (PPS) is reporting this stay as a
     day outlier.
61 = Operating cost cost outlier - A hospital
     is being paid under a prospective payment
     system (PPS) is requesting additional payment
     for this stay as a cost outlier.
62 = Payer Code - providers do not report this code.
     PIP bill - This bill is a periodic interim
     payment bill. Obsolete
63 = Payer Code - providers do not report this code.
     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)
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64 = Payer Code - providers do not report this code.
     Other than cleam claim - the claim is not a
     'clean claim'. Obsolete
65 = Payer Code - Providers do not report this code.
     Non-PPS code - The bill is not a prospective
     payment system bill.  Obsolete
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 = IME/DGME/N&AH Payment Only - providers
     request for supplemental IME/DGME/N&AH 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
     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
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          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 path-
     ology services were provided off site.
80 = Home Dialysis - Nursing Facility - Home
     dialysis furnished in a SNF or nursing
     facility.  (eff. 4/4/05)
81 - 99 = Reserved for state assignment.
85 = Delayed Recertification of Hospice Terminal
     Illness (eff. 1/2017)
A0 = TRICARE External Partnership Program -
     This code identifies TRICARE claims submitted
     under the External Partnership Program.
A0 = Special Zip Code Reporting - five digit
     zip code of the location from which the
     beneficiary is initially placed on board
     the ambulance. (eff. 9/01) Obsolete
A0 = CHAMPUS external partnership program
     special program indicator code. (eff 10/93)
     (obsolete)
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
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             use by state uniform billing
             committees.
             Special program indicator code (eff 10/93)
A6 = PPV/Medicare 100% Payment - 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)
AA = Abortion Performed due to Rape (eff. 10/1/02)
AB = Abortion Performed due to Incest (eff. 10/1/02)
AC = Abortion Performed due to Serious Fetal
             Genetic Defect, Deformity or Abnormality
             (eff. 10/1/02)
AD = Abortion Performed due to a Life Endangering
             Physical Condition Caused by, arising from
             or exacerbated by the Pregnancy itself
             (eff. 10/1/02)
AE = Abortion Performed due to physical health of
             mother that is not life endangering (eff.
             10/1/02)
AF = Abortion Performed due to emotional/
             psychological health of mother (eff. 10/1/02)
AG = Abortion performed due to social economic
             reasons (eff. 10/1/02)
AH = Elective Abortion (eff. 10/1/02)
AI = Sterilization (eff. 10/1/02)
AJ = Payer Responsible for copayment (4/1/03)
AK = Air Ambulance Required - For ambulance
             claims.  Time needed to transport poses a
             threat. (eff. 10/16/03)
AL = Specialized Treatment/bed Unavailable -
             For ambulance claims. Specialized treatment
             bed unavailable. Transported to alternate
             facility. (eff. 10/16/03)
AM = Non-emergency Medically Necessary Stretcher
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        Transport Required - For ambulance claims.
        Non-emergency medically necessary stretcher
        transport required. (eff. 10/16/03)
AN = Preadmission Screening Not Required - person
     meets the criteria for an exemption from
     preadmission screening. (eff. 1/1/04)
B0 = Medicare Coordinated Care Demonstration
     Program - patient is a participant in
     a Medicare Coordinated Care Demonstration
     (eff. 10/01)
B1 = Beneficiary ineligible for demonstration
     program (eff. 10/01).
B2 = Critical Access Hospital Ambulance Attestation -
     Attestation by CAH that it meets the criteria
     for exemption from the Ambulance Fee Schedule
B3 = Pregnancy Indicator - Indicates the patient is
     pregnant. Required when mandated by law.
     (eff. 10/16/03)
B4 = Admission Unrelated to Discharge - Admission
     unrelated to discharge on same day.  This
     code is for discharges starting on January
     1, 2004.
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.
BP = Gulf Oil Spill of 2010 - The code identifies
     claims where the provision of all services
     on the claim are related, in whole or in
     part, to an illness, injury, or condition
     that was caused by or exacerbated by the
     effects, direct or indirect, of the 2010 oil
     spill in the Gulf of Mexico and/or circum-
     stances related to such spill, including but
     not limited to subsequent clean-up activites.
C0 = Reserved for national assignment.
C1 = Approved as billed - The services
     provided for this billing period have
     been reviewed by the QIO/UR or
     intermediary and are fully approved
     including any day or cost outlier. (eff 10/93)
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            NOTE: Beginning July 2005, this code is
            relevant to type of bills other than inpatient
            (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C2 = Automatic approval as billed based on
     focused review.  (No longer used for
     Medicare)
     QIO approval indicator services (eff 10/93)
     NOTE: Beginning July 2005, this code is
     relevant to type of bills other than inpatient
     (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C3 = Partial approval - The services
     provided for this billing period have
     been reviewed by the QIO/UR or
     intermediary and some portion has been
     denied (days or services). (eff 10/93)
     NOTE: Beginning July 2005, this code is
     relevant to type of bills other than inpatient
     (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C4 = Admission/services denied - Indicates
     that all of the services were denied
     by the QIO/UR.
     QIO approval indicator services (eff 10/93)
     NOTE: Beginning July 2005, this code is
     relevant to types of bill other than inpatient
     (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C5 = Postpayment review applicable - QIO/UR
     review to take place after payment.
     QIO approval indicator services (eff 10/93)
     NOTE: Beginning July 2005, this code is
     relevant to types of bill other than inpatient
     (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C6 = Admission preauthorization - The
     QIO/UR authorized this admission/
     service but has not reviewed the
     services provided.
     QIO approval indicator services (eff 10/93)
     NOTE: Beginning July 2005, this code is
     relevant to types of bill other than inpatient
     (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C7 = Extended authorization - the QIO has
     authorized these services for an
     extended length of time but has not
     reviewed the services provided.
     QIO approval indicator services (eff 10/93)
     NOTE: Beginning July 2005, this code is
     relevant to types of bill other than inpatient
     (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
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C8 = Reserved for national assignment.
     QIO approval indicator services (eff 10/93)
C9 = Reserved for national assignment.
     QIO 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/HIPPS
     Rate Code
     Change condition (eff 10/93)
D3 = Second or subsequent interim
     PPS bill.
     Change condition (eff 10/93)
D4 = Change in ICD-9-CM diagnosis and/or
     procedure code
     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)
DR = Disaster Relief (eff. 10/2005) - Code used
     to facilitate claims processing and track
     services and items provided to victims of
     Hurricane Katrina and any future disasters.
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) Obsolete
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
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         PPS -- eff. 7/3/00).
H0 = Delayed Filing, Statement of Intent
     Submitted -- statement of intent was sub-
     mitted within the qualifying period to
     specifically identify  the existence of
     another third party liability situation.
     (eff. 9/01)
H2 = Discharge by a Hospice Provider for Cause
     (eff. 1/1/09).
M0 = Reserved for national assignment.
M0 = All inclusive rate for outpatient services.
     (payer only code). Obsolete
M1 = Reserved for national assignment.
M1 = Roster billed influenza virus vaccine.
     (payer only code)
     Eff 10/96, also includes pneumoccocal
     pneumonia vaccine (PPV)  Obsolete
M2 = Reserved for national assignment.
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) Obsolete
     (payer only code)
P1 = Do Not Resuscitate Order (DNR) - for
     public health reporting only - code
     indicates that a DNR order was written at
     the time of or within the first 24 hours
     of the patient's admission to the hospital
     and is clearly documented in the patient's
     medical record.
P7 = Direct Inpatient Admission from Emergency
     Room - for public health reporting only
     when required by state or federal law or
     regulations.  Code indicates that patient
     was admitted directly from this facility's
     emergency room department.  (eff. 7/1/10)
W0 = United Mine Workers of America (UMWA)
     SNF demonstration indicator (eff 1/97);
     but no claims transmitted until 2/98)
W2 = Duplicate of Original Bill - code indicates
     bill is exact duplicate of the original bill
     submitted. (eff. 10/1/08)
W3 = Level I Appeal - code indicates bill is
     submitted for reconsideration; the Level
     of appeal/reconsideration (I) is specified/
     defined by the payer. (eff. 10/1/08)
W4 = Level II Appeal - Code indicates bill is
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submitted for reconsideration; the Level of
            appeal/reconsideration (II) is specified/
            defined by the payer. (eff. 10/1/08)
    W5 = Level III Appeal - Code indicates bill is
            submitted for reconsideration; the Level of
            appeal/reconsideration (III) is specified/
            defined by the payer. (eff. 10/1/08)
    XX = Transgender/Hermaphrodite Beneficiaries
            (eff. 1/2/07) Obsolete

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 = Accident/No medical liability coverage -
            code indicating accident related injury
            for which there is no medical payment or
            third payrt liability coverage. Provide
            the date of accident/injury.
    05 = Other accident - The date of an accident
            not described by the codes 01 thru 04.
            (obsolete)
    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.
    09 = Start of Infertility Treatment Cycle -

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            code indicating the start date of
            infertility treatment cycle.
10 = Last Menstrual Period - code indicating
     the date of the last mentrual period;
     ONLY applies when patient is being
     treated for maternity related condi-
     tions.
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 = Date of Last Therapy - code denotes
     last day of therapy services (e.g.,
     physical therapy, occupational therapy,
     speech therapy).
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 & SNF
     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
     hospital or date on which patient was
     released on a trial basis from a resi-
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                dential facility.  Code is not required
                if code "21" is used.
23 = Cancellation of Hospice benefits - The
                date the RHHI cancelled the hospice benefit.
                (eff. 10/00).  NOTE: this will be different
                than the revocation of the hospice benefit
                by beneficiaries.
                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 of Hospice Certification or Re-Certifi-
                cation -- code indicates the date of certifi-
                cation or recertification of the hospice
                benefit period, beginning with the first two
                initial benefit periods of 90 days each and
                the subsequent 60-day benefit periods.
                (eff. 9/01)
27 = Date home health plan established or
                last reviewed - Code indicating the
                date a home health plan of treatment
                was established or last reviewed. (Obsolete)
                not used by hospital unless owner of facility
28 = Date comprehensive outpatient rehabi-
                litation plan established or last re-
                viewed - 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
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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.
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 Religious Nonmedical Health Care
Institutions 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 = Date of First Test for Pre-admission Testing - 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). (eff. 10/01)

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 = Scheduled Date of Canceled Surgery - date which ambulatory surgery was scheduled. (eff. 9/01)

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 = Date Cost Outlier Status Begins - code indicates that this is the first day the cost outlier threshold is reached. For Medicare purposes, a bene must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments. (eff. 9/01)

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

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          internal use only by third party
          payers.  HCFA assigns as needed for
          your use.  Providers will not report it.
     50 = Assessment Date - code indicating an
          assessment date as defined by the
          assessment instrument applicable to this
          provider type (e.g. Minimum Data Set (MDS)
          for skilled nursing).  eff. 1/1/11
     51 = Date of Last Kt/V Reading - for in-center
          hemodialysis patients, this is the date
          of the last reading taken during the
          billing period.   For peritoneal dialysis
          patients (and home hemodialysis patients),
          this date may be before the current billing
          period but should be within 4 months of the
          date of service.  eff. 7/1/10
     52 = Medical Certification/recertification
          date - the date of the most recent non-
          hospice medical certification or recerti-
          fication of the patient.  Use occurrence
          code 27 for Date of Hospice Certification
          or Recertification.  eff. 1/1/11
     54 = Physician Follow-up Date - Last date of a
          physician follow-up with the patient.
          eff. 1/1/11
     55 = Used to report date of death.
          NOTE: The date of death will be present when
          the patient discharge status code is
          20, 40, 41 or 42.
     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)
     A4 = Split Bill Date - date patient became
          eligible due to medically needy spend
          down (sometimes referred to as "Split
          Bill Date").
     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
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                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) Obsolete
        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)
                Obsolete
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CLM_RMTNC_ADVC_TB                      Claim Remittance Advice Code Table

        M1 =    X-ray not taken within the past 12 months
                or near enough to the start of treatment.
                Start: 01/01/1997
        M2 =    Not paid separately when the patient is
                an inpatient.
                Start: 01/01/1997
        M3 =    Equipment is the same or similar to
                equipment already being used.
                Start: 01/01/1997
        M4 =    Alert: This is the last monthly
                installment payment for this durable
                medical equipment.
                Start: 01/01/1997
        M5 =    Monthly rental payments can continue
                until the earlier of the 15th month from
                the first rental month, or the month when
                the equipment is no longer needed.
                Start: 01/01/1997
        M6 =    Alert: You must furnish and service this
                item for any period of medical need for
                the remainder of the reasonable useful
                lifetime of the equipment.
                Start: 01/01/1997
        M7 =    No rental payments after the item is
                purchased, or after the total of issued
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                    rental payments equals the purchase
                    price.
                    Start: 01/01/1997
 M8  =    We do not accept blood gas tests results
                    when the test was conducted by a medical
                    supplier or taken while the patient is on
                    oxygen.
                    Start: 01/01/1997
 M9  =    Alert: This is the tenth rental month.
                    You must offer the patient the choice of
                    changing the rental to a purchase
                    agreement.
                    Start: 01/01/1997 ¦
M10  =    Equipment purchases are limited to the
                    first or the tenth month of medical
                    necessity.
                    Start: 01/01/1997
M11  =    DME, orthotics and prosthetics must be
                    billed to the DME carrier who services
                    the patient's zip code.
                    Start: 01/01/1997
M12  =    Diagnostic tests performed by a
                    physician
                    must indicate whether purchased services
                    are included on the claim.
                    Start: 01/01/1997
M13  =    Only one initial visit is covered per
                    specialty per medical group.
                    Start: 01/01/1997 ¦
M14  =    No separate payment for an injection
                    administered during an office visit, and
                    no payment for a full office visit if the
                    patient only received an injection.
                    Start: 01/01/1997
M15  =    Separately billed services/tests have
                    been bundled as they are considered
                    components of the same procedure.
                    Separate payment is not allowed.
                    Start: 01/01/1997
M16  =    Alert: Please see our web site,
                    mailings,
                    or bulletins for more details concerning
                    this policy/procedure/decision.
                    Start: 01/01/1997 ¦
                    Notes: (Reactivated 4/1/04, Modified
                    11/18/05, 4/1/07)
M17  =    Alert: Payment approved as you did not
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know, and could not reasonably have been
expected to know, that this would not
normally have been covered for this
patient. In the future, you will be
liable for charges for the same
service(s) under the same or similar
conditions.
Start: 01/01/1997
M18 =   Certain services may be approved for
        home
        use. Neither a hospital nor a Skilled
        Nursing Facility (SNF) is considered to
        be a patient's home.
        Start: 01/01/1997
M19 =   Missing oxygen certification/
        recertification.
        Start: 01/01/1997
M20 =   Missing/incomplete/invalid HCPCS.
        Start: 01/01/1997
M21 =   Missing/incomplete/invalid place of
        residence for this service/item provided
        in a home.
        Start: 01/01/1997
M22 =   Missing/incomplete/invalid number of
        miles traveled.
        Start: 01/01/1997
M23 =   Missing invoice.
        Start: 01/01/1997
M24 =   Missing/incomplete/invalid number of
        doses per vial.
        Start: 01/01/1997 ¦
M25 =   The information furnished does not
        substantiate the need for this level
        of service. If you believe the service
        should have been fully covered as billed,
        or if you did not know and could not
        reasonably have been expected to know
        that we would not pay for this level of
        service, or if you notified the patient
        in writing in advance that we would not
        pay for this level of service and he/she
        agreed in writing to pay, ask us to
        review your claim within 120 days of the
        date of this notice. If you do not
        request an appeal, we will, upon
        application from the patient, reimburse
        him/her for the amount you have collected

from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
Start: 01/01/1997 ¦
Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07, 11/1/10)

M26 =   The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice.= The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.
Start: 01/01/1997 ¦
Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)

M27 =   Alert: The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this

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            office.
            Start: 01/01/1997 ¦
            Notes: (Modified 10/1/02, 8/1/05,
            4/1/07, 8/1/07)
M28 =   This does not qualify for payment under
            Part B when Part A coverage is exhausted
            or not otherwise available.
            Start: 01/01/1997
M29 =   Missing operative note/report.
            Start: 01/01/1997 ¦
            Notes: (Modified 2/28/03, 7/1/2008)
            Related to N233
M30 =   Missing pathology report.
            Start: 01/01/1997 ¦
            Notes: (Modified 8/1/04, 2/28/03)
            Related to N236
M31 =   Missing radiology report.
            Start: 01/01/1997 ¦
            Notes: (Modified 8/1/04, 2/28/03) Related
            to N240
M32 =   Alert: This is a conditional payment
            made pending a decision on this service
            by the patient's primary payer. This
            payment may be subject to refund upon
            your receipt of any additional payment
            for this service from another payer. You
            must contact this office immediately
            upon receipt of an additional payment
            for this service.
            Start: 01/01/1997 ¦
            Notes: (Modified 4/1/07)
M33 =   Missing/incomplete/invalid UPIN for the
            ordering/referring/performing provider.
            Start: 01/01/1997 ¦ Stop: 08/01/2004
            Notes: Consider using M68
M34 =   Claim lacks the CLIA certification
            number.
            Start: 01/01/1997 ¦
            Stop: 08/01/2004
            Notes: Consider using MA120
M35 =   Missing/incomplete/invalid pre-
            operative
            photos or visual field results.
            Start: 01/01/1997 ¦ Stop: 02/05/2005
            Notes: Consider using N178
M36 =   This is the 11th rental month. We
            cannot
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         pay for this until you indicate that the
         patient has been given the option of
         changing the rental to a purchase.
         Start: 01/01/1997
M37 =    Not covered when the patient is under
         age 35.
         Start: 01/01/1997 ¦
         Notes: (Modified 3/8/11)
M38 =    The patient is liable for the charges
         for this service as you informed the
         patient in writing before the service
         was furnished that we would not pay for
         it, and the patient agreed to pay.
         Start: 01/01/1997
M39 =    The patient is not liable for payment
         for this service as the advance notice
         of non-coverage you provided the patient
         did not comply with program
         requirements.
         Start: 01/01/1997 ¦
         Notes: (Modified 2/1/04, 4/1/07,
         11/1/09, 11/1/12) Related to N563
M40 =    Claim must be assigned and must be
         filed
         by the practitioner's employer.
         Start: 01/01/1997
M41 =    We do not pay for this as the patient
         has no legal obligation to pay for this.
         Start: 01/01/1997
M42 =    The medical necessity form must be
         personally signed by the attending
         physician.
         Start: 01/01/1997
M43 =    Payment for this service previously
         issued to you or another provider by
         another carrier/intermediary.
         Start: 01/01/1997 ¦
         Stop: 01/31/2004
         Notes: Consider using Reason Code 23
M44 =    Missing/incomplete/invalid condition
         code.
         Start: 01/01/1997 ¦
         Notes: (Modified 2/28/03)
M45 =    Missing/incomplete/invalid occurrence
         code(s).
         Start: 01/01/1997 ¦
         Notes: (Modified 12/2/04) Related to
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N299

M46 = Missing/incomplete/invalid occurrence
span code(s).
Start: 01/01/1997 ¦
Notes: (Modified 12/2/04) Related to
N300

M47 = Missing/incomplete/invalid internal or
document control number.
Start: 01/01/1997 ¦
Notes: (Modified 2/28/03)

M48 = Payment for services furnished to
hospital inpatients (other than
professional services of physicians) can
only be made to the hospital. You must
request payment from the hospital rather
than the patient for this service.
Start: 01/01/1997 ¦
Stop: 01/31/2004
Notes: Consider using M97

M49 = Missing/incomplete/invalid value
code(s)
or amount(s).
Start: 01/01/1997 ¦
Notes: (Modified 2/28/03)

M50 = Missing/incomplete/invalid revenue
code(s).
Start: 01/01/1997 ¦
Notes: (Modified 2/28/03)

M51 = Missing/incomplete/invalid procedure
code(s).
Start: 01/01/1997 ¦
Notes: (Modified 12/2/04) Related to N301

M52 = Missing/incomplete/invalid "from"
date(s) of service.
Start: 01/01/1997 ¦
Notes: (Modified 2/28/03)

M53 = Missing/incomplete/invalid days or
units
of service.
Start: 01/01/1997 ¦
Notes: (Modified 2/28/03)

M54 = Missing/incomplete/invalid total
charges.
Start: 01/01/1997 ¦

M55 = We do not pay for self-administered
anti-emetic drugs that are not
administered with a covered oral

anti-cancer drug.
Start: 01/01/1997
M56 =   Missing/incomplete/invalid payer
        identifier.
        Start: 01/01/1997 ¦
        Notes: (Modified 2/28/03)
M57 =   Missing/incomplete/invalid provider
        identifier.
        Start: 01/01/1997 ¦
        Stop: 06/02/2005
M58 =   Missing/incomplete/invalid claim
        information. Resubmit claim after
        corrections.
        Start: 01/01/1997 ¦ Stop: 02/05/2005
M59 =   Missing/incomplete/invalid "to" date(s)
        of service.
        Start: 01/01/1997 ¦
        Notes: (Modified 2/28/03)
M60 =   Missing Certificate of Medical
        Necessity.
        Start: 01/01/1997 ¦
        Notes: (Modified 8/1/04, 6/30/03)
        Related to N227
M61 =   We cannot pay for this as the approval
        period for the FDA clinical trial has
        expired.
        Start: 01/01/1997
M62 =   Missing/incomplete/invalid treatment
        authorization code.
        Start: 01/01/1997 ¦
        Notes: (Modified 2/28/03)
M63 =   We do not pay for more than one of
        these
        on the same day.
        Start: 01/01/1997 ¦
        Stop: 01/31/2004
        Notes: Consider using M86
M64 =   Missing/incomplete/invalid other
        diagnosis.
        Start: 01/01/1997 ¦
        Notes: (Modified 2/28/03)
M65 =   One interpreting physician charge can
        be submitted per claim when a purchased
        diagnostic test is indicated.
        Please submit a separate claim for each
        interpreting physician.
        Start: 01/01/1997

M66 = Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.
Start: 01/01/1997

M67 = Missing/incomplete/invalid other procedure code(s).
Start: 01/01/1997
Notes: (Modified 12/2/04) Related to N302

M68 = Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.
Start: 01/01/1997
Stop: 06/02/2005

M69 = Paid at the regular rate as you did not submit documentation to justify the modified procedure code.
Start: 01/01/1997 ¦
Notes: (Modified 2/1/04)

M70 = Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.
Start: 01/01/1997 ¦
Notes: (Modified 4/1/2007, 8/1/07)

M71 = Total payment reduced due to overlap of tests billed.
Start: 01/01/1997

M72 = Did not enter full 8-digit date (MM/DD/CCYY).
Start: 01/01/1997 ¦
Stop: 10/16/2003
Notes: Consider using MA52

M73 = The HPSA/Physician Scarcity bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components.
Start: 01/01/1997
Notes: (Modified 8/1/04)

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M74 =    This service does not qualify for a
         HPSA/Physician Scarcity bonus payment.
         Start: 01/01/1997
         Notes: (Modified 12/2/04)
M75 =    Multiple automated multichannel tests
         performed on the same day combined for
         payment.
         Start: 01/01/1997
         Notes: (Modified 11/5/07)
M76 =    Missing/incomplete/invalid diagnosis or
         condition.
         Start: 01/01/1997
         Notes: (Modified 2/28/03)
M77 =    Missing/incomplete/invalid place of
         service.
         Start: 01/01/1997
         Last Modified: 02/28/2003
         Notes: (Modified 2/28/03)
M78 =    Missing/incomplete/invalid HCPCS
         modifier.
         Start: 01/01/1997
         Stop: 05/18/2006
         Notes: (Modified 2/28/03,) Consider
         using Reason Code 4
M79 =    Missing/incomplete/invalid charge.
         Start: 01/01/1997
         Notes: (Modified 2/28/03)
M80 =    Not covered when performed during the
         same session/date as a previously
         processed service for the patient.
         Start: 01/01/1997
         Notes: (Modified 10/31/02)
M81 =    You are required to code to the highest
         level of specificity.
         Start: 01/01/1997
         Notes: (Modified 2/1/04)
M82 =    Service is not covered when patient is
         under age 50.
         Start: 01/01/1997
M83 =    Service is not covered unless the
         patient is classified as at high risk.
         Start: 01/01/1997
M84 =    Medical code sets used must be the
         codes
         in effect at the time of service
         Start: 01/01/1997
         Notes: (Modified 2/1/04)
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M85 =    Subjected to review of physician
         evaluation and management services.
         Start: 01/01/1997
M86 =    Service denied because payment already
         made for same/similar procedure within
         set time frame.
         Start: 01/01/1997
M87 =    Claim/service(s) subjected to CFO-CAP
         prepayment review.
         Start: 01/01/1997
M88 =    We cannot pay for laboratory tests
         unless billed by the laboratory that did
         the work.
         Start: 01/01/1997
         Stop: 08/01/2004
         Notes: Consider using Reason Code B20
M89 =    Not covered more than once under age
         40.
         Start: 01/01/1997
M90 =    Not covered more than once in a 12
         month
         period.
         Start: 01/01/1997
M91 =    Lab procedures with different CLIA
         certification numbers must be billed on
         separate claims.
         Start: 01/01/1997
M92 =    Services subjected to review under the
         Home Health Medical Review Initiative.
         Start: 01/01/1997 ¦ Stop: 08/01/2004
M93 =    Information supplied supports a break
         in
         therapy. A new capped rental period
         began with delivery of this equipment.
         Start: 01/01/1997
M94 =    Information supplied does not support a
         break in therapy. A new capped rental
         period will not begin.
         Start: 01/01/1997
M95 =    Services subjected to Home Health
         Initiative medical review/cost report
         audit.
         Start: 01/01/1997
M96 =    The technical component of a service
         furnished to an inpatient may only be
         billed by that inpatient facility. You
         must contact the inpatient facility for
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              technical component reimbursement. If
              not already billed, you should bill us
              for the professional component only.
              Start: 01/01/1997
M97  =   Not paid to practitioner when provided
              to patient in this place of service.
              Payment included in the reimbursement
              issued the facility.
              Start: 01/01/1997
M98  =   Begin to report the Universal Product
              Number on claims for items of this type.
              We will soon begin to deny payment for
              items of this type if billed without the
              correct UPN.
              Start: 01/01/1997
              Stop: 01/31/2004
              Notes: Consider using M99
M99  =   Missing/incomplete/invalid Universal
              Product Number/Serial Number.
              Start: 01/01/1997
M100 =   We do not pay for an oral anti-emetic
              drug that is not administered for use
              immediately before, at, or within 48
              hours of administration of a covered
              chemotherapy drug.
              Start: 01/01/1997
M101 =   Begin to report a G1-G5 modifier with
              this HCPCS. We will soon begin to deny
              payment for this service if billed
              without a G1-G5 modifier.
              Start: 01/01/1997
              Stop: 01/31/2004
              Notes: Consider using M78
M102 =   Service not performed on equipment
              approved by the FDA for this purpose.
              Start: 01/01/1997
M103 =   Information supplied supports a break
              in therapy.  However, the medical info-
              mation we have for this patient does not
              support the need for this item
              as billed. We have approved payment for
              this item at a reduced level, and a new
              capped rental period will begin with the
              delivery of this equipment.
              Start: 01/01/1997
M104 =   Information supplied supports a break
              in therapy. a new capped rental period
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will begom wieth delivery of the
equipment. This is the maximum approved
under the fee schedule for this item or
service.
Start: 01/01/1997
M105 = Information supplied does not support a
break in therapy. The medical
information we have for this patient
does not support the need for this item
as billed. We have approved payment for
this item at a reduced level, and a new
capped rental period will not begin.
Start: 01/01/1997
M106 = Information supplied does not support a
break in therapy. A new capped rental
period will not begin. This is the
maximum approved under the fee schedule
for this item or service.
Start: 01/01/1997 ¦
Stop: 01/31/2004
Notes: Consider using MA 31
M107 = Payment reduced as 90-day rolling
average hematocrit for ESRD patient
exceeded 36.5%.
Start: 01/01/1997
M108 = Missing/incomplete/invalid provider
identifier for the provider who
interpreted the diagnostic test.
Start: 01/01/1997 ¦ Stop: 06/02/2005
M109 = We have provided you with a bundled
payment for a teleconsultation. You must
send 25 percent of the teleconsultation
payment to the referring practitioner.
Start: 01/01/1997
M110 = Missing/incomplete/invalid provider
identifier for the provider from whom
you purchased interpretation services.
Start: 01/01/1997 ¦ Stop: 06/02/2005
M111 = We do not pay for chiropractic
manipulative treatment when the patient
refuses to have an x-ray taken.
Start: 01/01/1997
M112 = Reimbursement for this item is based on
the single payment amount required under
the DMEPOS Competitive Bidding Program
for the area where the patient resides.
Start: 01/01/1997

M113 = Our records indicate that this patient
        began using this item/service prior to
        the current contract period for the
        DMEPOS Competitive Bidding Program.
        Start: 01/01/1997
M114 = This service was processed in
        accordance with rules and guidelines
        under the DMEPOS Competitive Bidding
        Program or a Demonstration Project.
        For more information regarding these
        these projects, contact your local
        contractor.
        Start: 01/01/1997
M115 = This item is denied when provided to
        this patient by a non-contract or non-
        demonstration supplier.
        Start: 01/01/1997
M116 = Processed under a demonstration project
        or program. Project or program is
        ending and additional services may not
        be paid under this project or program.
        Start: 01/01/1997
M117 = Not covered unless submitted via
        electronic claim.
        Start: 01/01/1997
M118 = Letter to follow containing further
        information.
        Start: 01/01/1997
        Stop: 01/01/2011
M119 = Missing/incomplete/invalid/
        deactivated/withdrawn National Drug
        Code (NDC).
        Start: 01/01/1997
M120 = Missing/incomplete/invalid provider
        identifier for the substituting
        physician who furnished the service(s)
        under a reciprocal billing or locum
        tenens arrangement.
        Start: 01/01/1997
        Stop: 06/02/2005
M121 = We pay for this service only when
        performed with a covered cryosurgical
        ablation.
        Start: 01/01/1997
M122 = Missing/incomplete/invalid level of
        subluxation.
        Start: 01/01/1997

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M123 =  Missing/incomplete/invalid name,
        strength, or dosage of the drug
        furnished.
        Start: 01/01/1997
M124 =  Missing indication of whether the
        patient owns the equipment that
        requires the part or supply.
        Start: 01/01/1997
        Notes: Related to N230
M125 =  Missing/incomplete/invalid information
        on the period of time for which the
        service/supply/equipment will be
        needed.
        Start: 01/01/1997 ¦
M126 =  Missing/incomplete/invalid individual
        lab codes included in the test.
        Start: 01/01/1997 ¦
M127 =  Missing patient medical record for this
        service.
        Start: 01/01/1997 ¦
        Notes: Related to N237
M128 =  Missing/incomplete/invalid date of the
        patient's last physician visit.
        Start: 01/01/1997 ¦
        Stop: 06/02/2005
M129 =  Missing/incomplete/invalid indicator of
        x-ray availability for review.
        Start: 01/01/1997
M130 =  Missing invoice or statement certifying
        the actual cost of the lens, less
        discounts, and/or the type of
        intraocular lens used.
        Start: 01/01/1997
        Notes: Related to N231
M131 =  Missing physician financial
        relationship form.
        Start: 01/01/1997
        Notes: Related to N239
M132 =  Missing pacemaker registration form.
        Start: 01/01/1997
        Notes: Related to N235
M133 =  Claim did not identify who performed
        the purchased diagnostic test or the
        amount you were charged for the test.
        Start: 01/01/1997
M134 =  Performed by a facility/supplier in
        which the provider has a financial
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            interest.
            Start: 01/01/1997
M135 =  Missing/incomplete/invalid plan of
            treatment.
            Start: 01/01/1997
M136 =  Missing/incomplete/invalid indication
            that the service was supervised or
            evaluated by a physician.
            Start: 01/01/1997
M137 =  Part B coinsurance under a
            demonstration project or pilot program.
            Start: 01/01/1997
M138 =  Patient identified as a demonstration
            participant but the patient was not
            enrolled in the demonstration at the
            time services were rendered. Coverage
            is limited to demonstration
            participants.
            Start: 01/01/1997
M139 =  Denied services exceed the coverage
            limit for the demonstration.
            Start: 01/01/1997
M140 =  Service not covered until after the
            patient's 50th birthday, i.e., no
            coverage prior to the day after the
            50th birthday
            Start: 01/01/1997
            Stop:  1/30/2004
            Notes: Consider using M82
M141 =  Missing physician certified plan of
            care.
            Start: 01/01/1997
            Notes: Related to N238
M142 =  Missing American Diabetes Association
            Certificate of Recognition.
            Start: 01/01/1997
            Last Modified: 02/28/2003
            Notes: Related to N226
M143 =  The provider must update license
            information with the payer.
            Start: 01/01/1997 ¦
M144 =  Pre-/post-operative care payment is
            included in the allowance for the
            surgery/procedure.
            Start: 01/01/1997
MA01 =  Alert: If you do not agree with what we
            approved for these services, you may
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           appeal our decision. To make sure that
           we are fair to you, we require another
           individual that did not process your
           initial claim to conduct the appeal.
           However, in order to be eligible for an
           appeal, you must write to us within 120
           days of the date you received this
           notice, unless you have a good reason
           for being late.
           Start: 01/01/1997
           8/1/05, 4/1/07)
MA02 =     Alert: If you do not agree with this
           determination, you have the right to
           appeal. You must file a written request
           for an appeal within 180 days of the
           date you receive this notice.
           Start: 01/01/1997
MA03 =     If you do not agree with the approved
           amounts and $100 or more is in dispute
           (less deductible and coinsurance), you
           may ask for a hearing within six months
           of the date of this notice. To meet the
           $100, you may combine amounts on other
           claims that have been denied, including
           reopened appeals if you received a
           revised decision. You must appeal each
           claim on time.
           Start: 01/01/1997
           Stop: 10/01/2006
           Last Modified: 11/18/2005
           Notes: Consider using MA02 (Modified
           10/31/02, 6/30/03, 8/1/05, 11/18/05)
MA04 =     Secondary payment cannot be considered
           without the identity of or payment
           information from the primary payer. The
           information was either not reported or
           was illegible.
           Start: 01/01/1997
MA05 =     Incorrect admission date patient status
           or type of bill entry on claim.
           Start: 01/01/1997
           Stop: 10/16/2003
           Notes: Consider using MA30, MA40 or
           MA43
MA06 =     Missing/incomplete/invalid beginning
           and/or ending date(s).
           Start: 01/01/1997
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            Stop: 08/01/2004
            Notes: Consider using MA31
MA07 =   Alert: The claim information has also
            been forwarded to Medicaid for review.
            Start: 01/01/1997
MA08 =   Alert: Claim information was not
            forwarded because the supplemental
            coverage is not with a Medigap plan,
            or you do not participate in Medicare.
            Start: 01/01/1997
MA09 =   Claim submitted as unassigned but
            processed as assigned. You agreed to
            accept assignment for all claims.
            Start: 01/01/1997
MA10 =   Alert: The patient's payment was in
            excess of the amount owed. You must
            refund the overpayment to the patient.
            Start: 01/01/1997
MA11 =   Payment is being issued on a
            conditional basis. If no-fault
            insurance, liability insurance,
            Workers' Compensation, Department of
            Veterans Affairs, or a group health
            plan for employees and dependents also
            covers this claim, a refund may be due
            us. Please contact us if the patient is
            covered by any of these sources.
            Start: 01/01/1997
            Stop: 01/31/2004
            Notes: Consider using M32
MA12 =   You have not established that you have
            the right under the law to bill for
            services furnished by the person(s)
            that furnished this (these) service(s).
            Start: 01/01/1997
MA13 =   Alert: You may be subject to penalties
            if you bill the patient for amounts not
            reported with the PR (patient
            responsibility) group code.
            Start: 01/01/1997
MA14 =   Alert: The patient is a member of an
            employer-sponsored prepaid health plan.
            Services from outside that health plan
            are not covered. However, as you were
            not previously notified of this, we are
            paying this time. In the future, we
            will not pay you for non-plan services.
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                    Start: 01/01/1997
MA15 =   Alert: Your claim has been separated to
         expedite handling. You will receive a
         separate notice for the other services
         reported.
                    Start: 01/01/1997 ¦
MA16 =   The patient is covered by the Black
         Lung Program. Send this claim to the
         Department of Labor, Federal Black Lung
         Program, P.O. Box 828, Lanham-Seabrook
         MD 20703.
                    Start: 01/01/1997
MA17 =   We are the primary payer and have paid
         at the primary rate. You must contact
         the patient's other insurer to refund
         any excess it may have paid due to its
         erroneous primary payment.
                    Start: 01/01/1997
MA18 =   Alert: The claim information is also
         being forwarded to the patient's
         supplemental insurer. Send any
         questions regarding supplemental
         benefits to them.
                    Start: 01/01/1997
MA19 =   Alert: Information was not sent to the
         Medigap insurer due to
         incorrect/invalid information you
         submitted concerning that insurer.
         Please verify your information and
         submit your secondary claim directly to
         that insurer.
                    Start: 01/01/1997
MA20 =   Skilled Nursing Facility (SNF) stay not
         covered when care is primarily related
         to the use of an urethral catheter for
         convenience or the control of
         incontinence.
                    Start: 01/01/1997
MA21 =   SSA records indicate mismatch with name
         and sex.
                    Start: 01/01/1997
MA22 =   Payment of less than $1.00 suppressed.
                    Start: 01/01/1997
MA23 =   Demand bill approved as result of
         medical review.
                    Start: 01/01/1997
MA24 =   Christian Science Sanitarium/ Skilled
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Nursing Facility (SNF) bill in the same benefit period.
Start: 01/01/1997 ¦

MA25 = A patient may not elect to change a hospice provider more than once in a benefit period.
Start: 01/01/1997

MA26 = Alert: Our records indicate that you were previously informed of this rule.
Start: 01/01/1997 ¦

MA27 = Missing/incomplete/invalid entitlement number or name shown on the claim.
Start: 01/01/1997 ¦

MA28 = Alert: Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.
Start: 01/01/1997 ¦

MA29 = Missing/incomplete/invalid provider name, city, state, or zip code.
Start: 01/01/1997 ¦
Stop: 06/02/2005

MA30 = Missing/incomplete/invalid type of bill.
Start: 01/01/1997 ¦

MA31 = Missing/incomplete/invalid beginning and ending dates of the period billed.
Start: 01/01/1997 ¦

MA32 = Missing/incomplete/invalid number of covered days during the billing period.
Start: 01/01/1997 ¦

MA33 = Missing/incomplete/invalid noncovered days during the billing period.
Start: 01/01/1997 ¦

MA34 = Missing/incomplete/invalid number of coinsurance days during the billing period.
Start: 01/01/1997

MA35 = Missing/incomplete/invalid number of lifetime reserve days.
Start: 01/01/1997 ¦

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MA36 =  Missing/incomplete/invalid patient
        name.
        Start: 01/01/1997 ¦
MA37 =  Missing/incomplete/invalid patient's
        address.
        Start: 01/01/1997 ¦
MA38 =  Missing/incomplete/invalid birth date.
        Start: 01/01/1997 ¦
        Stop: 06/02/2005
MA39 =  Missing/incomplete/invalid gender.
        Start: 01/01/1997 ¦
MA40 =  Missing/incomplete/invalid admission
        date.
        Start: 01/01/1997 ¦
MA41 =  Missing/incomplete/invalid admission
        type.
        Start: 01/01/1997 ¦
MA42 =  Missing/incomplete/invalid admission
        source.
        Start: 01/01/1997 ¦
MA43 =  Missing/incomplete/invalid patient
        status.
        Start: 01/01/1997 ¦
MA44 =  Alert: No appeal rights. Adjudicative
        decision based on law.
        Start: 01/01/1997
MA45 =  Alert: As previously advised, a portion
        or all of your payment is being held in
        a special account.
        Start: 01/01/1997
MA46 =  The new information was considered but
        additional payment will not be issued.
        Start: 01/01/1997 ¦
MA47 =  Our records show you have opted out of
        Medicare, agreeing with the patient not
        to bill Medicare for
        services/tests/supplies furnished. As
        result, we cannot pay this claim. The
        patient is responsible for payment.
        Start: 01/01/1997
MA48 =  Missing/incomplete/invalid name or
        address of responsible party or primary
        payer.
        Start: 01/01/1997
        Last Modified: 02/28/2003
        Notes: (Modified 2/28/03)
MA49 =  Missing/incomplete/invalid six-digit
```

provider identifier for home health
agency or hospice for physician(s)
performing care plan oversight
services.
Start: 01/01/1997
Stop: 08/01/2004
Notes: Consider using MA76

MA50 = Missing/incomplete/invalid
Investigational Device Exemption number
for FDA-approved clinical trial
services.
Start: 01/01/1997 ¦

MA51 = Missing/incomplete/invalid CLIA
certification number for laboratory
services billed by physician office
laboratory.
Start: 01/01/1997 ¦
Stop: 02/05/2005
Notes: Consider using MA120

MA52 = Missing/incomplete/invalid date.
Start: 01/01/1997 ¦ Stop: 06/02/2005

MA53 = Missing/incomplete/invalid Competitive
Bidding Demonstration Project
identification.
Start: 01/01/1997 ¦

MA54 = Physician certification or election
consent for hospice care not received
timely.
Start: 01/01/1997

MA55 = Not covered as patient received medical
health care services, automatically
revoking his/her election to receive
religious non-medical health care
services.
Start: 01/01/1997

MA56 = Our records show you have opted out of
Medicare, agreeing with the patient not
to bill Medicare for
services/tests/supplies furnished. As
result, we cannot pay this claim. The
patient is responsible for payment, but
under Federal law, you cannot charge
the patient more than the limiting
charge amount.
Start: 01/01/1997

MA57 = Patient submitted written request to
revoke his/her election for religious

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             non-medical health care services.
             Start: 01/01/1997
MA58 =   Missing/incomplete/invalid release of
             information indicator.
             Start: 01/01/1997 ¦
MA59 =   Alert: The patient overpaid you for
             these services. You must issue the
             patient a refund within 30 days for the
             difference between his/her payment and
             the total amount shown as patient
             responsibility on this notice.
             Start: 01/01/1997 ¦
MA60 =   Missing/incomplete/invalid patient
             relationship to insured.
             Start: 01/01/1997 ¦
MA61 =   Missing/incomplete/invalid social
             security number or health insurance
             claim number.
             Start: 01/01/1997 ¦
MA62 =   Alert: This is a telephone review
             decision.
             Start: 01/01/1997 ¦
MA63 =   Missing/incomplete/invalid principal
             diagnosis.
             Start: 01/01/1997 ¦
MA64 =   Our records indicate that we should be
             the third payer for this claim. We
             cannot process this claim until we have
             received payment information from the
             primary and secondary payers.
             Start: 01/01/1997
MA65 =   Missing/incomplete/invalid admitting
             diagnosis.
             Start: 01/01/1997 ¦
MA66 =   Missing/incomplete/invalid principal
             procedure code.
             Start: 01/01/1997 ¦
             Notes: Related to N303
MA67 =   Correction to a prior claim.
             Start: 01/01/1997
MA68 =   Alert: We did not crossover this claim
             because the secondary insurance
             information on the claim was incomplete.
             Please supply complete information or
             use the PLANID of the insurer to assure
             correct and timely routing of the claim.
             Start: 01/01/1997 ¦
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MA69 =   Missing/incomplete/invalid remarks.
         Start: 01/01/1997
MA70 =   Missing/incomplete/invalid provider
         representative signature.
         Start: 01/01/1997 ¦
MA71 =   Missing/incomplete/invalid provider
         representative signature date.
         Start: 01/01/1997 ¦
MA72 =   Alert: The patient overpaid you for
         these assigned services. You must issue
         the patient a refund within 30 days for
         the difference between his/her payment
         to you and the total of the amount
         shown as patient responsibility and as
         paid to the patient on this notice.
         Start: 01/01/1997 ¦
MA73 =   Informational remittance associated
         with a Medicare demonstration. No
         payment issued under fee-for-service
         Medicare as patient has elected managed
         care.
         Start: 01/01/1997
MA74 =   This payment replaces an earlier
         payment for this claim that was either
         lost, damaged or returned.
         Start: 01/01/1997
MA75 =   Missing/incomplete/invalid patient or
         authorized representative signature.
         Start: 01/01/1997
MA76 =   Missing/incomplete/invalid provider
         identifier for home health agency or
         hospice when physician is performing
         care plan oversight services.
         Start: 01/01/1997
MA77 =   Alert: The patient overpaid you. You
         must issue the patient a refund within
         30 days for the difference between the
         patient's payment less the total of our
         and other payer payments and the amount
         shown as patient responsibility on this
         notice.
         Start: 01/01/1997
MA78 =   The patient overpaid you. You must
         issue the patient a refund within 30
         days for the difference between our
         allowed amount total and the amount
         paid by the patient.
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           Start: 01/01/1997
           Stop: 01/31/2004
           Notes: Consider using MA59
MA79 =     Billed in excess of interim rate.
           tart: 01/01/1997
MA80 =     Informational notice. No payment issued
           for this claim with this notice.
           Payment issued to the hospital by its
           intermediary for all services for this
           encounter under a demonstration
           project.
           Start: 01/01/1997
MA81 =     Missing/incomplete/invalid
           provider/supplier signature.
           Start: 01/01/1997 ¦
MA82 =     Missing/incomplete/invalid
           provider/supplier billing
           number/identifier or billing name,
           address, city, state, zip code, or
           phone number.
           Start: 01/01/1997 ¦
           Stop: 06/02/2005
MA83 =     Did not indicate whether we are the
           primary or secondary payer.
           Start: 01/01/1997 ¦
MA84 =     Patient identified as participating in
           the National Emphysema Treatment Trial
           but our records indicate that this
           patient is either not a participant,
           or has not yet been approved for this
           phase of the study. Contact Johns
           Hopkins University, the study coordinator,
           to resolve if there was a discrepancy.
           Start: 01/01/1997
MA85 =     Our records indicate that a primary
           payer exists (other than ourselves);
           however, you did not complete or enter
           accurately the insurance
           plan/group/program name or
           identification number. Enter the PlanID
           when effective.
           Start: 01/01/1997 ¦
           Stop: 08/01/2004
           Notes: Consider using MA92
MA86 =     Missing/incomplete/invalid group or
           policy number of the insured for the
           primary coverage.
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         Start: 01/01/1997 ¦
         Stop: 08/01/2004
         Notes: Consider using MA92
MA87 =   Missing/incomplete/invalid insured's
         name for the primary payer.
         Start: 01/01/1997 ¦
         Stop: 08/01/2004
         Notes: Consider using MA92
MA88 =   Missing/incomplete/invalid insured's
         address and/or telephone number for the
         primary payer.
         Start: 01/01/1997 ¦
MA89 =   Missing/incomplete/invalid patient's
         relationship to the insured for the
         primary payer.
         Start: 01/01/1997 ¦
MA90 =   Missing/incomplete/invalid employment
         status code for the primary insured.
         Start: 01/01/1997
MA91 =   This determination is the result of the
         appeal you filed.
         Start: 01/01/1997
MA92 =   Missing plan information for other
         insurance.
         Start: 01/01/1997
         Notes: Related to N245
         N245
MA93 =   Non-PIP (Periodic Interim Payment)
         claim.
         Start: 01/01/1997
MA94 =   Did not enter the statement "Attending
         physician not hospice employee" on the
         claim form to certify that the
         rendering physician is not an employee
         of the hospice.
         Start: 01/01/1997
         Notes: (Reactivated 4/1/04, Modified
         8/1/05)
MA95 =   A not otherwise classified or unlisted
         procedure code(s) was billed but a
         narrative description of the procedure
         was not entered on the claim. Refer to
         item 19 on the HCFA-1500.
         Start: 01/01/1997
         Stop:  01/01/2004
         Notes: (Deactivated 2/28/2003)
         (Erroneous description corrected
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                9/2/2008) Consider using M51
MA96  =  Claim rejected. Coded as a Medicare
         Managed Care Demonstration but patient
         is not enrolled in a Medicare managed
         care plan.
         Start: 01/01/1997
MA97  =  Missing/incomplete/invalid Medicare
         Managed Care Demonstration contract
         number or clinical trial registry
         number.
         Start: 01/01/1997 ¦
MA98  =  Claim Rejected. Does not contain the
         correct Medicare Managed Care
         Demonstration contract number for this
         beneficiary.
         Start: 01/01/1997 ¦
         Stop: 10/16/2003
         Notes: Consider using MA97
MA99  =  Missing/incomplete/invalid Medigap
         information.
         Start: 01/01/1997 ¦
MA100 =  Missing/incomplete/invalid date of
         current illness or symptoms
         Start: 01/01/1997 ¦
MA101 =  A Skilled Nursing Facility (SNF) is
         responsible for payment of outside
         providers who furnish these
         services/supplies to residents.
         Start: 01/01/1997
         Stop: 01/01/2011
         Notes: Consider using N538
MA102 =  Missing/incomplete/invalid name or
         provider identifier for the
         rendering/referring/ ordering/
         supervising provider.
         Start: 01/01/1997
         Stop: 08/01/2004
         Notes: Consider using M68
MA103 =  Hemophilia Add On.
         Start: 01/01/1997
MA104 =  Missing/incomplete/invalid date the
         patient was last seen or the provider
         identifier of the attending physician.
         Start: 01/01/1997
         Stop: 01/31/2004
         Notes: Consider using M128 or M57
MA105 =  Missing/incomplete/invalid provider
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                  number for this place of service.
                  Start: 01/01/1997
                  Stop: 06/02/2005
MA106 = PIP (Periodic Interim Payment) claim.
                  Start: 01/01/1997
MA107 = Paper claim contains more than three
                  separate data items in field 19.
                  Start: 01/01/1997
MA108 = Paper claim contains more than one data
                  item in field 23.
                  Start: 01/01/1997
MA109 = Claim processed in accordance with
                  ambulatory surgical guidelines.
                  Start: 01/01/1997
MA110 = Missing/incomplete/invalid information
                  on whether the diagnostic test(s) were
                  performed by an outside entity or if no
                  purchased tests are included on the
                  claim.
                  Start: 01/01/1997
MA111 = Missing/incomplete/invalid purchase
                  price of the test(s) and/or the
                  performing laboratory's name and
                  address.
                  Start: 01/01/1997
MA112 = Missing/incomplete/invalid group
                  practice information.
                  Start: 01/01/1997
MA113 = Incomplete/invalid taxpayer
                  identification number (TIN) submitted
                  by you per the Internal Revenue
                  Service. Your claims cannot be
                  processed without your correct TIN, and
                  you may not bill the patient pending
                  correction of your TIN. There are no
                  appeal rights for unprocessable claims,
                  but you may resubmit this claim after
                  you have notified this office of your
                  correct TIN.
                  Start: 01/01/1997
MA114 = Missing/incomplete/invalid information
                  on where the services were furnished.
                  Start: 01/01/1997
MA115 = Missing/incomplete/invalid physical
                  location (name and address, or PIN)
                  where the service(s) were rendered in a
                  Health Professional Shortage Area
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                    (HPSA).
                    Start: 01/01/1997
MA116 = Did not complete the statement
                    'Homebound' on the claim to validate
                    whether laboratory services were
                    performed at home or in an institution.
                    Start: 01/01/1997
                    Notes: (Reactivated 4/1/04)
MA117 = This claim has been assessed a $1.00
                    user fee.
                    Start: 01/01/1997
MA118 = Coinsurance and/or deductible amounts
                    apply to a claim for services or
                    supplies furnished to a Medicare-
                    eligible veteran through a facility of
                    the Department of Veterans Affairs. No
                    Medicare payment issued.
                    Start: 01/01/1997
MA119 = Provider level adjustment for late
                    claim filing applies to this claim.
                    Start: 01/01/1997
                    Stop: 05/01/2008
                    Notes: Consider using Reason Code B4
MA120 = Missing/incomplete/invalid CLIA
                    certification number.
                    Start: 01/01/1997
MA121 = Missing/incomplete/invalid x-ray date.
                    Start: 01/01/1997
MA122 = Missing/incomplete/invalid initial
                    treatment date.
                    Start: 01/01/1997
MA123 = Your center was not selected to
                    participate in this study, therefore,
                    we cannot pay for these services.
                    Start: 01/01/1997
MA124 = Processed for IME only.
                    Start: 01/01/1997
                    Stop: 01/31/2004
                    Notes: Consider using Reason Code 74
MA125 = Per legislation governing this program,
                    payment constitutes payment in full.
                    Start: 01/01/1997
MA126 = Pancreas transplant not covered unless
                    kidney transplant performed.
                    Start: 10/12/2001
MA127 = Reserved for future use.
                    Start: 10/12/2001
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           Stop:  06/02/2005
MA128 = Missing/incomplete/invalid FDA approval
        number.
        Start: 10/12/2001
MA129 = This provider was not certified for
        this procedure on this date of service.
        Start: 10/12/2001
        Stop:  01/31/2004
        Notes: Consider using MA120 and Reason
        Code B7
MA130 = Your claim contains incomplete and/or
        invalid information, and no appeal
        rights are afforded because the claim
        is unprocessable. Please submit a new
        claim with the complete/correct
        information.
        Start: 10/12/2001
MA131 = Physician already paid for services in
        conjunction with this demonstration
        claim. You must have the physician
        withdraw that claim and refund the
        payment before we can process your
        claim.
        Start: 10/12/2001
MA132 = Adjustment to the pre-demonstration
        rate.
        Start: 10/12/2001
MA133 = Claim overlaps inpatient stay. Rebill
        only those services rendered outside
        the inpatient stay.
        Start: 10/12/2001
MA134 = Missing/incomplete/invalid provider
        number of the facility where the patient resides.
        Start: 10/12/2001
N1 = Alert: You may appeal this decision in
     writing within the required time limits
     following receipt of this notice by
     following the instructions included in
     your contract or plan benefit
     documents.
     Start: 01/01/2000
N2 = This allowance has been made in
     accordance with the most appropriate
     course of treatment provision of the
     plan.
     Start: 01/01/2000
N3 = Missing consent form.
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        Start: 01/01/2000
        Notes: Related to N228
N4  = Missing/Incomplete/Invalid prior Insurance
        Carrier(s) EOB.
        Start: 01/01/2000
N5  = EOB received from previous payer. Claim
        not on file.
        Start: 01/01/2000
N6  = Under FEHB law (U.S.C. 8904(b)), we
        cannot pay more for covered care than
        the amount Medicare would have allowed
        if the patient were enrolled in
        Medicare Part A and/or Medicare Part B.
        Start: 01/01/2000
N7  = Processing of this claim/service has
        included consideration under Major
        Medical provisions.
        Start: 01/01/2000
N8  = Crossover claim denied by previous
        payer and complete claim data not
        forwarded. Resubmit this claim to this
        payer to provide adequate data for
        adjudication.
        Start: 01/01/2000
N9  = Adjustment represents the estimated
        amount a previous payer may pay.
        Start: 01/01/2000
N10 = Payment based on the findings of a
        review organization/professional
        consult/manual adjudication/medical or
        dental advisor.
        Start: 01/01/2000
N11 = Denial reversed because of medical
        review.
        Start: 01/01/2000
N12 = Policy provides coverage supplemental
        to Medicare. As the member does not
        appear to be enrolled in the applicable
        part of Medicare, the member is
        responsible for payment of the portion
        of the charge that would have been
        covered by Medicare.
        Start: 01/01/2000 ¦
N13 = Payment based on professional/technical
        component modifier(s).
        Start: 01/01/2000
N14 = Payment based on a contractual amount
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or agreement, fee schedule, or maximum
allowable amount.
Start: 01/01/2000 ¦
Stop: 10/01/2007
Notes: Consider using Reason Code 45

N15 = Services for a newborn must be billed
separately.
Start: 01/01/2000

N16 = Family/member Out-of-Pocket maximum has
been met. Payment based on a higher
percentage.
Start: 01/01/2000

N17 = Per admission deductible.
Start: 01/01/2000
Stop: 08/01/2004
Notes: Consider using Reason Code 1

N18 = Payment based on the Medicare allowed
amount.
Start: 01/01/2000
Stop: 01/31/2004
Notes: Consider using N14

N19 = Procedure code incidental to primary
procedure.
Start: 01/01/2000

N20 = Service not payable with other service
rendered on the same date.
Start: 01/01/2000

N21 = Alert: Your line item has been
separated into multiple lines to
expedite handling.
Start: 01/01/2000

N22 = This procedure code was added/changed
because it more accurately describes
the services rendered.
Start: 01/01/2000

N23 = Alert: Patient liability may be
affected due to coordination of
benefits with other carriers and/or
maximum benefit provisions.
Start: 01/01/2000

N24 = Missing/incomplete/invalid Electronic
Funds Transfer (EFT) banking
information.
Start: 01/01/2000

N25 = This company has been contracted by
your benefit plan to provide
administrative claims payment services

only. This company does not assume
financial risk or obligation with
respect to claims processed on behalf
of your benefit plan.
Start: 01/01/2000

N26 = Missing itemized bill/statement.
Start: 01/01/2000
Related to N232

N27 = Missing/incomplete/invalid treatment
number.
Start: 01/01/2000
Last Modified: 02/28/2003
Notes: (Modified 2/28/03)

N28 = Consent form requirements not
fulfilled.
Start: 01/01/2000

N29 = Missing documentation/orders/
notes/summary/report/chart.
Start: 01/01/2000
Notes: Related to N225

N30 = Patient ineligible for this service.
Start: 01/01/2000 ¦ Last Modified: 06/30/2003

N31 = Missing/incomplete/invalid prescribing
provider identifier.
Start: 01/01/2000

N32 = Claim must be submitted by the provider
who rendered the service.
Start: 01/01/2000

N33 = No record of health check prior to
initiation of treatment.
Start: 01/01/2000

N34 = Incorrect claim form/format for this
service.
Start: 01/01/2000

N35 = Program integrity/utilization review
decision.
Start: 01/01/2000

N36 = Claim must meet primary payer's
processing requirements before we can
consider payment.
Start: 01/01/2000

N37 = Missing/incomplete/invalid tooth
number/letter.
Start: 01/01/2000

N38 = Missing/incomplete/invalid place of
service.
Start: 01/01/2000

```
             Stop: 02/05/2005
             Notes: Consider using M77
N39 = Procedure code is not compatible with
      tooth number/letter.
      Start: 01/01/2000
N40 = Missing radiology film(s)/image(s).
      Start: 01/01/2000
      Notes: Related to N242
N41 = Authorization request denied.
      Start: 01/01/2000 ¦
      Stop: 10/16/2003
      Notes: Consider using Reason Code 39
N42 = No record of mental health assessment.
      Start: 01/01/2000
N43 = Bed hold or leave days exceeded.
      Start: 01/01/2000
N44 = Payer's share of regulatory surcharges,
      assessments, allowances or health
      care-related taxes paid directly to the
      regulatory authority.
      Start: 01/01/2000 ¦
      Stop: 10/16/2003
      Notes: Consider using Reason Code 137
N45 = Payment based on authorized amount.
      Start: 01/01/2000
N46 = Missing/incomplete/invalid admission
      hour.
      Start: 01/01/2000
N47 = Claim conflicts with another inpatient
      stay.
      Start: 01/01/2000
N48 = Claim information does not agree with
      information received from other
      insurance carrier.
      Start: 01/01/2000
N49 = Court ordered coverage information
      needs validation.
      Start: 01/01/2000
N50 = Missing/incomplete/invalid discharge
      information.
      Start: 01/01/2000
N51 = Electronic interchange agreement not on
      file for provider/submitter.
      Start: 01/01/2000
N52 = Patient not enrolled in the billing
      provider's managed care plan on the
      date of service.
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        Start: 01/01/2000
N53 = Missing/incomplete/invalid point of
      pick-up address.
      Start: 01/01/2000
      Notes: (Modified 2/28/03)
N54 = Claim information is inconsistent with
      pre-certified/authorized services.
      Start: 01/01/2000
N55 = Procedures for billing with
      group/referring/performing providers
      were not followed.
      Start: 01/01/2000
N56 = Procedure code billed is not
      correct/valid for the services billed
      or the date of service billed.
      Start: 01/01/2000
N57 = Missing/incomplete/invalid prescribing
      date.
      Start: 01/01/2000
      Notes: Related to N304
N58 = Missing/incomplete/invalid patient
      liability amount.
      Start: 01/01/2000
N59 = Please refer to your provider manual
      for additional program and provider
      information.
      Start: 01/01/2000
N60 = A valid NDC is required for payment of
      drug claims effective October 02.
      Start: 01/01/2000
      Stop: 01/31/2004
      Notes: Consider using M119
N61 = Rebill services on separate claims.
      Start: 01/01/2000
N62 = Dates of service span multiple rate
      periods. Resubmit separate claims.
      Start: 01/01/2000
N63 = Rebill services on separate claim
      lines.
      Start: 01/01/2000
N64 = The "from" and "to" dates must be
      different.
      Start: 01/01/2000
N65 = Procedure code or procedure rate count
      cannot be determined, or was not on
      file, for the date of service/provider.
      Start: 01/01/2000
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N66 = Missing/incomplete/invalid
      documentation.
      Start: 01/01/2000
      Stop: 02/05/2005
      Notes: Consider using N29 or N225.
N67 = Professional provider services not paid
      separately. Included in facility
      payment under a demonstration project.
      Apply to that facility for payment, or
      resubmit your claim if: the facility
      notifies you the patient was excluded
      from this demonstration; or if you
      furnished these services in another
      location on the date of the patient's
      admission or discharge from a
      demonstration hospital. If services
      were furnished in a facility not
      involved in the demonstration on the
      same date the patient was discharged
      from or admitted to a demonstration facility,
      you must report the provider
      ID number for the non-demonstration
      facility on the new claim.
      Start: 01/01/2000
N68 = Prior payment being cancelled as we
      were subsequently notified this patient
      was covered by a demonstration project
      in this site of service. Professional
      services were included in the payment
      made to the facility. You must contact
      the facility for your payment. Prior
      payment made to you by the patient or
      another insurer for this claim must be
      refunded to the payer within 30 days.
      Start: 01/01/2000
N69 = PPS (Prospective Payment System) code
      changed by claims processing system.
      Start: 01/01/2000
N70 = Consolidated billing and payment
      applies.
      Start: 01/01/2000
N71 = Your unassigned claim for a drug or
      biological, clinical diagnostic
      laboratory services or ambulance
      service was processed as an assigned
      claim. You are required by law to
      accept assignment for these types of
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          claims.
          Start: 01/01/2000
   N72 = PPS (Prospective Payment System) code
          changed by medical reviewers. Not
          supported by clinical records.
          Start: 01/01/2000
   N73 = A Skilled Nursing Facility is
          responsible for payment of outside
          providers who furnish these services/
          supplies under arrangement to
          its residents.
          Start: 01/01/2000
          Stop: 01/31/2004
          Notes: Consider using MA101 or N200
   N74 = Resubmit with multiple claims, each
          claim covering services provided in
          only one calendar month.
          Start: 01/01/2000
   N75 = Missing/incomplete/invalid tooth
          surface information.
          Start: 01/01/2000
   N76 = Missing/incomplete/invalid number of
          riders.
          Start: 01/01/2000
   N77 = Missing/incomplete/invalid designated
          provider number.
          Start: 01/01/2000
   N78 = The necessary components of the child
          and teen checkup (EPSDT) were not
          completed.
          Start: 01/01/2000
   N79 = Service billed is not compatible with
          patient location information.
          Start: 01/01/2000
   N80 = Missing/incomplete/invalid prenatal
          screening information.
          Start: 01/01/2000 ¦
   N81 = Procedure billed is not compatible with
          tooth surface code.
          Start: 01/01/2000
   N82 = Provider must accept insurance payment
          as payment in full when a third party
          payer contract specifies full
          reimbursement.
          Start: 01/01/2000
   N83 = No appeal rights. Adjudicative decision
          based on the provisions of a
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demonstration project.
Start: 01/01/2000

N84 = Alert: Further installment payments are
forthcoming.
Start: 01/01/2000 ¦

N85 = Alert: This is the final installment
payment.
Start: 01/01/2000 ¦ Last Modified: 04/01/2007
Notes: (Modified 4/1/07, 8/1/07)

N86 = A failed trial of pelvic muscle
exercise training is required in order
for biofeedback training for the
treatment of urinary incontinence to be
covered.
Start: 01/01/2000

N87 = Home use of biofeedback therapy is not
covered.
Start: 01/01/2000

N88 = Alert: This payment is being made
conditionally. An HHA episode of care
notice has been filed for this patient.
When a patient is treated under a HHA
episode of care, consolidated billing
requires that certain therapy services
and supplies, such as this, be included
in the HHA's payment. This payment will
need to be recouped from you if we
establish that the patient is
concurrently receiving treatment under
a HHA episode of care.
Start: 01/01/2000

N89 = Alert: Payment information for this
claim has been forwarded to more than
one other payer, but format limitations
permit only one of the secondary payers
to be identified in this remittance
advice.
Start: 01/01/2000

N90 = Covered only when performed by the
attending physician.
Start: 01/01/2000

N91 = Services not included in the appeal
review.
Start: 01/01/2000

N92 = This facility is not certified for
digital mammography.
Start: 01/01/2000

N93 = A separate claim must be submitted for
      each place of service. Services
      furnished at multiple sites may not be
      billed in the same claim.
      Start: 01/01/2000
N94 = Claim/Service denied because a more
      specific taxonomy code is required for
      adjudication.
      Start: 01/01/2000
N95 = This provider type/provider specialty
      may not bill this service.
      Start: 07/31/2001
N96 = Patient must be refractory to
      conventional therapy (documented
      behavioral, pharmacologic and/or
      surgical corrective therapy) and be an
      appropriate surgical candidate such
      that implantation with anesthesia can
      occur.
      Start: 08/24/2001
N97 = Patients with stress incontinence,
      urinary obstruction, and specific
      neurologic diseases (e.g., diabetes
      with peripheral nerve involvement)
      which are associated with secondary
      manifestations of the above three
      indications are excluded.
      Start: 08/24/2001
N98 = Patient must have had a successful test
      stimulation in order to support
      subsequent implantation. Before a
      patient is eligible for permanent
      implantation, he/she must demonstrate a
      50 percent or greater improvement
      through test stimulation. Improvement
      is measured through voiding diaries.
      Start: 08/24/2001
N99 = Patient must be able to demonstrate
      adequate ability to record voiding
      diary data such that clinical results
      of the implant procedure can be
      properly evaluated.
      Start: 08/24/2001
N100 = PPS (Prospect Payment System) code
       corrected during adjudication.
       Start: 09/14/2001
N101 = Additional information is needed in

order to process this claim. Please
resubmit the claim with the
identification number of the provider
where this service took place. The
Medicare number of the site of service
provider should be preceded with the
letters 'HSP' and entered into item #32
on the claim form. You may bill only one
site of service provider number per
claim.
Start: 10/31/2001
Stop: 01/31/2004
Notes: Consider uisng MA105
N102 = This claim has been denied without
reviewing the medical record because
the requested records were not received
or were not received timely.
Start: 10/31/2001
N103 = Social Security records indicate that
this patient was a prisoner when the
service was rendered. This payer does
not cover items and services furnished
to an individual while he or she is in
a Federal facility, or while he or she
is in State or local custody under a
penal authority, unless under State or
local law, the individual is personally
liable for the cost of his or her
health care while incarcerated and the
State or local government pursues such
debt in the same way and with the same
vigor as any other debt.
Start: 10/31/2001
N104 = This claim/service is not payable under
our claims jurisdiction area. You can
identify the correct Medicare
contractor to process this
claim/service through the CMS website
at www.cms.gov.
Start: 01/29/2002
N105 = This is a misdirected claim/service for
an RRB beneficiary. Submit paper claims
to the RRB carrier: Palmetto GBA, P.O.
Box 10066, Augusta, GA 30999. Call
866-749-4301 for RRB EDI information
for electronic claims processing.
Start: 01/29/2002

N106 = Payment for services furnished to
       Skilled Nursing Facility (SNF)
       inpatients (except for excluded
       services) can only be made to the SNF.
       You must request payment from the SNF
       rather than the patient for this
       service.
       Start: 01/31/2002
N107 = Services furnished to Skilled Nursing
       Facility (SNF) inpatients must be
       billed on the inpatient claim. They
       cannot be billed separately as
       outpatient services.
       Start: 01/31/2002
N108 = Missing/incomplete/invalid upgrade
       information.
       Start: 01/31/2002 ¦
       Last Modified: 02/28/2003
       Notes: (Modified 2/28/03)
N109 = This claim/service was chosen for
       complex review and was denied after
       reviewing the medical records.
       Start: 02/28/2002
       Last Modified: 03/01/2009
       Notes: (Modified 3/1/2009)
N110 = This facility is not certified for film
       mammography.
       Start: 02/28/2002
N111 = No appeal right except duplicate
       claim/service issue. This service was
       included in a claim that has been
       previously billed and adjudicated.
       Start: 02/28/2002
N112 = This claim is excluded from your
       electronic remittance advice.
       Start: 02/28/2002
N113 = Only one initial visit is covered per
       physician, group practice or provider.
       Start: 04/16/2002
N114 = During the transition to the Ambulance
       Fee Schedule, payment is based on the
       lesser of a blended amount calculated
       using a percentage of the reasonable
       charge/cost and fee schedule amounts,
       or the submitted charge for the
       service. You will be notified yearly
       what the percentages for the blended

payment calculation will be.
Start: 05/30/2002

N115 = This decision was based on a Local
Coverage Determination (LCD). An LCD
provides a guide to assist in
determining whether a particular item
or service is covered. A copy of this
policy is available at www.cms.gov/mcd,
or if you do not have web access, you
may contact the contractor to request a
copy of the LCD.
Start: 05/30/2002

N116 = This payment is being made
conditionally because the service was
provided in the home, and it is
possible that the patient is under a
home health episode of care. When a
patient is treated under a home health
episode of care, consolidated billing
requires that certain therapy services
and supplies, such as this, be included
in the home health agency's (HHA's)
payment. This payment will need to be
recouped from you if we establish that
the patient is concurrently receiving
treatment under an HHA episode of care.
Start: 06/30/2002

N117 = This service is paid only once in a
patient's lifetime.
Start: 07/30/2002

N118 = This service is not paid if billed more
than once every 28 days.
Start: 07/30/2002

N119 = This service is not paid if billed once
every 28 days, and the patient has
spent 5 or more consecutive days in any
inpatient or Skilled /nursing Facility
(SNF) within those 28 days.
Start: 07/30/2002

N120 = Payment is subject to home health
prospective payment system partial
episode payment adjustment. Patient was
transferred/discharged/readmitted
during payment episode.
Start: 08/09/2002

N121 = Medicare Part B does not pay for items
or services provided by this type of

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              practitioner for beneficiaries in a
              Medicare Part A covered Skilled Nursing
              Facility (SNF) stay.
              Start: 09/09/2002
N122 = Add-on code cannot be billed by itself.
              Start: 09/12/2002
N123 = This is a split service and represents
              a portion of the units from the
              originally submitted service.
              Start: 09/24/2002
N124 = Payment has been denied for the/made
              only for a less extensive service/item
              because the information furnished does
              not substantiate the need for the (more
              extensive) service/item. The patient is
              liable for the charges for this
              service/item as you informed the
              patient in writing before the
              service/item was furnished that we
              would not pay for it, and the patient
              agreed to pay.
              Start: 09/26/2002
              "Payment has been (denied for the/made
              only for a less extensive) service/item
              because the information furnished does
              not substantiate the need for the (more
              extensive) service/item. If you have
              collected any amount from the patient,
              you must refund that amount to the
              patient within 30 days of receiving
              this notice.
              The requirements for a refund are in
              º1834(a)(18) of the Social Security Act
              (and in ºº1834(j)(4) and 1879(h) by
              cross-reference to º1834(a)(18)).
              Section 1834(a)(18)(B) specifies that
              suppliers which knowingly and willfully
              fail to make appropriate refunds may be
              subject to civil money penalties and/or
              exclusion from the Medicare program. If
              you have any questions about this
              notice, please contact this office."
              Start: 09/26/2002
N126 = Social Security Records indicate that
              this individual has been deported. This
              payer does not cover items and services
              furnished to individuals who have been
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            deported.
            Start: 10/17/2002
N127 = This is a misdirected claim/service for
            a United Mine Workers of America (UMWA)
            beneficiary. Please submit claims to
            them.
            Start: 10/31/2007
N128 = This amount represents the prior to
            coverage portion of the allowance.
            Start: 10/31/2002
N129 = Not eligible due to the patient's age.
            Start: 10/31/2002
N130 = Consult plan benefit
            documents/guidelines for information
            about restrictions for this service.
            Start: 10/31/2002
N131 = Total payments under multiple contracts
            cannot exceed the allowance for this
            service.
            Start: 10/31/2002
N132 = Alert: Payments will cease for services
            rendered by this US Government debarred
            or excluded provider after the 30 day
            grace period as previously notified.
            Start: 10/31/2002
N133 = Alert: Services for predetermination
            and services requesting payment are
            being processed separately.
            Start: 10/31/2002
N134 = Alert: This represents your scheduled
            payment for this service. If treatment
            has been discontinued, please contact
            Customer Service.
            Start: 10/31/2002
N135 = Record fees are the patient's
            responsibility and limited to the
            specified co-payment.
            Start: 10/31/2002
N136 = Alert: To obtain information on the
            process to file an appeal in Arizona,
            call the Department's Consumer
            Assistance Office at (602) 912-8444
            or (800) 325-2548.
            Start: 10/31/2002
N137 = Alert: The provider acting on the
            Member's behalf, may file an appeal with
            the Payer. The provider, acting on the
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Member's behalf, may file a complaint
with the State Insurance Regulatory
Authority without first filing an appeal,
if the coverage decision involves an
urgent condition for which care has not
been rendered. The address may be
obtained from the State Insurance
Regulatory Authority.
Start: 10/31/2002

N138 = Alert: In the event you disagree with
the Dental Advisor's opinion and have
additional information relative to the
case, you may submit radiographs to the
Dental Advisor Unit at the subscriber's
dental insurance carrier for a second
Independent Dental Advisor Review.
Start: 10/31/2002

N139 = Alert: Under the Code of Federal
Regulations, Chapter 32, Section 199.13
a non-participating provider is not an
appropriate appealing party. Therefore,
if you disagree with the Dental
Advisor's opinion, you may appeal the
determination if appointed in writing,
by the beneficiary, to act as his/her
representative. Should you be appointed
as a representative, submit a copy of
this letter, a signed statement
explaining the matter in which you
disagree, and any radiographs and
relevant information to the subscriber's
Dental insurance carrier within 90 days
from the date of this letter.
Start: 10/31/2002

N140 = Alert: You have not been designated as
an authorized OCONUS provider therefore
are not considered an appropriate
appealing party. If the beneficiary has
appointed you, in writing, to act as
his/her representative and you disagree
with the Dental Advisor's opinion, you
may appeal by submitting a copy of this
letter, a signed statement explaining
the matter in which you disagree, and
any relevant information to the
subscriber's Dental insurance carrier
within 90 days from the date of this

letter.
Start: 10/31/2002
N141 = The patient was not residing in a
        long-term care facility during all or
        part of the service dates billed.
        Start: 10/31/2002
N142 = The original claim was denied. Resubmit
        a new claim, not a replacement claim.
        Start: 10/31/2002
N143 = The patient was not in a hospice
        program
        during all or part of the service dates
        billed.
        Start: 10/31/2002
N144 = The rate changed during the dates of
        service billed.
        Start: 10/31/2002
N145 = Missing/incomplete/invalid provider
        identifier for this place of service.
        Start: 10/31/2002
        Stop: 06/02/2005
N146 = Missing screening document.
        Start: 10/31/2002
        Notes: Related to N243
N147 = Long term care case mix or per diem
        rate cannot be determined because the
        patient ID number is missing, incomplete
        or invalid on the assignment request.
        Start: 10/31/2002
N148 = Missing/incomplete/invalid date of last
        menstrual period.
        Start: 10/31/2002
N149 = Rebill all applicable services on a
        single claim.
        Start: 10/31/2002
N150 = Missing/incomplete/invalid model
        number.
        Start: 10/31/2002
N151 = Telephone contact services will not be
        paid until the face-to-face contact
        requirement has been met.
        Start: 10/31/2002
N152 = Missing/incomplete/invalid replacement
        claim information.
        Start: 10/31/2002
N153 = Missing/incomplete/invalid room and
        board rate.

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          Start: 10/31/2002
N154 = Alert: This payment was delayed for
       correction of provider's mailing
       address.
       Start: 10/31/2002
N155 = Alert: Our records do not indicate that
       other insurance is on file. Please
       submit other insurance information for
       our records.
       Start: 10/31/2002
N156 = Alert: The patient is responsible for
       the difference between the approved
       treatment and the elective treatment.
       Start: 10/31/2002
N157 = Transportation to/from this destination
       is not covered.
       Start: 02/28/2003
N158 = Transportation in a vehicle other than
       an ambulance is not covered.
       Start: 02/28/2003
N159 = Payment denied/reduced because mileage
       is not covered when the patient is not
       in the ambulance.
       Start: 02/28/2003
N160 = The patient must choose an option
       before a payment can be made for this
        procedure/ equipment/ supply/ service.
        Start: 02/28/2003
N161 = This drug/service/supply is covered
       only when the associated service is
       covered.
       Start: 02/28/2003
N162 = Alert: Although your claim was paid,
       you have billed for a test/specialty
       not included in your laboratory
       Certification. Your failure to correct
       the laboratory certification information
       will result in a denial of payment in
       the near future.
       Start: 02/28/2003¦
N163 = Medical record does not support code
       billed per the code definition.
       Start: 02/28/2003
N164 = Transportation to/from this destination
       is not covered.
       Start: 02/28/2003
       Stop: 01/31/2004
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          Notes: Consider using N157
N165 = Transportation in a vehicle other than
       an ambulance is not covered.
       Start: 02/28/2003
       Stop: 01/31/2004
       Notes: Consider using N158)
N166 = Payment denied/reduced because mileage
       is not covered when the patient is not
       in the ambulance.
       Start: 02/28/2003
       Stop: 01/31/2004
       Notes: Consider using N159
N167 = Charges exceed the post-transplant
       coverage limit.
       Start: 02/28/2003
N168 = The patient must choose an option
        before
        a payment can be made for this
        procedure/ equipment/ supply/ service.
        Start: 02/28/2003
        Stop: 01/31/2004
        Notes: Consider using N160
N169 = This drug/service/supply is covered
       only when the associated service is
       covered.
       Start: 02/28/2003
       Stop: 01/31/2004
       Notes: Consider using N161
N170 = A new/revised/renewed certificate of
       medical necessity is needed.
       Start: 02/28/2003
N171 = Payment for repair or replacement is
       not covered or has exceeded the purchase
       price.
       Start: 02/28/2003
N172 = The patient is not liable for the
       denied/adjusted charge(s) for receiving
       any updated service/item.
       Start: 02/28/2003
N173 = No qualifying hospital stay dates were
       provided for this episode of care.
       Start: 02/28/2003
N174 = This is not a covered
       service/procedure/
       equipment/bed, however patient liability
       is limited to amounts shown in the
       adjustments under group 'PR'.
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          Start: 02/28/2003
N175 = Missing review organization approval.
          Start: 02/28/2003
          Notes: Related to N241
N176 = Services provided aboard a ship are
          covered only when the ship is of United
          States registry and is in United States
          waters. In addition, a doctor licensed
          to practice in the United States must
          provide the service.
          Start: 02/28/2003
N177 = Alert: We did not send this claim to
          patient's other insurer. They have
          indicated no additional payment can be
          made.
          Start: 02/28/2003
N178 = Missing pre-operative photos or visual
          field results.
          Start: 02/28/2003
          Notes: Related to N244
N179 = Additional information has been
          requested from the member. The charges
          will be reconsidered upon receipt of that
          information.
          Start: 02/28/2003
N180 = This item or service does not meet the
          criteria for the category under which it
          was billed.
          Start: 02/28/2003
N181 = Additional information is required from
          another provider involved in this service.
          Start: 02/28/2003
          Last Modified: 12/01/2006
          Notes: (Modified 12/1/06)
N182 = This claim/service must be billed
          according to the schedule for this plan.
          Start: 02/28/2003
N183 = Alert: This is a predetermination
          advisory message, when this service is
          submitted for payment additional
          documentation as specified in plan
          documents will be required to process
          benefits.
          Start: 02/28/2003
N184 = Rebill technical and professional
          components separately.
          Start: 02/28/2003
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N185 = Alert: Do not resubmit this
       claim/service.
       Start: 02/28/2003
N186 = Non-Availability Statement (NAS)
       required for this service. Contact the
       nearest Military Treatment Facility
       (MTF) for assistance.
        Start: 02/28/2003
N187 = Alert: You may request a review in
       writing within the required time limits
       following receipt of this notice by
       following the instructions included in
       your contract or plan benefit documents.
       Start: 02/28/2003
N188 = The approved level of care does not
       match the procedure code submitted.
       Start: 02/28/2003
N189 = Alert: This service has been paid as a
       one-time exception to the plan's benefit
       restrictions.
       Start: 02/28/2003
N190 = Missing contract indicator.
       Start: 02/28/2003
       Notes: Related to N229
N191 = The provider must update insurance
       information directly with payer.
       Start: 02/28/2003
N192 = Patient is a Medicaid/Qualified
       Medicare Beneficiary
       Start: 02/28/2003
N193 = Specific federal/state/local program may
       cover this service through another payer.
       Start: 02/28/2003
N194 = Technical component not paid if
       provider does not own the equipment
       used.
       Start: 02/25/2003
N195 = The technical component must be billed
       separately.
       Start: 02/25/2003
N196 = Alert: Patient eligible to apply for
       other coverage which may be primary.
       Start: 02/25/2003
N197 = The subscriber must update insurance
       information directly with payer.
       Start: 02/25/2003
N198 = Rendering provider must be affiliated
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              with the pay-to provider.
              Start: 02/25/2003
N199 = Additional payment/recoupment approved
              based on payer-initiated review/audit.
              Start: 02/25/2003
N200 = The professional component must be
              billed separately.
              Start: 02/25/2003
N201 = A mental health facility is responsible
              for payment of outside providers who
              furnish these services/supplies to residents.
              Start: 02/25/2003
              Stop: 01/01/2011
              Notes: Consider using N538
N202 = Additional information/explanation will
              be sent separately
              Start: 06/30/2003
N203 = Missing/incomplete/invalid anesthesia
              time/units
              Start: 06/30/2003
N204 = Services under review for possible
              pre-existing condition. Send medical
              records for prior 12 months
              Start: 06/30/2003
N205 = Information provided was illegible
              Start: 06/30/2003
N206 = The supporting documentation does not
              match the information sent on the claim.
              Start: 06/30/2003
              Notes: (Modified 3/6/12)
N207 = Missing/incomplete/invalid weight.
              Start: 06/30/2003
N208 = Missing/incomplete/invalid DRG code
              Start: 06/30/2003
N209 = Missing/incomplete/invalid taxpayer
              identification number (TIN).
              Start: 06/30/2003
N210 = Alert: You may appeal this decision
              Start: 06/30/2003
N211 = Alert: You may not appeal this decision
              Start: 06/30/2003
N212 = Charges processed under a Point of
              Service benefit
              Start: 02/01/2004
N213 = Missing/incomplete/invalid
              facility/discrete unit DRG/DRG exempt
              status information
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              Start: 04/01/2004
N214 = Missing/incomplete/invalid history of
       the related initial surgical
       procedure(s)
       Start: 04/01/2004
N215 = Alert: A payer providing supplemental
       or secondary coverage shall not require
       a claims determination for this service
       from a primary payer as a condition of
       making its own claims determination.
       Start: 04/01/2004
N216 = We do not offer coverage for this type
       of service or the patient is not
       enrolled in this portion of our benefit
       package
       Start: 04/01/2004
N217 = We pay only one site of service per
       provider per claim
       Start: 08/01/2004
N218 = You must furnish and service this item
       for as long as the patient continues to
       need it. We can pay for maintenance
       and/or servicing for the time period
       specified in the contract or coverage manual.
       Start: 08/01/2004
N219 = Payment based on previous payer's
       allowed amount.
       Start: 08/01/2004
N220 = Alert: See the payer's web site or
       contact the payer's Customer Service
       department to obtain forms and
       instructions for filing a provider
       dispute.
       Start: 08/01/2004
N221 = Missing Admitting History and Physical
       report.
       Start: 08/01/2004
N222 = Incomplete/invalid Admitting History
       and Physical report.
       Start: 08/01/2004
N223 = Missing documentation of benefit to the
       patient during initial treatment period.
N224 = Incomplete/invalid documentation of
       benefit to the patient during initial
       treatment period.
       Start: 08/01/2004
N225 = Incomplete/invalid
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        documentation/orders/notes/summary/
        report/chart.
        Start: 08/01/2004
N226 = Incomplete/invalid American Diabetes
        Association Certificate of Recognition.
        Start: 08/01/2004
N227 = Incomplete/invalid Certificate of
        Medical Necessity.
        Start: 08/01/2004
N228 = Incomplete/invalid consent form.
        Start: 08/01/2004
N229 = Incomplete/invalid contract indicator.
        Start: 08/01/2004
N230 = Incomplete/invalid indication of
        whether the patient owns the equipment
        equipment that requires the part or
        or supply.
        Start: 08/01/2004
N231 = Incomplete/invalid invoice or statement
        certifying the actual cost of the lens,
        less discounts, and/or the type of
        intraocular lens used.
        Start: 08/01/2004
N232 = Incomplete/invalid itemized
        bill/statement.
        Start: 08/01/2004
N233 = Incomplete/invalid operative
        note/report.
        Start: 08/01/2004
N234 = Incomplete/invalid oxygen
        certification/re-certification.
        Start: 08/01/2004
N235 = Incomplete/invalid pacemaker
        registration form.
        Start: 08/01/2004
N236 = Incomplete/invalid pathology report.
        Start: 08/01/2004
N237 = Incomplete/invalid patient medical
        record for this service.
        Start: 08/01/2004
N238 = Incomplete/invalid physician certified
        plan of care
        Start: 08/01/2004
N239 = Incomplete/invalid physician financial
        relationship form.
        Start: 08/01/2004
N240 = Incomplete/invalid radiology report.
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           Start: 08/01/2004
N241 = Incomplete/invalid review organization
       approval.
       Start: 08/01/2004
N242 = Incomplete/invalid radiology film(s)
       /image(s).
       Start: 08/01/2004
N243 = Incomplete/invalid/not approved
       screening document.
       Start: 08/01/2004
N244 = Incomplete/invalid pre-operative
       photos/visual field results.
       Start: 08/01/2004
N245 = Incomplete/invalid plan information for
       other insurance
       Start: 08/01/2004
N246 = State regulated patient payment
       limitations apply to this service.
       Start: 12/02/2004
N247 = Missing/incomplete/invalid assistant
       surgeon taxonomy.
       Start: 12/02/2004
N248 = Missing/incomplete/invalid assistant
       surgeon name.
       Start: 12/02/2004
N249 = Missing/incomplete/invalid assistant
       surgeon primary identifier.
       Start: 12/02/2004
N250 = Missing/incomplete/invalid assistant
       surgeon secondary identifier.
       Start: 12/02/2004
N251 = Missing/incomplete/invalid attending
       provider taxonomy.
       Start: 12/02/2004
N252 = Missing/incomplete/invalid attending
       provider name.
       Start: 12/02/2004
N253 = Missing/incomplete/invalid attending
       provider primary identifier.
       Start: 12/02/2004
N254 = Missing/incomplete/invalid attending
       provider secondary identifier.
       Start: 12/02/2004
N255 = Missing/incomplete/invalid billing
       provider taxonomy.
       Start: 12/02/2004
N256 = Missing/incomplete/invalid billing
```

```
       provider/supplier name.
       Start: 12/02/2004
N257 = Missing/incomplete/invalid billing
       provider/supplier primary identifier.
       Start: 12/02/2004
N258 = Missing/incomplete/invalid billing
       provider/supplier address.
       Start: 12/02/2004
N259 = Missing/incomplete/invalid billing
       provider/supplier secondary identifier.
       Start: 12/02/2004
N260 = Missing/incomplete/invalid billing
       provider/supplier contact information.
       Start: 12/02/2004
N261 = Missing/incomplete/invalid operating
       provider name.
       Start: 12/02/2004
N262 = Missing/incomplete/invalid operating
       provider primary identifier.
       Start: 12/02/2004
N263 = Missing/incomplete/invalid operating
       provider secondary identifier.
       Start: 12/02/2004
N264 = Missing/incomplete/invalid ordering
       provider name.
       Start: 12/02/2004
N265 = Missing/incomplete/invalid ordering
       provider primary identifier.
       Start: 12/02/2004
N266 = Missing/incomplete/invalid ordering
       provider address.
       Start: 12/02/2004
N267 = Missing/incomplete/invalid ordering
       provider secondary identifier.
       Start: 12/02/2004
N268 = Missing/incomplete/invalid ordering
       provider contact information.
       Start: 12/02/2004
N269 = Missing/incomplete/invalid other
       provider name.
       Start: 12/02/2004
N270 = Missing/incomplete/invalid other
       provider primary identifier.
       Start: 12/02/2004
N271 = Missing/incomplete/invalid other
       provider secondary identifier.
       Start: 12/02/2004
```

N272 = Missing/incomplete/invalid other payer
       attending provider identifier.
       Start: 12/02/2004
N273 = Missing/incomplete/invalid other payer
       operating provider identifier.
       Start: 12/02/2004
N274 = Missing/incomplete/invalid other payer
       other provider identifier.
       Start: 12/02/2004
N275 = Missing/incomplete/invalid other payer
       purchased service provider identifier.
       Start: 12/02/2004
N276 = Missing/incomplete/invalid other payer
       referring provider identifier.
       Start: 12/02/2004
N277 = Missing/incomplete/invalid other payer
       rendering provider identifier.
       Start: 12/02/2004
N278 = Missing/incomplete/invalid other payer
       service facility provider identifier.
       Start: 12/02/2004
N279 = Missing/incomplete/invalid pay-to
       provider name.
       Start: 12/02/2004
N280 = Missing/incomplete/invalid pay-to
       provider primary identifier.
       Start: 12/02/2004
N281 = Missing/incomplete/invalid pay-to
       provider address.
       Start: 12/02/2004
N282 = Missing/incomplete/invalid pay-to
       provider secondary identifier.
       Start: 12/02/2004
N283 = Missing/incomplete/invalid purchased
       service provider identifier.
       Start: 12/02/2004
N284 = Missing/incomplete/invalid referring
       provider taxonomy.
       Start: 12/02/2004
N285 = Missing/incomplete/invalid referring
       provider name.
       Start: 12/02/2004
N286 = Missing/incomplete/invalid referring
       provider primary identifier.
       Start: 12/02/2004
N287 = Missing/incomplete/invalid referring
       provider secondary identifier.

N288 = Missing/incomplete/invalid rendering
       provider taxonomy.
       Start: 12/02/2004
N289 = Missing/incomplete/invalid rendering
       provider name.
       Start: 12/02/2004
N290 = Missing/incomplete/invalid rendering
       provider primary identifier.
       Start: 12/02/2004
N291 = Missing/incomplete/invalid rendering
       provider secondary identifier.
       Start: 12/02/2004
N292 = Missing/incomplete/invalid service
       facility name.
       Start: 12/02/2004
N293 = Missing/incomplete/invalid service
       facility primary identifier.
       Start: 12/02/2004
N294 = Missing/incomplete/invalid service
       facility primary address.
       Start: 12/02/2004
N295 = Missing/incomplete/invalid service
       facility secondary identifier.
       Start: 12/02/2004
N296 = Missing/incomplete/invalid supervising
       provider name.
       Start: 12/02/2004
N297 = Missing/incomplete/invalid supervising
       provider primary identifier.
       Start: 12/02/2004
N298 = Missing/incomplete/invalid supervising
       provider secondary identifier.
       Start: 12/02/2004
N299 = Missing/incomplete/invalid occurrence
       date(s).
       Start: 12/02/2004
N300 = Missing/incomplete/invalid occurrence
       span date(s).
       Start: 12/02/2004
N301 = Missing/incomplete/invalid procedure
       date(s).
       Start: 12/02/2004
N302 = Missing/incomplete/invalid other
       procedure date(s).
       Start: 12/02/2004
N303 = Missing/incomplete/invalid principal

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              procedure date.
              Start: 12/02/2004
N304 = Missing/incomplete/invalid dispensed
              date.
              Start: 12/02/2004
N305 = Missing/incomplete/invalid accident
              date.
              Start: 12/02/2004
N306 = Missing/incomplete/invalid acute
              manifestation date.
              Start: 12/02/2004
N307 = Missing/incomplete/invalid adjudication
              or payment date.
              Start: 12/02/2004
N308 = Missing/incomplete/invalid appliance
              placement date.
              Start: 12/02/2004
N309 = Missing/incomplete/invalid assessment
              date.
              Start: 12/02/2004
N310 = Missing/incomplete/invalid assumed or
              relinquished care date.
              Start: 12/02/2004
N311 = Missing/incomplete/invalid authorized
              to return to work date.
              Start: 12/02/2004
N312 = Missing/incomplete/invalid begin
              therapy date.
              Start: 12/02/2004
N313 = Missing/incomplete/invalid
              certification revision date.
              Start: 12/02/2004
N314 = Missing/incomplete/invalid diagnosis
              date.
              Start: 12/02/2004
N315 = Missing/incomplete/invalid disability
              from date.
              Start: 12/02/2004
N316 = Missing/incomplete/invalid disability
              to date.
              Start: 12/02/2004
N317 = Missing/incomplete/invalid discharge
              hour.
              Start: 12/02/2004
N318 = Missing/incomplete/invalid discharge or
              end of care date.
              Start: 12/02/2004
```

N319 = Missing/incomplete/invalid hearing or
       vision prescription date.
       Start: 12/02/2004
N320 = Missing/incomplete/invalid Home Health
       Certification Period.
       Start: 12/02/2004
N321 = Missing/incomplete/invalid last
       admission period.
       Start: 12/02/2004
N322 = Missing/incomplete/invalid last
       certification date.
       Start: 12/02/2004
N323 = Missing/incomplete/invalid last contact
       date.
       Start: 12/02/2004
N324 = Missing/incomplete/invalid last
       seen/visit date.
       Start: 12/02/2004
N325 = Missing/incomplete/invalid last worked
       date.
       Start: 12/02/2004
N326 = Missing/incomplete/invalid last x-ray
       date.
       Start: 12/02/2004
N327 = Missing/incomplete/invalid other insured
       birth date.
       Start: 12/02/2004
N328 = Missing/incomplete/invalid Oxygen
       Saturation Test date.
       Start: 12/02/2004
N329 = Missing/incomplete/invalid patient
       birth date
       Start: 12/02/2004
N330 = Missing/incomplete/invalid patient
       death date.
       Start: 12/02/2004
N331 = Missing/incomplete/invalid physician
       order date.
       Start: 12/02/2004
N332 = Missing/incomplete/invalid prior
       hospital discharge date.
       Start: 12/02/2004
N333 = Missing/incomplete/invalid prior
       placement date.
       Start: 12/02/2004
N334 = Missing/incomplete/invalid re- evaluation
       date

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                 Start: 12/02/2004
N335 = Missing/incomplete/invalid referral
       date.
       Start: 12/02/2004
N336 = Missing/incomplete/invalid replacement
       date.
       Start: 12/02/2004
N337 = Missing/incomplete/invalid secondary
       diagnosis date.
       Start: 12/02/2004
N338 = Missing/incomplete/invalid shipped  date.
       Start: 12/02/2004
N339 = Missing/incomplete/invalid similar
       illness or symptom date.
       Start: 12/02/2004
N340 = Missing/incomplete/invalid subscriber
       birth date.
       Start: 12/02/2004
N341 = Missing/incomplete/invalid surgery date.
       Start: 12/02/2004
N342 = Missing/incomplete/invalid test
       performed date.
       Start: 12/02/2004
N343 = Missing/incomplete/invalid
       Transcutaneous Electrical Nerve
       Stimulator (TENS) trial start date.
       Start: 12/02/2004
N344 = Missing/incomplete/invalid
       Transcutaneous Electrical Nerve
       Stimulator (TENS) trial end date.
       Start: 12/02/2004
N345 = Date range not valid with units
       submitted.
       Start: 03/30/2005
N346 = Missing/incomplete/invalid oral cavity
       designation code.
       Start: 03/30/2005
N347 = Your claim for a referred or purchased
       service cannot be paid because payment
       has already been made for this same
       service to another provider by a payment
       contractor representing the payer.
       Start: 03/30/2005
N348 = You chose that this service/supply/drug
       would be rendered/supplied and billed by
       a different practitioner/supplier.
       Start: 08/01/2005
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N349 = The administration method and drug must
       be reported to adjudicate this service.
       Start: 08/01/2005
N350 = Missing/incomplete/invalid description
       of service for a Not Otherwise Classified
       (NOC) code or for an Unlisted/By Report
       procedure.
       Start: 08/01/2005
N351 = Service date outside of the approved
       treatment plan service dates.
       Start: 08/01/2005
N352 = Alert: There are no scheduled payments
       for this service. Submit a claim for
       each patient visit.
       Start: 08/01/2005
N353 = Alert: Benefits have been estimated,
       when the actual services have been
       rendered, additional payment will be
       considered based on the submitted claim.
       Start: 08/01/2005
N354 = Incomplete/invalid invoice
       Start: 08/01/2005
      "Alert: The law permits exceptions to
       the refund requirement in two cases: -
       If you did not know, and could not have
       reasonably been expected to know, that
       we would not pay for this service; or -
       If you notified the patient in writing
       before providing the service that you
       believed that we were likely to deny the
       service, and the patient signed a
       statement agreeing to pay for the
       service.
       If you come within either exception, or
       if you believe the carrier was wrong in
       its determination that we do not pay for
       this service, you should request appeal
       of this determination within 30 days of
       the date of this notice. Your request
       for review should include any additional
       information necessary to support your
       position.
       If you request an appeal within 30 days
       of receiving this notice, you may delay
       refunding the amount to the patient
       until you receive the results of the
       review. If the review decision is
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favorable to you, you do not need to
make any refund. If, however, the review
is unfavorable, the law specifies that
you must make the refund within 15 days
of receiving the unfavorable review
decision.
The law also permits you to request an
appeal at any time within 120 days of
the date you receive this notice.
However, an appeal request that is
received more than 30 days after the
date of this notice, does not permit you
to delay making the refund. Regardless
of when a review is requested, the
patient will be notified that you have
requested one, and will receive a copy
of the determination.
The patient has received a separate
notice of this denial decision. The
notice advises that he/she may be
entitled to a refund of any amounts
paid, if you should have known that we
would not pay and did not tell him/her.
It also instructs the patient to contact
our office if he/she does not hear
anything about a refund within 30 days"
Start: 08/01/2005

N356 = Not covered when performed with, or
subsequent to, a non-covered service.
Start: 08/01/2005

N357 = Time frame requirements between this
service/procedure/supply and a related
service/procedure/supply have not been
met.
Start: 11/18/2005

N358 = Alert: This decision may be reviewed if
additional documentation as described in
the contract or plan benefit documents
is submitted.
Start: 11/18/2005

N359 = Missing/incomplete/invalid height.
Start: 11/18/2005

N360 = Alert: Coordination of benefits has not
been calculated when estimating benefits
for this pre-determination. Submit
payment information from the primary
payer with the secondary claim.

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         Start: 11/18/2005
N361 = Payment adjusted based on multiple
         diagnostic imaging procedure rules
         Start: 11/18/2005
         Stop: 10/01/2007
         Notes: (Modified 12/1/06)
         Consider using Reason Code 59
N362 = The number of Days or Units of Service
         exceeds our acceptable maximum.
         Start: 11/18/2005
N363 = Alert: in the near future we are
         implementing new policies/procedures
         that would affect this determination.
         Start: 11/18/2005
N364 = Alert: According to our agreement, you
         must waive the deductible and/or
         coinsurance amounts.
         Start: 11/18/2005
N365 = This procedure code is not payable.
         It is for reporting/information purposes
         only.
         Start: 04/01/2006
N366 = Requested information not provided. The
         claim will be reopened if the
         information previously requested is
         submitted within one year after the date
         of this denial notice.
         Start: 04/01/2006
N367 = Alert: The claim information has been
         forwarded to a Consumer Spending Account
         processor for review; for example,
         flexible spending account or health
         savings account.
         Start: 04/01/2006
         Last Modified: 07/01/2008
N368 = You must appeal the determination of
         the previously adjudicated claim.
         Start: 04/01/2006
N369 = Alert: Although this claim has been
         processed, it is deficient according to
         state legislation/regulation.
         Start: 04/01/2006
N370 = Billing exceeds the rental months
         covered/approved by the payer.
         Start: 08/01/2006
N371 = Alert: title of this equipment must be
         transferred to the patient.
```

```
              Start: 08/01/2006
N372 = Only reasonable and necessary
       maintenance/service charges are covered.
       Start: 08/01/2006
N373 = It has been determined that another
       payer paid the services as primary when
       they were not the primary payer.
       Therefore, we are refunding to the payer
       that paid as primary on your behalf.
       Start: 12/01/2006
N374 = Primary Medicare Part A insurance has
       been exhausted and a Part B Remittance
       Advice is required.
       Start: 12/01/2006
N375 = Missing/incomplete/invalid
       questionnaire/information required to
       determine dependent eligibility.
       Start: 12/01/2006
N376 = Subscriber/patient is assigned to
       active military duty, therefore
       primary coverage may be TRICARE.
       Start: 12/01/2006
N377 = Payment based on a processed
       replacement claim.
       Start: 12/01/2006
N378 = Missing/incomplete/invalid prescription
       quantity.
       Start: 12/01/2006
N379 = Claim level information does not match
       line level information.
       Start: 12/01/2006
N380 = The original claim has been processed,
       submit a corrected claim.
       Start: 04/01/2007
N381 = Consult our contractual agreement for
       restrictions/billing/payment information
       related to these charges.
       Start: 04/01/2007
N382 = Missing/incomplete/invalid patient
       identifier.
       Start: 04/01/2007
N383 = Not covered when deemed cosmetic.
       Start: 04/01/2007
       Last Modified: 03/08/2011
       Notes: (Modified 3/8/11)
N384 = Records indicate that the referenced
       body part/tooth has been removed in a
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                previous procedure.
                Start: 04/01/2007
N385 = Notification of admission was not
                timely
                according to published plan procedures.
                Start: 04/01/2007
N386 = This decision was based on a National
                Coverage Determination (NCD). An NCD
                provides a coverage determination as to
                whether a particular item or service is
                covered. A copy of this policy is
                available at www.cms.gov/mcd/search.asp.
                If you do not have web access, you may
                contact the contractor to request a copy
                of the NCD.
                Start: 04/01/2007
N387 = Alert: Submit this claim to the
                patient's other insurer for potential
                payment of supplemental benefits. We did
                not forward the claim information.
                Start: 04/01/2007
N388 = Missing/incomplete/invalid prescription
                number.
                Start: 08/01/2007
N389 = Duplicate prescription number
                submitted.
                Start: 08/01/2007
N390 = This service/report cannot be billed
                separately.
                Start: 08/01/2007
N391 = Missing emergency department records.
                Start: 08/01/2007
N392 = Incomplete/invalid emergency department
                records.
                Start: 08/01/2007
N393 = Missing progress notes/report.
                Start: 08/01/2007
N394 = Incomplete/invalid progress
                notes/report.
                Start: 08/01/2007
N395 = Missing laboratory report.
                Start: 08/01/2007
N396 = Incomplete/invalid laboratory report.
                Start: 08/01/2007
N397 = Benefits are not available for
                incomplete service(s)/undelivered
                item(s).
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                Start: 08/01/2007
N398 = Missing elective consent form.
                Start: 08/01/2007
N399 = Incomplete/invalid elective consent
            form.
                Start: 08/01/2007
N400 = Alert: Electronically enabled providers
            should submit claims electronically.
                Start: 08/01/2007
N401 = Missing periodontal charting.
                Start: 08/01/2007
N402 = Incomplete/invalid periodontal
            charting.
                Start: 08/01/2007
N403 = Missing facility certification.
                Start: 08/01/2007
N404 = Incomplete/invalid facility
            certification.
                Start: 08/01/2007
N405 = This service is only covered when the
            donor's insurer(s) do not provide
            coverage for the service.
                Start: 08/01/2007
N406 = This service is only covered when the
            recipient's insurer(s) do not provide
            coverage for the service.
                Start: 08/01/2007
N407 = You are not an approved submitter for
            this transmission format.
                Start: 08/01/2007
N408 = This payer does not cover deductibles
            assessed by a previous payer.
                Start: 08/01/2007
N409 = This service is related to an
            accidental injury and is not covered
            unless provided within a specific time
            frame from the date of the accident.
                Start: 08/01/2007
N410 = Not covered unless the prescription
            changes.
                Start: 08/01/2007
N411 = This service is allowed one time in a
            6-month period. (This temporary code
            will be deactivated on 2/1/09. Must be
            used with Reason Code 119.)
                Start: 08/01/2007
                Stop: 02/01/2009
```

N412 = This service is allowed 2 times in a
       12-month period. (This temporary code
       will be deactivated on 2/1/09. Must be
       used with Reason Code 119.)
       Start: 08/01/2007
       Stop: 02/01/2009
N413 = This service is allowed 2 times in a
       benefit year. (This temporary code will
       be deactivated on 2/1/09. Must be used
       with Reason Code 119.)
       Start: 08/01/2007
       Stop: 02/01/2009
N414 = This service is allowed 4 times in a
       12-month period. (This temporary code
       will be deactivated on 2/1/09. Must be
       used with Reason Code 119.)
       Start: 08/01/2007
       Stop: 02/01/2009
N415 = This service is allowed 1 time in an
       18-month period. (This temporary code
       will be deactivated on 2/1/09. Must be
       used with Reason Code 119.)
       Start: 08/01/2007
       Stop: 02/01/2009
N416 = This service is allowed 1 time in a
       3-year period. (This temporary code will
       be deactivated on 2/1/09. Must be used
       with Reason Code 119.)
       Start: 08/01/2007
       Stop: 02/01/2009
N417 = This service is allowed 1 time in a
       5-year period. (This temporary code will
       be deactivated on 2/1/09. Must be used
       with Reason Code 119.)
       Start: 08/01/2007
       Stop: 02/01/2009
N418 = Misrouted claim. See the payer's claim
       submission instructions.
       Start: 08/01/2007
N419 = Claim payment was the result of a
       payer's retroactive adjustment due to a
       retroactive rate change.
       Start: 08/01/2007
N420 = Claim payment was the result of a
       payer's retroactive adjustment due to a
       Coordination of Benefits or Third Party
       Liability Recovery.

Start: 08/01/2007

N421 = Claim payment was the result of a
payer's retroactive adjustment due to a
review organization decision.
Start: 08/01/2007

N422 = Claim payment was the result of a
payer's retroactive adjustment due to a
payer's contract incentive program.
Start: 08/01/2007

N423 = Claim payment was the result of a
payer's retroactive adjustment due to a
non standard program.
Start: 08/01/2007

N424 = Patient does not reside in the
geographic area required for this type
of payment.
Start: 08/01/2007

N425 = Statutorily excluded service(s).
Start: 08/01/2007

N426 = No coverage when self-administered.
Start: 08/01/2007

N427 = Payment for eyeglasses or contact
lenses can be made only after cataract
surgery.
Start: 08/01/2007

N428 = Not covered when performed in this
place of surgery.
Start: 08/01/2007

N429 = Not covered when considered routine.
Start: 08/01/2007

N430 = Procedure code is inconsistent with the
units billed.
Start: 11/05/2007

N431 = Not covered with this procedure.
Start: 11/05/2007

N432 = Adjustment based on a Recovery Audit.
Start: 11/05/2007

N433 = Resubmit this claim using only your
National Provider Identifier (NPI)
Start: 02/29/2008

N434 = Missing/Incomplete/Invalid Present on
Admission indicator.
Start: 07/01/2008

N435 = Exceeds number/frequency approved
/allowed within time period without
support documentation.
Start: 07/01/2008

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N436 = The injury claim has not been accepted
       and a mandatory medical reimbursement
       has been made.
       Start: 07/01/2008
N437 = Alert: If the injury claim is accepted,
       these charges will be reconsidered.
       Start: 07/01/2008
N438 = This jurisdiction only accepts paper
       claims
       Start: 07/01/2008
N439 = Missing anesthesia physical status
       report/indicators.
       Start: 07/01/2008
N440 = Incomplete/invalid anesthesia physical
       status report/indicators.
       Start: 07/01/2008
N441 = This missed appointment is not covered.
       Start: 07/01/2008
N442 = Payment based on an alternate fee
       schedule.
       Start: 07/01/2008
N443 = Missing/incomplete/invalid total time
       or begin/end time.
       Start: 07/01/2008
N444 = Alert: This facility has not filed the
       Election for High Cost Outlier form with
       the Division of Workers' Compensation.
       Start: 07/01/2008
N445 = Missing document for actual cost or
       paid amount.
       Start: 07/01/2008
N446 = Incomplete/invalid document for actual
       cost or paid amount.
       Start: 07/01/2008
N447 = Payment is based on a generic
       equivalent
       as required documentation was not
       provided.
       Start: 07/01/2008
N448 = This drug/service/supply is not
       included
       in the fee schedule or
       contracted/legislated fee arrangement
       Start: 07/01/2008
N449 = Payment based on a comparable
       drug/service/supply.
       Start: 07/01/2008
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N450 = Covered only when performed by the
       primary treating physician or the
       designee.
       Start: 07/01/2008
N451 = Missing Admission Summary Report.
       Start: 07/01/2008
N452 = Incomplete/invalid Admission Summary
       Report.
       Start: 07/01/2008
N453 = Missing Consultation Report.
       Start: 07/01/2008
N454 = Incomplete/invalid Consultation Report.
       Start: 07/01/2008
N455 = Missing Physician Order.
       Start: 07/01/2008
N456 = Incomplete/invalid Physician Order.
       Start: 07/01/2008
N457 = Missing Diagnostic Report.
       Start: 07/01/2008
N458 = Incomplete/invalid Diagnostic Report.
       Start: 07/01/2008
N459 = Missing Discharge Summary.
       Start: 07/01/2008
N460 = Incomplete/invalid Discharge Summary.
       Start: 07/01/2008
N461 = Missing Nursing Notes.
       Start: 07/01/2008
N462 = Incomplete/invalid Nursing Notes.
       Start: 07/01/2008
N463 = Missing support data for claim.
       Start: 07/01/2008
N464 = Incomplete/invalid support data for
       claim.
       Start: 07/01/2008
N465 = Missing Physical Therapy Notes/Report.
       Start: 07/01/2008
N466 = Incomplete/invalid Physical Therapy
       Notes/Report.
       Start: 07/01/2008
N467 = Missing Report of Tests and Analysis
       Report.
       Start: 07/01/2008
N468 = Incomplete/invalid Report of Tests and
       Analysis Report.
       Start: 07/01/2008
N469 = Alert: Claim/Service(s) subject to
       appeal process, see section 935 of
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              Medicare Prescription Drug, Improvement,
              and Modernization Act of 2003 (MMA).
              Start: 07/01/2008
N470 = This payment will complete the
       mandatory
       medical reimbursement limit.
       Start: 07/01/2008
N471 = Missing/incomplete/invalid HIPPS Rate
       Code.
       Start: 07/01/2008
N472 = Payment for this service has been
       issued
       to another provider.
       Start: 07/01/2008
N473 = Missing certification.
       Start: 07/01/2008
N474 = Incomplete/invalid certification
       Start: 07/01/2008
N475 = Missing completed referral form.
       Start: 07/01/2008
N476 = Incomplete/invalid completed referral
       form
       Start: 07/01/2008
N477 = Missing Dental Models.
       Start: 07/01/2008
N478 = Incomplete/invalid Dental Models
       Start: 07/01/2008
N479 = Missing Explanation of Benefits
       (Coordination of Benefits or Medicare
       Secondary Payer).
       Start: 07/01/2008
N480 = Incomplete/invalid Explanation of
       Benefits (Coordination of Benefits or
       Medicare Secondary Payer).
       Start: 07/01/2008
N481 = Missing Models.
       Start: 07/01/2008
N482 = Incomplete/invalid Models
       Start: 07/01/2008
N483 = Missing Periodontal Charts.
       Start: 07/01/2008
N484 = Incomplete/invalid Periodontal Charts
       Start: 07/01/2008
N485 = Missing Physical Therapy Certification.
       Start: 07/01/2008
N486 = Incomplete/invalid Physical Therapy
       Certification.
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              Start: 07/01/2008
N487 = Missing Prosthetics or Orthotics
       Certification.
       Start: 07/01/2008
N488 = Incomplete/invalid Prosthetics or
       Orthotics Certification
       Start: 07/01/2008
N489 = Missing referral form.
       Start: 07/01/2008
N490 = Incomplete/invalid referral form
       Start: 07/01/2008
N491 = Missing/Incomplete/Invalid Exclusionary
       Rider Condition.
       Start: 07/01/2008
N492 = Alert: A network provider may bill the
       member for this service if the member
       requested the service and agreed in
       writing, prior to receiving the service,
       to be financially responsible for the
       billed charge.
       Start: 07/01/2008
N493 = Missing Doctor First Report of Injury.
       Start: 07/01/2008
N494 = Incomplete/invalid Doctor First Report
       of Injury.
       Start: 07/01/2008
N495 = Missing Supplemental Medical Report.
       Start: 07/01/2008
N496 = Incomplete/invalid Supplemental Medical
       Report.
       Start: 07/01/2008
N497 = Missing Medical Permanent Impairment or
       Disability Report.
       Start: 07/01/2008
N498 = Incomplete/invalid Medical Permanent
       Impairment or Disability Report.
       Start: 07/01/2008
N499 = Missing Medical Legal Report.
       Start: 07/01/2008
N500 = Incomplete/invalid Medical Legal
       Report.
       Start: 07/01/2008
N501 = Missing Vocational Report.
       Start: 07/01/2008
N502 = Incomplete/invalid Vocational Report.
       Start: 07/01/2008
N503 = Missing Work Status Report.
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            Start: 07/01/2008
N504 = Incomplete/invalid Work Status Report.
            Start: 07/01/2008
N505 = Alert: This response includes only
            services that could be estimated in real
            time. No estimate will be provided for
            the services that could not be estimated
            in real time.
            Start: 11/01/2008
N506 = Alert: This is an estimate of the
            member's liability based on the
            information available at the time the
            estimate was processed. Actual coverage
            and member liability amounts will be
            determined when the claim is processed.
            This is not a pre-authorization or a
            guarantee of payment.
            Start: 11/01/2008
N507 = Plan distance requirements have not
            been met.
            Start: 11/01/2008
N508 = Alert: This real time claim
            adjudication response represents the
            the member responsibility to the
            provider for services reported.  The
            member will receive an Explanation of
            Benefits electronically or in the mail.
            Contact the insurer if there are any
            questions.
            Start: 11/01/2008
N509 = Alert: A current inquiry shows the
            member's Consumer Spending Account
            contains sufficient funds to cover the
            member liability for this claim/service.
            Actual payment from the Consumer
            Spending Account will depend on the
            availability of funds and determination
            of eligible services at the time of
            payment processing.
            Start: 11/01/2008
N510 = Alert: A current inquiry shows the
            members Consumer Spending Account does
            not contain sufficient funds to cover
            the member's liability for this
            claim/service. Actual payment from the
            Consumer Spending Account will depend on
            the availability of funds and
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              determination of eligible services at
              the time of payment processing.
              Start: 11/01/2008
N511 = Alert: Information on the availability
              of Consumer Spending Account funds to
              cover the member liability on this
              claim/service is not available at this
              time.
              Start: 11/01/2008
N512 = Alert: This is the initial remit of a
              non-NCPDP claim originally submitted
              real-time without change to the
              adjudication.
              Start: 11/01/2008
N513 = Alert: This is the initial remit of a
              non-NCPDP claim originally submitted
              real-time with a change to the
              adjudication.
              Start: 11/01/2008
N514 = Consult plan benefit
              documents/guidelines for information
              about restrictions for this service.
              Start: 11/01/2008
              Stop: 01/01/2011
              Notes: Consider using N130
N515 = Alert: Submit this claim to the
              patient's other insurer for potential
              payment of supplemental benefits. We did
              not forward the claim information. (use
              N387 instead)
              Start: 11/01/2008
              Stop: 10/1/2009
N516 = Records indicate a mismatch between the
              submitted NPI and EIN.
              Start: 03/01/2009
N517 = Resubmit a new claim with the requested
              information.
              Start: 03/01/2009
N518 = No separate payment for accessories
              when furnished for use with oxygen
              equipment.
              Start: 03/01/2009
N519 = Invalid combination of HCPCS modifiers.
              Start: 07/01/2009
N520 = Alert: Payment made from a Consumer
              Spending Account.
              Start: 07/01/2009
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N521 = Mismatch between the submitted provider
       information and the provider information
       stored in our system.
       Start: 11/01/2009
N522 = Duplicate of a claim processed, or to
       be processed, as a crossover claim.
       Start: 11/01/2009
N523 = The limitation on outlier payments
       defined by this payer for this service
       period has been met. The outlier payment
       otherwise applicable to this claim has
       not been paid.
       Start: 03/01/2010
N524 = Based on policy this payment
       constitutes payment in full.
       Start: 03/01/2010
N525 = These services are not covered when
       performed within the global period of
       another service.
       Start: 03/01/2010
N526 = Not qualified for recovery based on
       employer size.
       Start: 03/01/2010
N527 = We processed this claim as the primary
       payer prior to receiving the recovery
       demand.
       Start: 03/01/2010
N528 = Patient is entitled to benefits for
       Institutional Services only.
       Start: 03/01/2010
N529 = Patient is entitled to benefits for
       Professional Services only.
       Start: 03/01/2010
N530 = Not Qualified for Recovery based on
       enrollment information.
       Start: 03/01/2010 ¦
N531 = Not qualified for recovery based on
       direct payment of premium.
       Start: 03/01/2010
N532 = Not qualified for recovery based on
       disability and working status.
       Start: 03/01/2010
N533 = Services performed in an Indian Health
       Services facility under a self-insured
       tribal Group Health Plan.
       Start: 07/01/2010
N534 = This is an individual policy, the
```

employer does not participate in plan
sponsorship.
Start: 07/01/2010

N535 = Payment is adjusted when procedure is
performed in this place of service based
on the submitted procedure code and
place of service.
Start: 07/01/2010

N536 = We are not changing the prior payer's
determination of patient responsibility,
which you may collect, as this service
is not covered by us.
Start: 07/01/2010

N537 = We have examined claims history and no
records of the services have been found.
Start: 07/01/2010

N538 = A facility is responsible for payment
to outside providers who furnish these
services/supplies/drugs to its
patients/residents.
Start: 07/01/2010

N539 = Alert: We processed appeals/waiver
requests on your behalf and that request
has been denied.
Start: 07/01/2010

N540 = Payment adjusted based on the
interrupted stay policy.
Start: 11/01/2010

N541 = Mismatch between the submitted
insurance type code and the information
stored in our system.
Start: 11/01/2010

N542 = Missing income verification.
Start: 03/08/2011

N543 = Incomplete/invalid income verification
Start: 03/08/2011

N544 = Alert: Although this was paid, you have
billed with a referring/ordering
provider that does not match our system
record. Unless, corrected, this will not
be paid in the future.
Start: 07/01/2011

N545 = Payment reduced based on status as an
unsuccessful eprescriber per the
Electronic Prescribing (eRx) Incentive
Program.
Start: 07/01/2011

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N546 = Payment represents a previous reduction
       based on the Electronic Prescribing
       (eRx) Incentive Program.
       Start: 07/01/2011
N547 = A refund request (Frequency Type Code
       8) was processed previously.
       Start: 03/06/2012
N548 = Alert: Patient's calendar year
       deductible has been met.
       Start: 03/06/2012
N549 = Alert: Patient's calendar year out-of-
       pocket maximum has been met.
       Start: 03/06/2012
N550 = Alert: You have not responded to
       requests to revalidate your
       provider/supplier enrollment
       information. Your failure to revalidate
       your enrollment information will result
       in a payment hold in the near future.
       Start: 03/06/2012
N551 = Payment adjusted based on the
       Ambulatory
       Surgical Center (ASC) Quality Reporting
       Program.
       Start: 03/06/2012
N552 = Payment adjusted to reverse a previous
       withhold/bonus amount.
       Start: 03/06/2012
N553 = Payment adjusted based on a Low Income
       Subsidy (LIS) retroactive coverage or
       status change.
       Start: 03/06/2012
       Stop:  11/1/2012
N554 = Missing/Incomplete/Invalid Family
       Planning Indicator
       Start: 07/01/2012
N555 = Missing medication list.
       Start: 07/01/2012
N556 = Incomplete/invalid medication list.
       Start: 07/01/2012
N557 = This claim/service is not payable under
       our service area. The claim must be
       filed to the Payer/Plan in whose service
       area the specimen was collected.
       Start: 07/01/2012
N558 = This claim/service is not payable under
       our service area. The claim must be
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filed to the Payer/Plan in whose service
        area the equipment was received.
        Start: 07/01/2012
N559 = This claim/service is not payable under
        our service area. The claim must be
        filed to the Payer/Plan in whose service
        area the Ordering Physician is located.
        Start: 07/01/2012
N560 = The pilot program requires an interim or
        final claim within 60 days of the Notice
        of Admission. A claim was not received.
        Start: 11/01/2012
N561 = The bundled claim originally submitted
        for this episode of care includes
        related readmissions. You may resubmit
        the original claim to receive a
        corrected payment based on this
        readmission.
        Start: 11/01/2012
N562 = The provider number of your incoming
        claim does not match the provider number
        on the processed Notice of Admission
        (NOA) for this bundled payment.
        Start: 11/01/2012
N563 = Missing required provider/supplier
        issuance of advance patient notice of
        non-coverage. The patient is not liable
        for payment for this service.
        Start: 11/01/2012
        Notes: Related to M39
N564 = Patient did not meet the inclusion
        criteria for the demonstration project
        or pilot program.
        Start: 11/01/2012
N565 = Alert: This procedure code requires a
        modifier. Future claims containing this
        procedure code must include an
        appropriate modifier for the claim to be
        processed.
        Start: 11/01/2012
N566 = Alert: This procedure code requires
        functional reporting. Future claims
        containing this procedure code must
        include an applicable non-payable code
        and appropriate modifiers for the claim
        to be processed.
        Start: 11/01/2012

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CLM_RRB_EXCLSN_IND_TB                    Claim RRB Exclusion Indicator Table


     Y = Exclude RRB beneficiary services from the prior authorization
         program
   Blank = Subject RRB beneficiary services to prior authorization



CLM_SRC_IP_ADMSN_TB                      Claim Source Of Inpatient Admission Table


            **For Inpatient/SNF Claims:**


     0 = ANOMALY: invalid value, if present,
         translate to '9'
     1 = Non-Health Care Facility Point of Origin
         (Physician Referral) - The patient was
         admitted to this facility upon an order
         of a physician.
     2 = Clinic referral - The patient was
         admitted upon the recommendation of
         this facility's clinic physician.
     3 = HMO referral - Reserved for national
         assignment. (eff. 3/08)
         Prior to 3/08, HMO referral - The patient
         was admitted upon the recommendation of
         an health maintenance organization (HMO)
         physician.
     4 = Transfer from hospital (Different Facility) -
         The patient was admitted to this facility
         as a hospital transfer from an acute care
         facility where he or she was an inpatient.
     5 = Transfer from a skilled nursing
         facility (SNF) or Intermediate Care Facility
         (ICF) - The patient was admitted to this
         facility as a transfer from a SNF or ICF
         where he or she was a resident.
     6 = Transfer from another health care
         facility - The patient was admitted
         to this facility as a transfer from
         another type of health care facility
         not defined elsewhere in this code list
         where he or she was an inpatient.
     7 = Emergency room - The patient was
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        admitted to this facility after receiving
        services in this facility's emergency
        room department. Obsolete - eff. 7/1/10
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.
        Includes transfers from incarceration facilities.
9 = Information not available -  The means
        by which the patient was admitted is
        not known.
A = Reserved for National Assignment. (eff. 3/08)
        Prior to 3/08 defined as: 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 Home Health Agency -
        The patient was admitted to this home
        health agency as a transfer from another
        home health agency.(Discontinued July 1,2010-
        See Condition Code 47)
C = Readmission to Same Home Health Agency -
        The patient was readmitted to this home
        health agency within the same home health
        episode period. (Discontinued July 1,2010)
D = Transfer from hospital inpatient in the
        same facility resulting in a separate
        claim to the payer - The patient was
        admitted to this facility as a transfer
        from hospital inpatient within this
        facility resulting in a separate
        claim to the payer.
E = Transfer from Ambulatory Surgery Center -
        The patient was admitted to this facility as
        a transfer from an ambulatory surgery center.
        (eff. 10/1/2007)
F = Transfer from Hospice and is under a Hospice
        Plan of Care or Enrolled in a Hospice Program -
        The patient was admitted to this facility as a
        transfer from a hospice.
        (eff. 10/1/2007)
    ----------------------------------------
        **For Newborn Type of Admission**

1 = Normal delivery - A baby delivered with
        out complications.  Obsolete eff. 10/1/07
2 = Premature delivery - A baby delivered
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                 with time and/or weight factors
                 qualifying it for premature status.
                 Obsolete eff. 10/1/07
            3 = Sick baby - A baby delivered with
                 medical complications, other than those
                 relating to premature status. Obsolete eff. 10/1/07
            4 = Extramural birth - A baby delivered in
                 a nonsterile environment.  Obsolete eff. 10/1/07
            5 = Born Inside this Hospital - eff. 10/1/07
            6 = Born Outside of this Hospital - eff. 10/1/07
            7-9 = Reserved for national assignment.



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) -- (Includes HHA medical and
             other health services not under a plan of
             treatment, hospital or SNF for diagnostic
             clinical laboratory services for "nonpatients,"
             and referenced diagnostic services.  For HHAs
             under PPS, indicates an osteoporosis claim.)
        5 = Intermediate care - level I
        6 = Intermediate care - level II
        7 = Subacute Inpatient (revenue code 019X required)
             (formerly Intermediate care - level III)
             NOTE:  17X & 27X are discontinued effective
             10/1/05.
        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 Clinic (RHC)
        2 = Hospital based or independent renal
             dialysis facility
        3 = Free-standing provider based federally
             qualified health center (FQHC) (eff 10/91)
        4 = Other Rehabilitation Facility (ORF) and
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          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


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


CLM_VAL_TB                            Claim Value Table

      01 = Most Common Semi-Private Rate - to
           provide for the recording of hospital's
           most common semi-private rate.
      02 = Hospital Has No Semi-Private Rooms -
           Entering this code requires $0.00
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             amount.
03 = Reserved for national assignment.
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.
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.
       (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
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             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
             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). Obsolete
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).  Obsolete
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). Obsolete
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
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          reporting.  Payer only code eff 9/93.)
          Obsolete
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)
25 = Offset to the Patient Payment Amount
     (Prescription Drugs) - Prescription
     drugs paid for out of a long-term
     care facility resident/patient's fund
     in the billing period submitted (State-
     ment Covers Period).
26 - Prescription Drugs Offset to Patient
     (Payment Amount - Hearing and Ear Services)
     Hearing and ear services paid for out of
     a long term care facility resident/patient's
     funds in the billing period submitted
     (Statement covers period).
27 = Offset to the Patient (Payment Amount - Vision
     and Eye Services) - Vision and eye services paid
     for out of a long term care facility resident/
     patient's funds in the billing period submitted
     (Statement Covers Period).
28 = Offset to the Patient (Payment Amount - Dental
     Services) - Dental services paid for out of a
     long term care facility resident/patient's funds
     in the billing period submitted (Statement
     Covers Period).
29 = Offset to the Patient (Payment Amount - Chiro-
     practic Services) - Chiropratic services paid
     for out of a long term care facility resident/
     patient's funds in the billing period submitted
     (Statement Covers Period).
30 = Preadmission Testing - the code used to reflect
     the charges for preadmission outpatient diag-
     nostic services in preparation for a previously
     scheduled admission.
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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.
32 = Multiple patient ambulance transport -
     The number of patients transported during
     one ambulance ride to the same destination.
     (eff. 4/1/2003)
33 = Offset to the Patient Payment Amount (Podiatric
     Services) -- Podiatric services paid out of
     a long-term care facility resident/patient's
     funds in the billing period submitted.
34 = Offset to the Patient Payment Amount (Medical
     Services) -- Other medical services paid out of
     a long-term care facility resident/patient's
     funds in the billing period submitted.
35 = Offset to the Patient Payment Amount (Health
     Insurance Premiums) -- Other medical services
     paid out of a long-term care facility resident/
     patient's funds in the billing period submitted.
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 Black Lung
     federal program made on behalf of
     bene the provider applied
     to Medicare covered services on this
     bill. Six zeroes indicate the
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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.
45 = Accident Hour - The hour the accident occurred
        that necessitated medical treatment.
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 patient's most
        recent hemoglobin reading taken before
        the start of the billing period (eff.
        1/3/2006). Prior to 1/3/2006 defined as
        the latest hemoglobin reading taken during
        the billing cycle.
49 = Hematocrit reading - The patient's most
        recent hematocrit reading taken before the
        start of the billing period (eff. 1/3/2006).
        Prior to 1/3/2006 defined as hematocrit
        reading taken during the billing cycle.
50 = Physical therapy visits - Indicates

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           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 = New birth weight in grams - Actual birth
           weight or weight at time of admission for
           an extramural birth.  Required on all claims
           with type of admission of '4' and on other
           claims as required by law.
55 = Eligibility Threshold for Charity Care - code
           identifies the corresponding value amount at
           which a health care facility determines the
           eligibility threshold of charity care.
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
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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.

NOTE: HHA claims with a thru date on or
before 12/31/05, the value code amount
field reflects the MSA code (followed by zeroes
to fill the field). HHA claims with a
thru date after 12/31/05, the value code
amount field reflects the CBSA code.

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 = Medicare Spend-down Amount -- The dollar
     amount that was used to meet th4e recipient's
     spend-down liability for this claim.
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 = State Charity Care Percent - code
     indicates the percentage of charity
     care eligibility for the patient.
70 = Interest amount - (Providers do not
     report this.) Report the amount

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        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 = New Technology Add-on Payment Amount -
     Amount of payments made for discharges
     involving approved new technologies. If
     the total covered costs of the discharge
     exceed the DRG payment for the case
     (including adjustments for IME and
     disporportionate share hospitals (DSH) but
     excluding outlier payments) an add-on
     amount is made indicating a new technology
     was used in the treatment of the beneficiary.
     (eff. 4/1/03, under Inpatient PPS)
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 = Covered days - the number of days covered by the
     primary payer as qualified by the payer.
81 = Non-covered Days - days of care not covered
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by the primary payer.

82 = Co-insurance Days - The inpatient Medicare days
     occurring after the 60th day and before the
     91st day or inpatient SNF/Swing bed days
     occurring after the 20th and before the 101st
     day in a single spell of illness.
83 = Lifetime Reserve Days - Under Medicare, each
     beneficiary has a lifetime reserve of 60
     additional days of inpatient hospital services
     after using 90 days of inpatient hospital
     services during a spell of illness.
84 = Medicare Lifetime Reserve Amount in the third
      or greater calendar years'. Eff. 1/7/2013
85 = Medicare Coinsurance Amount in the third
      or greater calendar years'. Eff. 1/7/2013
86 - 99 = Reserved for national assignment.
A0 = Special Zip Code Reporting - five digit
     zip code of the location from which the
     beneficiary is initially placed on board
     the ambulance. (eff. 9/01)
A1 = Deductible Payer A - The amount assumed by
     the provider to be applied to the patient's
     deductible amount to the invovling 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)
A3 = Estimated Responsibility Payer A - The amount
     estimated by the provider to be paid by the
     indicated payer.
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)
A5 = Covered self-administered drugs -- The amount
     included in covered charges for self-admini-
     strable drugs administered to the patient be-
     cause the drug was not self-administered in the
     form and situation in which it was furnished to
     the patient.
A6 = Covered self-administered drugs -Diagnostic
     study and Other --- the amount included in
     covered charges for self-administrable drugs

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                  administered to the patient because the drug
                  was necessary for diagnostic study or other
                  reasons.  For use with Revenue Center 0637.
      A7 = Copayment A -- The amount assumed by the pro-
                  vider to be applied toward the patient's co-
                  payment amount involving the indicated payer.
      A8 = Patient Weight -- Weight of patient in kilograms.
                  Report this data only when the health plan has
                  a predefined change in reimbursement that is
                  affected by weight.
      A9 = Patient Height - Height of patient in centimeters
                  Report this data only when the health plan has
                  a predefined change in reimbursement that is
                  affected by height.
      AA = Regulatory Surcharges, Assessments, Allowances
                  or Health Care Related Taxes (Payer A) -- The
                  amount of regulatory surcharges, assessments,
                  allowances or health care related taxes per-
                  taining to the indicated payer (eff. 10/2003).
      AB = Other Assessments or Allowances (Payer A) --
                  The amount of other assessments or allowances
                  pertaining to the indicated payer. (eff. 10/2003).
      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)
      B3 = Estimated Responsibility Payer B - The
                  amount estimated by the provider to be
                  paid by the indicated payer.
      B7 = Copayment B -- The amount assumed by the pro-
                  vider to be applied toward the patient's co-
                  payment amount involving the indicated payer.
      BA = Regulatory Surcharges, Assessments, Allowances
                  or Health Care Related Taxes (Payer B) -- The
                  amount of regulatory surcharges, assessments,
                  allowances or health care related taxes per-
                  taining to the indicated payer (eff. 10/2003).
      BB = Other Assessments or Allowances (Payer B) --
                  The amount of other assessments or allowances
                  pertaining to the indicated payer. (eff. 10/2003).
      C1 = Deductible Payer C - The amount
                  assumed by the provider to be applied
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         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)
C3 = Estimated Responsibility Payer C - The
C7 = Copayment C -- The amount assumed by the pro-
     vider to be applied toward the patient's co-
     payment amount involving the indicated payer.
CA = Regulatory Surcharges, Assessments, Allowances
     or Health Care Related Taxes (Payer C) -- The
     amount of regulatory surcharges, assessments,
     allowances or health care related taxes per-
     taining to the indicated payer (eff. 10/2003).
CB = Other Assessments or Allowances (Payer C) --
     The amount of other assessments or allowances
     pertaining to the indicated payer. (eff. 10/2003).
D3 = Estimated Responsibility Patient - The
     amount estimated by the provider to be
     paid by the indicated patient.
D4 = Clinical Trial Number Assigned by NLM/NIH -
     Eight digit numeric National Library of
     Medicine/National Institute of Health clinical
     trial registry number or a default number of
     '99999999' if the trial does not have an
     8-digit registry number. (Eff. 10/1/07)
D5 = Last Kt/V Reading - result of last Kt/V
     reading.  For in-center hemodialysis patients,
     this is the last reading taken during the
     billing period.   For peritoneal dialysis
     patients (and home hemodialysis patients), this
     may be before the current billing period but
     should be within 4 months of the date of
     service. (eff. 7/1/10)
FC = Patient Paid Amount - The amount the provider
     has received from the patient toward payment
     of this bill (7/1/08).
FD = Credit Received from the Manufacturer for a
     Replaced Medical Device - the amount the
     provider has received from a medical device
     manufacturer as credit for a replaced device.
     (eff. 7/1/08)
G8 = Facility Where Inpatient Hospice Service Is
     Delivered - MSA or Core Based Statistical Area
     (CBSA) number (or rural state code) of the
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             facility where inpatient hospice is delivered.
             (Eff. 1/1/08)
Q0 = ACO Payment Adjustment Amount (Pioneer Reduction)-
     the amount that would have been paid if not for
     the Pioneer reduction. (eff. 1/2014)
Q1 = ACO Payment Reduction Amount (Pioneer Reduction)-
     the actual amount of the Pioneer reduction.
     (eff. 1/2014)
Q5 = EHR Reduction
Q7 = ISLET Add-On Payment Amount (eff. 10/2016)
Q8 = Total Transitional Drug Add-On Payment Adjustment
     (TDAPA) Amount  (eff. 1/2018)
Q9 = Medicare Advantage (MA) Plan Amount (eff. 10/2014)
QN = First APC device offset
QO = Second APC device offset
QP = Placeholder reserved for future use
QQ = Terminated procedure with pass-through device OR
     condition for device credit present
QR = First APC pass-through drug or biological offset
QS = Second APC pass-through drug or biological offset
QT = Third APC pass-through drug or biological offset
QU = Reserved for future use
QV = Home Health Value Based Purchasing (HHVBP) adjustment
     amount (negative or positive) - eff. 4/2018
QW = Reserved for future use
XX = Total Charge Amount for all Part A visits
     on RIC 'U' claims - for Home Health claims
     containing both Part A and Part B services
     this code identifies the total charge amount
     for the Part A visits (based on revenue
     center codes 042X, 043X, 044X, 055X, 056X,
     & 057X).  Code created internally in the
     CWFMQA system (eff. 10/31/01 with HHPPS).
XY = Total Charge Amount for all Part B visits
     on RIC 'U' claims - for Home Health claims
     containing both Part A and Part B services
     this code identifies the total charge amount
     for the Part B visits (based on revenue
     center codes 042X, 043X, 044X, 055X, 056X,
     & 057X).  Code created internally in the
     CWFMQA system (eff. 10/31/01 with HHPPS).
XZ = Total Charge Amount for all Part B non-
     visit charges on the RIC 'U' claims - for
     Home Health claims containing both Part A
     & Part B services, this code identifies the
     total charge amount for the Part B non-visit
     charges.  Code created internally in the
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                CWFMQA system (eff. 10/31/01 with HHPPS).
    Y1 = Part A demo payment - Portion of the
         payment designated as reimbursement for
         Part A services under the demonstration.
         This amount is instead of the traditional
         prospective DRG payment (operating and
         capital) as well as any outlier payments
         that might have been applicable in the
         absence of the demonstration.  No deductible
         or coinsurance has been applied. Payments
         for operating IME and DSH which are pro-
         cessed in the traditional manner are also
         not included in this amount.

    Y2 = Part B demo payment - Portion of the
         payment designated as reimbursement for
         Part B services under the demonstration.
         No deductible or coinsurance has been
         applied.
    Y3 = Part B coinsurance - Amount of Part B
         coinsurance applied by the intermediary
         to this demo claim. For demonstration
         claims this will be a fixed copayment
         unique to each hospital and DRG (or
         DRG/procedure group).
    Y4 = Conventional Provider Payment Amount
         for Non-Demonstration Claims - This
         the amount Medicare would have reim-
         bursed the provider for Part A services
         if there had been no demonstration.  This
         should include the prospective DRG payment
         (both capital as well as operational) as
         well as any outlier payment, which would be
         applicable.  It does not include any pass
         through amounts such as that for direct
         medical education nor interim payments for
         operating IME and DSH.
    Y5 = Part B deductible, applicable for a Model 4
         demonstration 64 claims


CLM_VBP_PRTCPNT_IND_TB                  Claim VBP Participant Indicator Table

    Y = Participating in Hospital Value Based Purchasing
    N = Not participating in Hospital Value Based Purchasing
    Blank = same as 'N'
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CLM_WC_IND_TB                          Workers' Compensation Indicator Table


    Y = The diagnosis codes on the claims are related to the diagnosis
        codes on the MSP auxiliary file in CWF.


    Spaces



CMS_PRVDR_SPCLTY_TB                     CMS Provider Specialty Table


    00 = Carrier wide
    01 = General practice
    02 = General surgery
    03 = Allergy/immunology
    04 = Otolaryngology
    05 = Anesthesiology
    06 = Cardiology
    07 = Dermatology
    08 = Family practice
    09 = Interventional Pain Management (IPM) (eff. 4/1/03)
    09 = Gynecology (osteopaths only)
         (discontinued 5/92 use code 16)
    10 = Gastroenterology
    11 = Internal medicine
    12 = Osteopathic manipulative therapy
    13 = Neurology
    14 = Neurosurgery
    15 = Speech Language Pathologists
    15 = Obstetrics (osteopaths only)
         (discontinued 5/92 use code 16)
    16 = Obstetrics/gynecology
    17 = Hospice and Palliative Care
    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 = Cardiac Electrophysiology
    21 = Pathologic anatomy, clinical
         pathology (osteopaths only)
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          (discontinued 5/92 use code 22)
22 = Pathology
23 = Sports medicine
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 = Geriatric Psychiatry Colorectal Surgery
27 = Psychiatry, neurology (osteopaths
     only) (discontinued 5/92 use code 86)
28 = Colorectal surgery (formerly
     proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Intensive Cardiac Rehabilitation
31 = Roentgenology, radiology (osteopaths
     only) (discontinued 5/92 use code 30)
32 = Anesthesiologist Assistants (eff. 4/1/03--previously
     grouped with Certified Registered Nurse Anesthetists
     (CRNA))
32 = Radiation therapy (osteopaths only)
     (discontinued 5/92 use code 92)
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry (revised 10/93 to
     mean optometrist)
42 = Certified nurse midwife (eff 1/87)
43 = CRNA (eff. 1/87) (Anesthesiologist Assistants
     were removed from this specialty 4/1/03)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology (eff 5/92)
47 = Independent Diagnostic Testing Facility
     (IDTF) (eff. 6/98)
48 = Podiatry
49 = Ambulatory surgical center
     (formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with
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       certified orthotist (certified by
       American Board for Certification in
       Prosthetics And Orthotics)
52 = Medical supply company with
       certified prosthetist
       (certified by American Board for
       Certification In Prosthetics And
       Orthotics)
53 = Medical supply company with
       certified prosthetist-orthotist
       (certified by American Board for
       Certification in Prosthetics
       and Orthotics)
54 = Medical supply company not included
       in 51, 52, or 53.  (Revised 10/93
       to mean medical supply company for DMERC)
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-orthotist
58 = Individuals not included in 55, 56, or 57,
       (revised 10/93  to mean medical supply company
       with registered pharmacist)
59 = Ambulance service supplier, e.g.,
       private ambulance companies, funeral homes, etc.
60 = Public health or welfare agencies
       (federal, state, and local)
61 = Voluntary health or charitable agencies (e.g.
       National Cancer Society, National Heart
       Association, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier
64 = Audiologist (billing independently)
65 = Physical therapist (private practice added 4/1/03)
       (independently practicing removed 4/1/03)
66 = Rheumatology (eff 5/92)
       Note: during 93/94 DMERC also used this to mean
       medical supply company with
       respiratory therapist
67 = Occupational therapist (private practice added 4/1/03)
       (independently practicing removed 4/1/03)
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Multispecialty clinic or group practice
71 = Registered Dietician/Nutrition Professional (eff. 1/1/02)
72 = Pain Management (eff. 1/1/02)
73 = Mass Immunization Roster Biller (eff. 4/1/03)
74 = Radiation Therapy Centers (added to differentiate
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           them from Independent Diagnostic Testing Facilities
           (IDTF --eff. 4/1/03)
74 = Occupational therapy (GPPP)
     (not to be assigned after 5/92)
75 = Slide Preparation Facilities (added to differentiate
     them from Independent Diagnostic Testing Facilites
     (IDTFs -- eff. 4/1/03)
75 = Other medical care (GPPP) (not to
     assigned after 5/92)
76 = Peripheral vascular disease
     (eff 5/92)
77 = Vascular surgery (eff 5/92)
78 = Cardiac surgery (eff 5/92)
79 = Addiction medicine (eff 5/92)
80 = Licensed clinical social worker
81 = Critical care (intensivists)
     (eff 5/92)
82 = Hematology (eff 5/92)
83 = Hematology/oncology (eff 5/92)
84 = Preventive medicine (eff 5/92)
85 = Maxillofacial surgery (eff 5/92)
86 = Neuropsychiatry (eff 5/92)
87 = All other suppliers (e.g. drug and
     department stores) (note: DMERC used
     87 to mean department store from 10/93
     through 9/94; recoded eff 10/94 to A7;
     NCH cross-walked DMERC reported 87 to A7.
88 = Unknown supplier/provider specialty
     (note: DMERC used 87 to mean grocery
     store from 10/93 - 9/94; recoded eff
     10/94 to A8; NCH cross-walked DMERC
     reported 88 to A8.
89 = Certified clinical nurse specialist
90 = Medical oncology (eff 5/92)
91 = Surgical oncology (eff 5/92)
92 = Radiation oncology (eff 5/92)
93 = Emergency medicine (eff 5/92)
94 = Interventional radiology (eff 5/92)
95 = Competative Acquisition Program (CAP)
     Vendor (eff. 07/01/06). Prior to
     07/01/06, known as 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)
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      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)
      A9 = Indian Health Service (IHS), tribe and
           tribal organizations (non-hospital or
           non-hospital based facilities.  DMERCs shall
           process claims submitted by IHS, tribe and
           non-tribal organizations for DMEPOS and drugs
           covered by the DMERCs. (eff. 1/2005)
      B1 = Supplier of oxygen and/or oxygen related
           equipment (eff. 10/2/07)
      B2 = Pedorthic Personnel (eff. 10/2/07)
      B3 = Medical Supply Company with Pedorthic Personnel
           (eff. 10/2/07)
      B4 = Rehabilitation Agency (eff. 10/2/07)
      B5 = Ocularist
      C0 = Sleep medicine
      C1 = Centralized Flu
      C5 = Dentist (eff. 7/2016)


CTGRY_EQTBL_BENE_IDENT_TB                Category Equatable Beneficiary Identification Code (BIC) Table

      NCH BIC              SSA Categories
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      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)
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              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
```

DRG_OUTLIER_STAY_TB   Diagnosis Related Group Outlier Patient Stay Table

    0 = No outlier
    1 = Day outlier (condition code 60)
    2 = Cost outlier, (condition code 61)

          *** Non-PPS Only ***

    6 = Valid diagnosis related groups (DRG)
        received from the intermediary
    7 = CMS developed DRG
    8 = CMS developed DRG using patient status
        code
    9 = Not groupable

END_REC_TB   End of Record Code Table

    EOR = End of record/segment
    EOC = End of claim

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 re-

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        quired.  For inpatient bills, a 'P'
        should be entered in the nonpayment
        code.)



FI_NUM_TB                               Fiscal Intermediary Number / Medicare Administrative Contractor Table

      00010 = Alabama BC - Alabama (term. 05/2009)
              (replaced with MAC #10101 -- see below)
      00011 = Alabama BC - Iowa (term. 10/2007)
              replaced by MAC # 03401 -- see below)
      00011 = Cahaba - (RHHI) (term. 06/2011)
              replaced by MAC # 03401  -- see below)
      00012 = Iowa  (terminated)
              replaced by MAC # 05101 -- see below)
      00012 = Arizona - Noridian - J3 A MAC (AZA)
              (term. 05/2008)
      00020 = Arkansas BC - Arkansas
      00021 = Arkansas BC - Rhode Island
              (term. 05/2009)
      00030 = Arizona BC (term. 09/2007)
              (replaced by MAC # 03101 -- see below)
      00040 = California BC (term. 11/2000)
      00041 = California - Oakland BC (terminated)
      00050 = New Mexico BC/CO (term. 06/89)
      00050 = Colorado BC (terminated)
      00060 = Connecticut BC (term. 06/99)
      00070 = Delaware BC - (term. 02/98)
      00080 = Florida BC (term. 03/88)
      00080 = District of Columbia BC (terminated)
      00090 = Florida BC (term. 02/2009)
              (replaced with MAC #09101 -- see below)

      00100 = Georgia - Atlantic BC (terminated)
      00101 = Georgia BC (term. 05/2009)
              (replaced with MAC #10201 -- see below)
      00110 = Idaho BC (terminated)
      00121 = Illinois - HCSC (term. 08/98)
      00122 = Illinois - BC (terminated)
      00123 = Michigan - HCSC (term. 08/98)
      00130 = Indiana BC/Administar Federal (term. 7/22/2012)
              (replaced with MAC # 08101 -- see below)
      00131 = Illinois - Anthem
      00140 = Iowa - Wellmark (term. 05/2000)
      00141 = Iowa - Souix City BC (terminated)
      00150 = Kansas BC (term. 02/2008)
```

```
               (replaced with MAC # 05201 -- see below)
00160 = Kentucky - Anthem (term. 4/30/2011)
               (replaced with MAC # 15101 -- see below)
00170 = Louisiana - Baton Rouge BC (terminated)
00171 = Louisiana - New Orleans BC (terminated)
00180 = Maine BC  (term. 05/2009)
               (replaced with MAC #14004 & 14101  -- see below)
00180 = Connecticut, Maine, Massachusetts,
         New Hampshire, Rhode Island (Maine RHHI)
         (term. 05/2009)
               (replaced with MAC #14004 & 14101  -- see below)
00181 = Massachusetts - Maine BC (term. 05/2009)
00190 = Carefirst of Maryland (term. 09/2005)
00191 = District of Columbia - Maryland BC (terminated)

00200 = Massachusetts BC (term. 7/97)
00210 = Michigan BC (term. 9/94)
00220 = Minnesota BC (term. 07/99)
00230 = Mississippi BC
00230 = Trispan Health Services (LA-MS) (term. 09/2009)
         (previously also MOA)
00231 = Mississippi BC - Louisiana (term. 09/1992)
00232 = Mississippi BC
00233 = Louisiana, Mississippi (J7 Interim)
         (eff 10/01/2009)
00234 = PBSI J7 A TEMP ROLLUP AK,LA,MS
         (terminated)
00240 = Kansas City BC - Missouri (terminated)
00241 = Missouri BC (term. 9/92)
00242 = Missouri (terminated)
               (replaced with MAC # 05301 --see below)
00242 = BCBS of MS (MOA) (term. 04/2008)
               (replaced with MAC # 05301 --see below)
00250 = Montana BC (term. 11/2006)
               (replaced by MAC # 03201 -- see below)
00260 = Nebraska BC (term. 11/2007)
               (replaced with MAC # 05401 --see below)
00270 = New Hampshire BC - New Hampshire, Vermont
         (term. 06/2009)
               (replaced with MAC #14501 -- see below)
00280 = New Jersey BC (term. 07/2000)
00290 = New Mexico BC - (term. 11/1995)
00291 = New Mexico BC - Colorado (terminated)

00300 = New York - Albany BC (terminated)
00301 = New York - Buffalo BC (terminated)
00302 = New York - Jamestown BC (terminated)
```

```
00303 = New York - New York City BC (terminated)
00304 = New York - Rochester BC (terminated)
00305 = New York - Syracuse BC (terminated)
00306 = New York - Utica BC (terminated)
00307 = New York - Watertown BC (terminated)
00308 = Empire BC - New York, Connecticut, Delaware
        (term. 11/2008)
        (replaced with MAC # 12101, 13201 & 13101 -- see below)
00310 = North Carolina BC (term. 09/2002)
00312 (terminated)
00320 = North Dakota BC - North Dakota (term. 12/1/2006)
        (replaced with MAC # 03301 -- see
        below)
00322 = North Dakota BC - Washington & Alaska
00323 = North Dakota BC - Idaho, Oregon & Utah
        (term. 11/2006)
        (replaced with MAC # 03501 --see below)
00325 = Noridian - Idaho, Oregon
00326 = J2 Rollup (Merge into a single CICS region)
        (temporary)  (terminated)
00330   NA (terminated)
00331 = Canton BC - Ohio (terminated)
00332 = Administar - Ohio
        Anthem - Ohio
00333 = Cleveland BC - Ohio (terminated)
        Ohio-Administar
00334 = Columbus BC - Ohio (terminated)
00335 = Lima BC - Ohio (terminated)
00337 = Toledo BC - Ohio (terminated)
00338 = Youngstown BC - Ohio (terminated)
00340 = Oklahoma BC (term. 02/2008)
        (replaced with MAC # 04301 -- see below)
00350 = Regence - Oregon, Idaho, Utah
        (term. 11/2005)
00351 = Oregon BC/ID. (term. 09/88)
00355 = Regence CWF - Oregon (term. 09/2004)
00360 = Allentown BC - Pennsylvania (terminated)
00361 = Harrisburg BC - Pennsylvania (terminated)
00361 = Independence BC - Pennsylvania (terminated)
00362 = Independence BC - terminated 8/97
00363 = Pennsylvania/Highmark - Veritus
        (term. 07/2008)
00364 = Wilkes Barre BC - Pennsylvania (terminated)
00366 = Highmark (MD & DC) - Part A (eff. 10/2005)
        (term. 07/2008)
00370 = Rhode Island BC
        (term. 03/2004)
```

```
             (replaced with MAC #14401 - see below)
00380 = South Carolina BC - South Carolina
             (term. 01/2011)
             (replaced with MAC #11004 & 11201 - see below)
00380 = Palmetto GBA - AL, AR, GA, FL, IL, IN, KY,
             LA, MS, MN, NC, OK, OH, SC, TN, TX
             (term. 01/2011)
00381   NA (terminated)
00382 = South Carolina BC - North Carolina
             (term. 10/2010)
             (replaced with MAC #11501 - see below)
00388 = Palmetto Drugs (terminated)
00390 = Riverbend BC - New Jersey, Tennessee
             (term. 08/2009)
             (replaced with MAC # 12001 & 10301 -- see below)
00392 = Memphis BC - Tennessee (terminated)

00400 = Texas BC - Colorado, New Mexico, Texas
             (term. 05/2008)
             (replaced with MAC #04101, 04201, 04401 -- see below)
00401   NA (terminated)
00410 = Utah BC (term. 09/2000)
00423 = Trigon - Virginia, West Virginia (term. 07/1999)
00424 = Roanoke BC - Virginia (terminated)
00425 = Virginia BC - West Virginia (term. 08/1992)
00430 = Premera BC - Washington, Alaska
             (term. 09/2004)
00440 = Bluefield BC - West Virginia (terminated)
00441 = West Virginia BC (term. 11/1990)
00443 = Parkersburg BC - West Virginia (terminated)
00444 = Wheeling BC - West Virginia (terminated)
00450 = Wisconsin BC - Wisconsin
00450 = Michigan, Minnesota, New Jersey, New York,
             Wisconsin (RHHI)
00452 = Wisconsin BC - Michigan (term. 7/22/2012)
             (replaced with MAC # 08201 -- see below)
00453 = Wisconsin BC - Virginia & West Virginia
             (term. 05/2011)
             (replaced with MAC #11301 & 11401 - see below)
00454 = Wisconsin BC - California, Hawaii, Nevada (RHHI)
             (term. 08/2008)
             (replaced by MAC #01101, 01201 & 01301 -- see below)
00456 = United Government Services, LLC (CAR)
             (eff 08/15/2008)
00460 = Wyoming BC
             (term. 10/2006)
             (replaced by MAC # 03601 -- see below)
```

```
00468 = N Carolina BC/CPRTIVA (terminated)
00470 = Puerto Rico BC (terminated)


00993 = BC/BS Assoc.
17120 = Hawaii Medical Service (term. 06/99)
18390 = Inter-County (terminated)
19050 = Kaiser Foundation (terminated)
20330 = New York State Dept of Health (terminated)
21230 = Community Health Association (term. 05/1969)
22400 = Puerto Rico - Cooperative De Saluda
        (term. 01/1970)
50050 = Travelers - Long Beach, California (terminated)
50051 = Travelers - Los Angeles, California (terminated)
50052 = Travelers - Pomona, California (terminated)
50053 = Travelers - San Francisco, California (terminated)
50070 = Travelers - Hartford, Connecticut (terminated)
50072 = Travelers - Hamden, Connecticut (terminated)
50100 = Travelers - Jacksonville, Florida (terminated)
50101 = Travelers - Miama, Florida (terminated)
50102 = Travelers - Tampa, Florida (terminated)
50110 = Travelers - Atlanta, Georgia (terminated)
50333 = Travelers; Connecticut United Healthcare
        (term. 07/2000)
50334 = Travelers; Syracuse, New York (terminated)
50390 = Travelers; Erie, Pennsylvania (terminated)
50391 = Travelers; Pittsburgh, PA (terminated)
50392 = Travelers; Wyomissing, PA (terminated)
50393 = Travelers; Philadelphia, PA (terminated)
50410 = Travelers; Providence, Rhode Island (terminated)


51050 = Aetna-Los Angeles - California (terminated)
51051 = Aetna California - terminated 6/97
51070 = Aetna Connecticut - terminated 6/97
51100 = Aetna Florida - terminated 6/97
51140 = Aetna Illinois - terminated 6/97
51220 = Aetna-Worcester - Massachusetts
51290 = Aetna-Reno, Nevada (terminated)
51390 = Aetna Pennsylvania - terminated 6/97
51440 = Aetna-Nashville, Tennessee (terminated)
51441 = Aetna-Memphis, Tennessee (terminated)
51490 = Aetna-Newport News - Virginia (terminated)
51500 = Seattle, Washington (terminated)
52280 = NE - Mutual of Omaha
53310 = Prudential-New Jersey (terminated)
56360 = Nationwide-Ohio (terminated)
57400 = Puerto Rico - Cooperativa (term.02/2009)
        (replaced with MAC # 09201)
```

```
61000 = Aetna (term. 06/97)
80883 = Contractor ID for Inpatient & Outpatient
        Risk Adjustment Data (data not sent through
        CWF; but through Palmetto)
99990 = SSA (terminated)


~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
   Medicare Administrative Contractor Numbers

JURISDICTION 1 - PART A MACs

01001 = J1 Roll-up
01101 = California (eff. 8/15/2008)
        (replaces FI #00454)
01201 = Hawaii (eff. 8/15/2008)
        (replaces FI #00454)
01301 = Nevada (eff. 8/15/2008)
        (replaces FI #00454)
01901 = Palmetto GBA J1
        (Mutual of Omaha Legacy)


JURISDICTION 2 - Part A MACs

02001 = JF Roll-up(2/3)
02101 = Alaska (eff 02/01/2012)
02201 = Idaho (eff 02/01/2012)
02301 = Oregon (eff 02/01/2012)
02401 = Washington (eff 02/01/2012)


JURISDICTION 3 - Part A MACs

03001 = JF Roll-up(2/3)
        (Orig. J3 term. 09/2007)
03101 = Arizona (eff. 10/1/2007)
        (replaces FI #00030)
03201 = Montana (eff. 12/1/2006)
        (replaces FI #00250)
03301 = N. Dakota (eff. 12/1/2006)
        (replaces FI #00320)
03401 = S. Dakota (eff. 3/1/2007)
        (replaces FI #00011)
03501 = Utah  (eff. 12/1/2006)
        (replaces FI #00323)
03601 = Wyoming (eff. 11/1/2006)
        (replaces FI #00460)


JURISDICTION 4 - Part A MACs
```

```
04001 = J4 Roll-up
04101 = Colorado (eff. 6/1/2008) (terminated)
        (replaces FI #00400)
04201 = New Mexico (eff. 6/16/2008)
        (replaces FI #00400)
04301 = Oklahoma (eff. 3/1/2008)
        (replaces FI #00340)
04401 = Texas (eff. 6/16/2008)
        (replaces FI #00400)
04901 = Trailblazer Health Enterprises
        (Mutual of Omaha Legacy)


JH Roll-up (4/7)
04111 = Colorado (eff. 10/29/2012)
        (CR 7812)
04211 = New Mexico (eff. 10/29/2012)
04311 = Oklahoma   (eff. 10/29/2012)
04411 = Texas      (eff. 10/29/2012)
04911 = WPS (Mutual of Omaha Legacy)
                   (eff. 10/29/2012)


JURISDICTION 5 - Part A MACs

05001 = J5 Roll-up
05101 = Iowa (eff. 5/1/2008)
        (replaces FI #00012)
05201 = Kansas (eff. 03/01/2008)
        (replaces FI #00150)
05301 = W. Missouri (eff. 5/1/2008)
        (replaces FI #00242)
05392 = E. Missouri (eff. 6/1/2008)
05402 = Nebraska (eff. 12/1/2007)
        (replaces FI #00260)
05902 = WPS J5 (Mutual of Omaha Legacy)


06001 = J6 Roll-up
06004 = (HHH D RHHI)
06101 = Illinois
06201 = Minnesota
06301 = Wisconsin


07001 = JH Roll-up (4/7)
07101 = Arkansas (eff. 08/20/2012) (CR7812)
07201 = Louisiana (eff. 08/20/2012)
07301 = Mississippi (eff. 08/20/2012)
```

```
JURISDICTION 8 - PART A MACs

08001 = J8 Roll-up
08101 = Indiana, WPS J8 (eff. 07/23/2012)
        (replaces FI #00130)
08201 = Michigan, WPS J8(eff. 07/23/2012)
        (replaces FI #00452)


JURISDICTION 9 - PART A MACs

09001 = J9 Roll-up
09101 = Florida (eff. 2/13/2009)
        (replaces FI #00090)
09201 = Puerto Rico (eff. 03/02/2009)
        (replaces FI #57400)
09301 = Virgin Island (eff. 03/02/2009)
        (replaces FI #57400)


JURISDICTION 10 - PART A MACs

10001 = J10 Roll-up
10101 = Alabama (eff. 5/18/2009)
        (replaces FI #00010)
10201 = Georgia (eff. 05/04/2009)
        (replaces FI #00101)
10301 = Tennessee (eff. 8/3/2009)
        (replaces FI #00390)


JURISDICTION 11 - PART A MACs

11001 = J11 Roll-up
11003 = J11 Roll-up (Shared CICS Region - 11301 & 11401)
11004 = Region C (HHH C RHHI) (eff. 1/24/2011)
        (replaces FI #00380)
11201 = South Carolina (eff. 1/24/2011)
        (replaces FI #00380)
11301 = Virginia (eff. 5/16/2011)
        (replaces FI #00453)
11401 = West Virginia (eff. 5/16/2011)
        (replaces FI #00453)
11501 = North Carolina (eff. 10/01/2010)
        (replaces FI #00390)


JURISDICTION 12 - PART A MACs

12001 = J12 Roll-up
12101 = Delaware (eff. 11/14/2008)
```

```
                (replaces FI # 00308)
12201 = District of Columbia (eff. 08/01/2008)
12301 = Maryland (eff. 08/01/2008)
12401 = New Jersey (eff. 9/1/2008)
                (replaces FI # 00390)
12501 = Pennsylvania (eff. 08/01/2008)
12901 = Novitas Solutions J12
                (Mutual of Omaha Legacy)


JURISDICTION 13 - PART A MACs

13001 = J13 Roll-up
13101 = Connecticut (eff. 8/1/2008)
                (replaces FI #00308)
13201 = NGS-New York (eff. 7/18/2008)
                (replaces FI #00308)
13282 = NGS-New York (eff. 9/1/2008)
                (replaces FI #00308)
13292 = NGS-New York (eff. 7/18/2008)
                (replaces FI #00308)


JURISDICTION 14 - PART A MACs

14001 = J14 Roll-up
14003 = J11 Roll-up (Shared CICS Region)
14004 = Region A (HHH A RHHI) (eff.5/15/2009)
                (replaces FI #00180)
14101 = Maine (eff. 5/15/2009)
                (replaces FI #00180)
14201 = Massachusetts (eff. 5/15/2009)
                (replaces FI #00181)
14301 = New Hampshire (eff. 6/15/2009)
                (replaces FI #00270)
14401 = Rhode Island (eff. 6/1/2009)
                (replaces FI #00370)
14501 = Vermont (eff. 6/5/2009)
                (replaces FI #00270)


JURISDICTION 15 - PART A MACs

15001 = J15 Roll-up
15004 = CGS Government Services (HHH B RHHI)
                (eff. 06/13/2011)
15101 = Kentucky (eff. 10/17/2011)
                (replaces FI #00160)
15201 = Ohio (eff. 10/17/2011)
                (replaces FI #00160)
```

```
      52280 = Mutual of Omaha (NT)
              Note: Nebraska - 00260 (NE) & 52280 (NT)




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.




GEO_SSA_STATE_TB                     State Table


      01 = Alabama
      02 = Alaska
      03 = Arizona
      04 = Arkansas
      05 = California
      06 = Colorado
      07 = Connecticut
      08 = Delaware
      09 = District of Columbia
      10 = Florida
      11 = Georgia
      12 = Hawaii
      13 = Idaho
      14 = Illinois
      15 = Indiana
      16 = Iowa
      17 = Kansas
```

```
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = California
56 = Canada & Islands
57 = Central America and West Indies
58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = U.S. Possessions
64 = American Samoa
```

```
         65 = Guam
         66 = Commonwealth of the Northern Marianas Islands
         67 = Texas
         68 = Florida (eff. 10/2005)
         69 = Florida (eff. 10/2005)
         70 = Kansas (eff. 10/2005)
         71 = Louisiana (eff. 10/2005)
         72 = Ohio (eff. 10/2005)
         73 = Pennsylvania (eff. 10/2005)
         74 = Texas (eff. 10/2005)
         80 = Maryland (eff. 8/2000)
         97 = Northern Marianas
         98 = Guam
         99 = With 000 county code is American Samoa;
              otherwise unknown


MCO_OPTN_TB                              MCO Option Table

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

     ***** For non-lock-in beneficiaries*****
     1 = HCFA to process all provider bills
     2 = MCO to process only in-plan Part A and
         Part B bills
     4 = Cost Plan-Chronic Care Organizations (eff. 10/2005)


NCH_CLM_BIC_MDFY_TB                      NCH Claim BIC Modify H Code Table

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


NCH_CLM_TYPE_TB                          NCH Claim Type Table

     10 = HHA claim
     20 = Non swing bed SNF claim
     30 = Swing bed SNF claim
     40 = Outpatient claim
     50 = Hospice claim
```

```
        60 = Inpatient claim
        61 = Inpatient 'Full-Encounter' claim
        62 = Medicare Advantage IME/GME Claims
        63 = Medicare Advantage (no-pay) claims
        64 = Medicare Advantage (paid as FFS) claims
        71 = RIC O local carrier non-DMEPOS claim
        72 = RIC O local carrier DMEPOS claim
        81 = RIC M DMERC non-DMEPOS claim
        82 = RIC M DMERC DMEPOS claim

    NOTE:  In the data element NCH_CLM_TYPE_CD
    (derivation rules) the numbers for these claim
    types need to be changed - dictionary reflects
    61 for all three.
```

NCH_COND_TRLR_IND_TB   NCH Condition Trailer Indicator Table

```
    C = Condition code trailer present
```

NCH_DEMO_TRLR_IND_TB   NCH Demonstration Trailer Indicator Table

```
    D = Demo trailer present
```

NCH_DGNS_E_TRLR_IND_TB   NCH Diagnosis E Trailer Indicator Code Table

```
    Valid Value:
    W = NCH Diagnosis E Code trailer
```

NCH_DGNS_TRLR_IND_TB   NCH Diagnosis Trailer Indicator Table

```
    Y = Diagnosis code trailer present
```

NCH_EDIT_DISP_TB   NCH Edit Disposition Table

```
    00 = No MQA errors
    10 = Possible duplicate
    20 = Utilization error
```

```
     30 = Consistency error
     40 = Entitlement error
     50 = Identification error
     60 = Logical duplicate
     70 = Systems duplicate



NCH_EDIT_TB                                    NCH EDIT TABLE


     A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
     A000 = (C) REIMB > $100,000 OR UNITS > 150
     A002 = (C) CLAIM IDENTIFIER (CAN)
     A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
     A004 = (C) PATIENT SURNAME BLANK
     A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
     A006 = (C) DATE OF BIRTH IS NOT NUMERIC
     A007 = (C) INVALID GENDER (0, 1, 2)
     A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
     A009 = (C) TYPE OF BILL RECEIVED IS 41A, 41B, OR 41D
     A010 = (C) DISPOSITION CODE VS. ACTION/ENTRY CODE
     A023 = (C) PORTABLE X-RAY WITHOUT MODIFIER
     A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
     A031 = (C) HOSPITAL CLAIMS--CLAIM SHOWS SERVICES WERE PAID
                BY AN HMO AND CODITION CODE '04' IS NOT PRESENT.
                (TOB '11' & '12')
     A041 = (C) HHA CLAIMS--TOB 32X OR 33X WITH >4 VISITS; DATE
                OF SERVICE > 9/30/00 AND LUPA IND IS PRESENT.
                BYPASS FOR NON-PAYMENT CODE B, C, Q, T-Y.
     A1X1 = (C) PERCENT ALLOWED INDICATOR
     A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589
     A1X3 = (C) DT>96365,DIAG=V725
     A1X4 = (C) INVALID DIAGNOSTIC CODES
     C050 = (U) HOSPICE - SPELL VALUE INVALID
     D102 = (C) DME DATE OF BIRTH INVALID
     D2X2 = (C) DME SCREEN SAVINGS INVALID
     D2X3 = (C) DME SCREEN RESULT INVALID
     D2X4 = (C) DME DECISION IND INVALID
     D2X5 = (C) DME WAIVER OF PROV LIAB INVALID
     D3X1 = (C) DME NATIONAL DRUG CODE INVALID
     D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID
     D4X2 = (C) DME OUT OF DMERC SERVICE AREA
     D4X3 = (C) DME STATE CODE INVALID
     D5X1 = (C) TOS INVALID FOR DME HCPCS
     D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING
     D5X3 = (C) DME INVALID USE OF MS MODIFIER
     D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED
```

```
D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS
D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID
D5X7 = (C) ANTI-EMETIC/ANTI-CANCER DRUG W/0 CANCER
           DIAGNOSIS
D5X8 = (C) TWO ANTI-EMETIC DRUGS PRESENT ON SAME CLAIM
           WITH IDENTICAL DATES OF SERVICE.
D6X1 = (C) DME SUPPLIER NUMBER MISSING
D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1
D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6
D922 = (C) THERAPEUTIC SHOE CODES 'A5505-A5501'
           W/MODIFIER 'LT' OR 'RT' MUST HAVE
           UNITS = '001'
XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1
Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
Y003 = (C) HCPCS R0075/UNITS=SERVICES
Y010 = (C) TOB=13X/14X AND T.C.>$7,500
Y011 = (C) INP CLAIM/REIM > $350,000
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
Z007 = (C) TOB VS TOTAL CHARGE
Z008 = (C) TOB VS TOTAL CHARGE W/O 20/21
           CONDITION CODE
Z237 = (E) HOSPICE OVERLAP - DATE ZERO
0011 = (C) ACTION CODE INVALID
0012 = (C) IME/GME CLAIM -- '04' OR '69'
           CONDITION CODE
0013 = (C) CABG/PCOE/MPPD AND INVALID ADMIT DATE
0014 = (C) DEMO NUM INVALID
0015 = (C) ESRD PLAN VS DEMO NUM
0016 = (C) INVALID VA CLAIM
0017 = (C) DEMO=38 W/O CONTRACTOR #80881/80882
0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
0019 = (C) DEMO 07/08 WITH CONDITION CODE B1
0020 = (C) CANCEL ONLY CODE INVALID
0021 = (C) DEMO COUNT > 1
0022 = (C) TOB '32X' OR '33X' W/DATES OF SERVICE >9/30/00
           AND HAS CANCEL ONLY CODE OTHER THAN A,B,E,F
0023 = (C) DEMO '46' AND HCPCS INCONSISTENT
0301 = (C) INVALID HI CLAIM NUMBER
0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK
04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)
```

```
04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
0401 = (C) BILL TYPE/PROVIDER INVALID
0402 = (C) BILL TYPE/REV CODE/PROVR RANGE
0403 = (C) TOB '41X'/PRVDR # 1990-1999) OR TOB '51X'/
           PRVDR #6990-6999, TRANS CODE SHOULD BE
           '0' OR '3'
0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092 OR SEX NOT F
0407 = (C) RESPITE CARE BILL TYPE NOT 34X,NO REV 66
0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974
041A = (C) TOB '11A' OR '11D' AND DEMO #'07' OR '08'
           NOT PRESENT
0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636
0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES
0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS
0414 = (C) VALU CD 61,MSA AMOUNT MISSING
0415 = (C) HOME HEALTH INCORRECT ALPHA RIC
0416 = (C) REVENUE CENTER '0022', TOB MUST BE
           '18X' OR '21X'
0417 = (C) REVENUE CENTER '0023', TOB MUST BE '32X'
           OR '33X'
0418 = (C) HHA--TOB '3X5' AND DATES OF SERVICE
           >9/30/00
0419 = (C) HHA--RIC 'W' MUST HAVE VALUE CODE '63'/
           RIC 'V' MUST HAVE VALUE CODE '62' AND
           RIC 'U' MUST HAVE VALUE CODES '62' AND
           '63' PRESENT FOR DATES OF SERVICE >
           9/30/00.
0420 = (C) HHA W/O REVENUE CODE '0023'
0421 = (C) START DATE MISSING
0422 = (C) COB VS. OVERRIDE CODE
05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE
05X5 = (C) UPIN REQUIRED FOR DME
0501 = (C) REFFERING UPIN REQUIRED FOR CLINICAL LAB
0502 = (C) REFERRING UPIN INVALID
0601 = (C) GENDER INVALID
0701 = (C) CONTRACTOR/POS 1-2 PROVIDER NUM INVALID
0702 = (C) PROVIDER NUMBER VS. TOB
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
0704 = (C) INVALID CONT FOR CABG DEMO
0705 = (C) INVALID CONT FOR PCOE DEMO
0706 = (C) REVENUE CENTER CODE MAMMOGRAPHY AND
           BENEFICIARY <35
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
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1301 = (C) LINE COUNT NOT NUMERIC OR > 13
1302 = (C) RECORD LENGTH INVALID
1401 = (C) INVALID MEDICARE STATUS CODE
1501 = (C) ADMIT DATE/START DATE/ENTRY CODE INVALID
1502 = (C) ADMIT DATE/START CARE 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/LINE ITEMS DENIED
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) PATIENT STATUS VS. TOB
2103 = (C) HIPPS RATE/CMG CODE VS. PATIENT STATUS
2201 = (C) FROM DATE/HCPCS YR INVALID
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
2208 = (C) TOB '21X', REV CODE 0022 FROM DATE
            < 06-03-98
2209 = (C) HHA WITH OVERLAPPING DATES JUNE/JULY,
            SEPT/OCT
2210 = (C) TOB 41X, SERVICE DATES 6/30/00,
            EXCEP/NONEXCEP IND = 1,2
2212 = (C) TOB 51X WITH SERVICE DATES >6/30/00
2213 = (C) TOB 32X OR 33X, SERVICE >9/30/00 DAYS
            CAN NOT = 60
2215 = (C) DEMO 37 WITH VALUE CODES 'A2', 'B2', 'C2'
2216 = (C) DEMO 37 OR CONDITION CODE 78 AND CHARGES
            SUB TO DED > 0
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) LATE CHARGE BILL WITH DATA FIELD PRESENT
2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT
2307 = (C) COND=40,UTIL DYS >0/VAL CDE A1,08,09
2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
2401 = (C) NON-UTIL DAYS INVALID
2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL
2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
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2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
2504 = (C) COINSURANCE AMOUNT EXCESSIVE
2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT
2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST
2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR
2508 = (C) COINSURANCE DAYS INVALID FOR TRAN
2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
2602 = (C) LR-DAYS, NO VAL 08,10/PD/DEN>CUR+27
2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
2604 = (C) PPS BILL, NO DAY OUTLIER
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
28XA = (C) UTIL DAYS > FROM TO BENEF EXH
28XB = (C) BENEFITS EXH DATE > FROM DATE
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN = (C) INVALID OCC CODE
28XO = (C) AN 'N' NO-PAY CODE IS PRESENT AND OCCURRENCE
           CODE '23' OR '42' IS NOT PRESENT AND THE
           DATE ASSOCIATED WITH CODE IS MISSING OR NOT
           EQUAL TO THRU DATE.
28XP = (C) THE OCCURRENCE CODE 23 DATE DOES NOT EQUAL THE
           THRU DATE
28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES
28X1 = (C) OCCUR DATE INVALID
28X2 = (C) OCCUR = 20 AND TRANS = 4
28X3 = (C) OCCUR 20 DATE < ADMIT DATE
28X4 = (C) OCCUR 20 DATE > ADMIT + 12
28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM
28X6 = (C) OCCUR 20 DATE < BENE EXH DATE
28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
28X8 = (C) OCCUR 22 DATE < FROM OR > THRU
28X9 = (C) UTIL > FROM - THRU LESS NCOV
33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)
33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)
33X3 = (C) QS DAYS/ADMISSION ARE INVALID
33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)
33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE
33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091
33X7 = (C) TOB<>18/21/28/51,COND=WO
33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001
33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT
33#A = (C) MULTIPLE PET SCANS
33#B = (C) MULITIPLE PET SCANS W/O MODIFIER 26
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                OR TC
3401 = (C) DEMO ID = 04 AND RIC NOT = 1 OR 2
34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN
34#3 = (C) CONDITION CODE = W0 AND DEMO NOT = 04
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
35#3 = (C) (SECOND CONDITION) CONDITION CODE = C3
                REQUIRES SPAN CODE 76 OR 77
35#4 = (C) CONDITION CODE = 69 AND TOB NOT 11X
36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU
36#1 = (C) SURGICAL DATE = ZEROES OR < FROM OR >
                THRU DATES
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
3XA/ = (C) COLORECTAL/PROSTATE SCREENING BILLED
                MULTIPLE TIMES
4001 = (C) BLOOD PINTS FURNISHED INVALID
4002 = (C) BLOOD FURNISHED/REPLACED INVALID
4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
4201 = (C) BLOOD PINTS UNREPLACED INVALID
4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED
4203 = (C) INVALID CPO PROVIDER NUMBER
4301 = (C) BLOOD DEDUCTABLE INVALID
4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
4304 = (C) BLOOD DEDUCT > 3 - REPLACED
4501 = (C) PRIMARY DIAGNOSIS INVALID
4502 = (C) SERVICE DATES > CURRENT DATE
46#A = (C) MSP VET AND VET AT MEDICARE
46#B = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
46#C = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
46#G = (C) VALU CODE 20 INVALID
46#L = (C) BLOOD FURNISHED < BLOOD REPLACED
46#N = (C) VALUE CODE 37,38,39 INVALID
46#O = (C) VALUE CDE 37,38,39 AMOUNT NOT > 00
46#P = (C) BLD UNREP VS REV CDS AND/OR UNITS
46#Q = (C) VALUE CDE 37=39 AND 38 IS PRESENT
46#R = (C) BLD FIELDS VS REV CDE 380,381,382
46#S = (C) VALU CODE 39, AND 37 IS NOT PRESENT
46#T = (C) CABG/PCOE/MPPD,VC<>Y1,Y2,Y3,Y4,VA NOT>0
46#U = (C) MSP VALUES ON CABG/PCOE/MPPD (INP)
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                    TOB '32X'/'33X' MUST HAVE VALUE 62/64
                    OR 63/65 (HHA)
46#V = (C) TOB '32X'/'33X' VISITS IN 62/63 NOT =
                    REVENUE CODE 42X-44X, 55X-57X
46#W = (C) CONDITION CODE =30/78 AND WITH VALUE
                    CODE = A1, B1, C1
46#1 = (C) VALUE AMOUNT INVALID
46#2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
46#3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
46#4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
46#5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
46#6 = (C) VALU 17 AND NO COND CODE 60 OR 61
46#7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
46#8 = (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
4604 = (C) DEMO = 03 WITH DATES OF SERVICE
                     > 09/31/01
4901 = (C) PCOE/CABG,DEN CD NOT D
4902 = (C) PCOE/CABG BUT DME
50#1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
50#2 = (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
51#A = (C) HCPCS EYEWARE & REV CODE NOT 274
51#C = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51#D = (C) HCPCS REQUIRES UNITS > ZERO
51#E = (C) HCPCS REQUIRES REVENUE CODE 636/294
51#F = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51#G = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
51#H = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044
51#I = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045
51#J = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
51#K = (C) TOB 21X/P82=2/3/4,REV CD = NNX
51#L = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83
51#M = (C) 21X,RC>9041/<9045,RC<>4/234
51#N = (C) 21X,RC>9032/<9042,RC<>4/234
51#O = (C) TWO ANTI-EMETIC/ANTI-CANCER DRUGS
                    ON SAME CLAIM
51#P = (C) HHA/OUTPATIENT RC DATE OF SRVC MISSING
51#Q = (C) NO RC 0636 OR DTE INVALID
51#R = (C) DEMO ID=01,RIC NOT=2
51#S = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21
51#V = (C) TOB 72X W HCPCS 'J1955' MISSING REVENUE
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                    CENTER 636
51#W = (C) TOB 12X, 13X, 22X, 23X, 34X, 74X, 75X,
           83X, HCPCS '97504', '97116', PRESENT
           ON SAME DAY
51#X = (C) TOB '32X-34X' REQUIRE HCPCS FOR REVENUE
           CODE '29X', '60X', '636'
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
5168 = (E) CLAIM IN HOSPICE WITH 2ND START DATE
           PRESENT
5169 = (U) PROVIDER NE TO WORK PROVIDER
5170 = (E) OCCURRENCE CODE = 42 AND < DOLBA
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
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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
5270 = (C) CONDITION CODE = 30 AND HMO REQUIRES
            MODIFIER = 'QV' OR 'KZ'/DED IND
5271 = (C) RISK HMO NOT PRESENT AND MOD 'KZ'/
            OR CONDITION CODE 78 PRESENT
527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0
527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
5299 = (U) HOSPICE PERIOD NUMBER ERROR
52#K = (C) HCPCS VS DIAGNOSIS
52#L = (C) HCPCS VS MODIFIER
52#M = (C) HCPCS VS DATES OF SERVICE
52#N = (C) TOB '71X' OR '73X' WITH REVENUE
            CENTER CODE 0403 MISSING REVENUE
            CENTER CODE 0521
52#O = (C) REVENUE CENTER CODE 0022/0024 WITH
            CHARGES >0
52#P = (C) REVENUE CENTER CODE 010X-021X MINUS
            18X <> 0022
52#Q = (C) REVENUE CENTER CODE 0022 AND HIPPS
            MISSING
52#R = (C) REVENUE CENTER CODE 0022 MISSING DATE
            OF SERVICE
52#T = (C) REVENUE CENTER CODE 0022 MISSING REVENUE
            CENTER CODE 042X-044X
5320 = (U) BILL > DOEBA AND IND-1 = 2
5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
5355 = (U) HOSPICE DAYS USED SECONDARY
5362 = (C) MAMMOGRAPHY AND BENE <35
5378 = (C) SERVICE DATE < AGE 50
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5379 = (C) HCPCS 'G0160' PRESENT MORE THAN
          ONCE
5381 = (C) HCPCS 'G0161' PRESENT MORE THAN
          ONCE
5382 = (C) HCPCS 'G0102-03' AND BENE <50
538Q = (C) SERVICE DATES WITHIN ALIEN RECORD
5397 = (C) DEMO '37' AND NOT CAT 74
5398 = (C) HCPCS 'G9001-G9005 & G9009-G9011 >1
          OR 2 ARE PRESENT
5399 = (U) HOSPICE PERIOD NUM MATCH
539A = (C) HCPCS 'G9008' PRESENT MORE THAN ONCE
539C = (C) HCPCS 'G9013-G9015' PRESENT MORE THAN
          ONCE OR 2 PRESENT
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
5604 = (D) LOGICAL DUPE, DATES
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
57X5 = (C) HCPCS 98940-2 MODIFIER NOT = 'AT'
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
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5804 = (C) UNITS/VISITS > 99
5805 = (C) OUTPATIENT CHARGE > $150,000
5806 = (C) REVENUE CENTER CODE '042X-044X'
            WITHOUT MODIFIER 'GN-GP'
58#4 = (C) REVENUE CENTER CODE MISSING REQUIRED
            HCPCS OR MODIFIER
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) INVALID TOS FOR DME
59XH = (C) HCPCS E0620/TYPE/DATE
59XI = (C) HCPCS E0627-9/ DATE < 1991
59XJ = (C) GLOBAL HCPCS TOS MUST = 2
59XK = (C) HCPCS PEN PUMP AND TOS <>9
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
5A#1 = (C) DEMO=37, UNITS >1 FOR 'G9001-05'
            'G9007-11', G9013-G9015'
60X1 = (C) ASSIGN IND INVALID
6000 = (U) ADJUSTMENT BILL SPELL DATA
6020 = (U) CURRENT SPELL DOEBA < 1990
6030 = (U) ADJUSTMENT BILL SPELL DATA
6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA
61X1 = (C) PAY PROCESS IND INVALID
61X2 = (C) DENIED CLAIM/NO DENIED LINE
61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
61X4 = (C) RATE MISSING OR NON-NUMERIC
61#E = (C) PROVIDER PAYMENT INCONSISTENCIES
61#F = (C) BENEFICIARY PAYMENT INCONSISTENCIES
61#G = (C) PATIENT RESPONSIBILITY INCONSISTENCIES
61#H = (C) MEDICARE PAYMENT INCONSISTENCIES
61#I = (C) LINE DATE OF SERVICE < FROM DATE
            > THRU DATE
61#J = (C) DUPLICATE HCPCS CODE '55873'
61#K = (C) HCPCS 'G0117-8' >2 OR BOTH PRESENT
61#L = (C) REVENUE CENTER CODE 0024 > 2
```

```
61#M = (C) REVENUE CENTER CODE 0024 VS PROVIDER
            NUMBER
61#N = (C) REVENUE CENTER CODE 0024 REQUIRES
            VALID HIPPS RATE CMG CODE
61#R = (C) HCPCS/TOB/REVENUE CENTER CODE
61#S = (C) HCPCS 'G0247' REQUIRES 'G0245-6' TO
            BE COVERED
61#T = (C) HCPCS CODE '0245-0246' PRESENT MULTIPLE
            TIMES
61#0 = (C) REVENUE CENTER CODE VS SPAN CODE '74'
61#6 = (C) PAYMENT METHOD INVALID
61#7 = (C) ANSI CODE MISSING
61#8 = (C) BLOOD CASH DEDUCTIBLE INCONSISTENCIES
61#9 = (C) CASH DEDUCTIBLE INCONSISTENCIES
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
6105 = (C) REVE CODE 0001 > 1
6106 = TOB 3X2 REVENUE CENTER CODE 0023 NOT =
            TOTAL CHARGE
6109 = (C) REIMBURSEMENT > 4 OR 6 TIMES
62XA = (C) PSYC OT PT/REIM/TYPE
62XC = (C) DEMO 37 WITH REIMBURSEMENT/DED IND
            <>1
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
66X7 = (C) DEMO 37/HCPCS/UNITS
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
68XA = (C) HCPCS G0117-8 >1 OR BOTH PRESENT
68XB = (C) HCPCS CODE G0245-46 > 1
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) ANTI-EMETIC WITHOUT ANTI-CANCER DRUG
6812 = (C) DEMO 37 WITH PRIMARY PAYER CODE
69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
69XB = (C) HCPCS CODE 97504/97116 PRESENT ON
           SAME DAY
69XC = (C) HCPCS CODE VS PAY PROCESS INDICATOR
69X3 = (C) PROC CODE MOD = LL / TYPE = R
69X6 = (C) PROC CODE MOD/NOT CAPPED
69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL
69X9 = (C) NURSE PRACTITIONER, MOD INVALID
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
```

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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
71X3 = (C) HCPCS 76092 PAY INDICATOR <> A,R,S
           & 76085 PAY INDICATOR A,R,S
72X1 = (C) ALLOWED CHGS INVALID
72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
72X3 = (C) DENIED LINE/ALLOWED CHARGES
7230 = (C) FRAMES >1, LENSES >2
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
78XB = (C) ANTI-CANCER BEFORE 01/01/1998
78X1 = (C) FROM DATE IMPOSSIBLE
78X2 = (C) FROM DATE > CURRENT DATE OR
           < 07/01/1966
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
79X1 = (C) THRU DATE IMPOSSIBLE
79X2 = (C) THRU DATE > CURRENT 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
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8029 = (U) HH BEFORE PERIOD NOT PRESENT
8030 = (U) HH BILL VISITS > PT A REMAINING
8031 = (U) HH PT A REMAINING > 0
8032 = (U) HH DOLBA+59 NOT GT FROM-DATE
8050 = (U) HH QUALIFYING INDICATOR = 1
8051 = (U) HH # VISITS NE AFT PT B APPLIED
8052 = (U) HH # VISITS NE AFT TRAILER
8053 = (U) HH BENEFIT PERIOD NOT PRESENT
8054 = (U) HH DOEBA/DOLBA NOT > 0
8060 = (U) HH QUALIFYING INDICATOR NE 1
8061 = (U) HH DATE NE DOLBA IN AFT TRLR
8062 = (U) HH NE PT-A VISITS REMAINING
81X1 = (C) NUM OF SERVICES INVALID
83X1 = (C) DIAGNOSIS INVALID
8301 = (C) HCPCS/GENDER DIAGNOSIS
8302 = (C) HCPCS G0101 V-CODE/SEX CODE
8303 = (C) HCPCS/GENDER
8304 = (C) BILL TYPE INVALID FOR G0123/4
8305 = (C) HCPCS/SERVICE DATES/GENDER
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
84X6 = (C) HCPCS/GENDER
84X7 = (C) HCPCS/SERVICE DATES/GENDER
84X8 = (C) DUPLICATE HCPCS
86X1 = (C) CLINICAL LAB HCPCS W/O CLINICAL
            LAB ID
86X2 = (C) NON-WAIVER HCPCS/PAY DENIAL CODE/
            MODIFIER
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
```

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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
9351 = (C) OTHER UPIN PRESENT/MISSING OTHER FIELDS
9352 = (C) OTHER UPIN INVALID
9353 = (C) OTHER UPIN INVALID
94A1 = (C) NON-COVERED FROM DATE INVALID
94A2 = (C) NON-COVERED FROM > THRU DATE
94A3 = (C) NON-COVERED THRU DATE INVALID
94A4 = (C) NON-COVERED THRU DATE > ADMIT
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
94C1 = (C) PR-PSYCH DAYS INVALID
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
94F1 = (C) REIMBURSEMENT AMOUNT INVALID
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
94G1 = (C) NO-PAY CODE INVALID
94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
94G4 = (C) NO PAY CODE = R & REIMB PRESENT
94X1 = (C) BLOOD LIMIT INVALID
94X2 = (C) TYPE/BLOOD DEDUCTIBLE
94X3 = (C) TYPE/DATE/LIMIT AMOUNT
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
9401 = (C) BLOOD DEDUCTIBLE AMT > 3
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
9404 = (C) INVALID GENDER CODE ON PRO-PAY
9407 = (C) INVALID DIAGNOSIS
9408 = (C) INVALID DRG NUMBER (GLOBAL)
9409 = (C) HCFA DRG<>DRG ON BILL
940X = (C) INVALID DRG
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
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      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
      9801 = (C) REV CENTER CODE 0910 WITH SERVICE
                 DATE > 10/15/2004
      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) BLOOD DEDUCTIBLE NON NUMERIC
      9911 = (C) BLOOD DEDUCTIBLE PRESENT WITHOUT
                 BLOOD FURNISHED
      9920 = (C) CASH DEDUCTIBLE INVALID
      9930 = (C) COINSURANCE INVALID
      9931 = (C) OUTPAT COINSURANCE VALUES
      9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT
      9934 = (C) HCPCS 76092 NON COVERED/76085 COVERED
      9940 = (C) PROVIDER PAYMENT INVALID
      9941 = (C) REIMBURSEMENT AMOUNT/COND/NON-PAYMENT/
                 PRIMARY PAYER
      9942 = (C) PATIENT DISTRIBUTION INVALID
      9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
      9945 = (C) HCPCS INVALID FOR SERVICE DATES
      9946 = (C) TOB INVALID FOR HCPCS
      9947 = (C) INVALID DATE FOR HCPCS
      9948 = (C) STAY FROM>96365,DIAG=V725
      9960 = (C) MED CHOICE BUT HMO DATA MISSING
      9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
      9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER
      9999 = (U) MAIN SPELL TRAILER NUMBER DOES NOT MATCH SPELL


NCH_EDIT_TRLR_IND_TB                      NCH Edit Trailer Indicator Table


    E = Edit code trailer present
```

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NCH_IP_PRO_APRVL_TYPE_TB              NCH Inpatient Peer Review Organization Approval Type Table


        1 = Approved by the PRO as billed - Code
            indicates that the claim has been
            reviewed by the PRO and has been fully
            approved including any day or cost
            outliers.
        2 = Automatic approval - Does not apply to
            Medicare claim.
        3 = Partial approval - Code indicates the
            bill has been reviewed by the PRO, and
            some portion (days or services) has
            been denied.  The from/thru dates of
            the approved portion of the stay,
            excluding grace days and any period at
            a noncovered level of care are shown
            on the bill.
        4 = Admission denied - Code indicates the
            patient's need for inpatient services
            was reviewed upon admission and the
            PRO found that the stay was not
            medically necessary.
        5 = Post payment review - Code indicates
            that any medical review will be
            completed after the claim is paid.
            The bill may be a day outlier, part of
            the sample review, or may not be
            reviewed.
        6 = Pre-admission authorization - Pre-
            admission authorization obtained, but
            services not reviewed by the PRO.
        7 THRU 9 = Reserved.



NCH_MCO_TRLR_IND_TB                    NCH Managed Care Organization (MCO) Trailer Indicator Table


    M = MCO trailer present



NCH_MQA_QUERY_PATCH_TB                 NCH MQA Query Patch Table


        Y = MQA changed bill query code on a action
            code 6 (force action code 2)
```

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          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)



NCH_MQA_RIC_TB                          NCH MQA Record Identification Code Table

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



NCH_NEAR_LINE_REC_VRSN_TB               NCH Near Line Record Version Table

      A = Record format as of January 1991
      B = Record format as of April 1991
      C = Record format as of May 1991
      D = Record format as of January 1992
      E = Record format as of March 1992
      F = Record format as of May 1992
      G = Record format as of October 1993
      H = Record format as of September 1998
      I = Record format as of July 2000
      J = Record format as of January 2011
      K = Record format as of April 2013



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)
```

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  U = Both Part A and B institutional home
      health agency (HHA) claim records --
      due to HHPPS and HHA A/B split.
      (effective 10/00)
  M = Part B DMEPOS claim record (processed
      by DME Regional Carrier) (effective 10/93)


NCH_OCRNC_TRLR_IND_TB                  NCH Occurrence Trailer Indicator Table

    O = Occurrence code trailer present


NCH_PATCH_TB                           NCH Patch Table

    01 = RRB Category Equatable BIC - changed (all
         claim types) -- applied during the Nearline
         'G' conversion to claims with NCH weekly
         process date before 3/91.   Prior to Version
         'H', patch indicator stored in redefined Claim
         Edit Group, 3rd occurrence, position 2.
    02 = Claim Transaction Code made consistent with
         NCH payment/edit RIC code (OP and HHA) --
         effective 3/94, CWFMQA began patch.  During
         'H' conversion, patch applied to claims with
         NCH weekly process date prior to 3/94.  Prior
         to version 'H', patch indicator stored in
         redefined Claim Edit Group, 4th occurrence,
         position 1.
    03 = Garbage/nonnumeric Claim Total Charge Amount
         set to zeroes (Instnl) --  during the Version
         'G' conversion, error occurred in the deriva-
         tion of this field where the claim was missing
         revenue center code = '0001'.   In 1994, patch
         was applied to the OP and HHA SAFs only. (This
         SAF patch indicator was stored in the redefined
         Claim Edit Group, 4th occurrence, position 2).
         During the 'H' ocnversion, patch applied to
         Nearline claims where garbage or nonnumeric
         values.
    04 = Incorrect bene residence SSA standard county
         code '999' changed (all claim types) --
         applied during the Nearline 'G' conversion and
         ongoing through 4/21/94, calling EQSTZIP
         routine to claims with NCH weekly process
```

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           date prior to 4/22/94.  Prior to Version 'H'
           patch indicator stored in redefined Claim
           Edit Group, 3rd occurrence, position 4.
05 = Wrong century bene birth date corrected (all
           claim types) -- applied during Nearline 'H'
           conversion to all history where century
           greater than 1700 and less than 1850; if
           century less than 1700, zeroes moved.
06 = Inconsistent CWF bene medicare status code
           made consistent with age (all claim types) --
           applied during Nearline 'H' conversion to all
           history and patched ongoing.  Bene age is
           calculated to determine the correct value;
           if greater than 64, 1st position MSC ='1';
           if less than 65, 1st position MSC = '2'.
07 = Missing CWF bene medicare status code derived
           (all claim types) -- applied during Nearline
           'H' conversion to all history and patched
           ongoing, except claims with unknown DOB and/
           or Claim From Date='0' (left blank).   Bene
           age is calculated to determine missing value;
           if greater than 64, MSC='10'; if less than
           65, MSC = '20'.
08 = Invalid NCH primary payer code set to blanks
           (Instnl) -- applied during Version 'H' con-
           version to claims with NCH weekly process
           date 10/1/93-10/30/95, where MSP values =
           invalid '0', '1', '2', '3' or '4' (caused
           by erroneous logic in HCFA program code,
           which was corrected on 11/1/95).
09 = Zero CWF claim accretion date replaced with
           NCH weekly process date (all claim types)
           -- applied during Version 'H' conversion to
           Instnl and DMERC claims; applied during
           Version 'G' conversion to non-institutional
           (non-DMERC) claims.  Prior to Version 'H',
           patch indicator stored in redefined claim
           edit group, 3rd occurrence, position 1.
10 = Multiple Revenue Center 0001 (Outpatient,
           HHA and Hospice) -- patch applied to 1998 &
           1999 Nearline and SAFs to delete any revenue
           codes that followed the first '0001' revenue
           center code.   The edit was applied across all
           institutional claim types, including Inpatient/
           SNF (the problem was only found with OP/HHA/
           Hospice claims).  The problem was corrected
           6/25/99.
```

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11 = Truncated claim total charge amount in the
     fixed portion replaced with the total charge
     amount in the revenue center 0001 amount field
     -- service years 1998 & 1999 patched during
     quarterly merge.  The 1998 & 1999 SAFs were
     corrected when finalized in 7/99.  The patch
     was done for records with NCH Daily Process
     Date 1/4/99 - 5/14/99.
12 = Missing claim-level HHA Total Visit Count --
     service years 1998, 1999 & 2000 patch applied
     during Version 'I' conversion of both the
     Nearline and SAFs.   Problem occurs in those
     claims recovered during the missing claims
     effort.
13 = Inconsistent Claim MCO Paid Switch made consistent
     with criteria used to identify an inpatient
     encounter claim -- if MCO paid switch equal to blank
     or '0' and ALL conditions are met to indicate an
     inpatient encounter claim (bene enrolled in a risk
     MCO during the service period), change the switch to
     a '1'.  The patch was applied during the Version 'I'
     conversion, for claims back to 7/1/97 service thru date.

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

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

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            (both Version 'H' & 'I' files).

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

            The patch applied date is 06/29/2001.


NCH_PATCH_TRLR_IND_TB                 NCH Patch Trailer Indicator Table

     P = Patch code trailer present



NCH_POA_DGNS_E_TRLR_IND_TB            NCH POA Diagnosis Trailer E Indicator Code  Table

     Valid Value:
     B = NCH POA Diagnosis E Code Trailer



NCH_POA_DGNS_TRLR_IND_TB              NCH POA Diagnosis Trailer Indicator Code Table

     Valid Value:
     A = NCH POA Diagnosis Code trailer



NCH_PRCDR_TRLR_IND_TB                 NCH Procedure Trailer Indicator Table

     Z = Procedure code trailer present



NCH_PTNT_STUS_IND_TB                  NCH Patient Status Indicator Table

     A = Discharged
     B = Died
     C = Still patient



NCH_REV_TRLR_IND_TB                   NCH Revenue Center Trailer Indicator Table
```

```
     R = Revenue code trailer present



NCH_SPAN_TRLR_IND_TB                        NCH Span Trailer Indicator Table

     S = Span code trailer present



NCH_STATE_SGMT_TB                           NCH State Segment Table

     NCH State Segment        State Codes
     -----------------        -----------------------
     B =                      01;02;03;04;06;07;08;09;
                              12;13;16;17;19;20;21;25;
                              27;28;29;30;32;35;37;38;
                              40;41;42;43;44;46;47;48;
                              50;51;53-99

     C =                      11;14;15;18;24;26;49;52

     D =                      11;14;15;18;24;26;31;34;
                              45;49;52

     E =                      22;23;31;34;36;45

     F =                      10;22;23;31;34;36;45

     G =                      10;22;23;36;39

     H =                      05;10;22;23;39

     I =                      05;10;39

     J =                      05;10;33;39

     K =                      05;33;39

     L =                      05;33;39

     M =                      05;33

     N =                      05;33

     O =                      33
```

```
P =                     33

Q =                     33

R =                     33


NCH_VAL_TRLR_IND_TB                     NCH Value Trailer Indicator Table

    V = Value code trailer present


NG_ACO_IND_TB                           Next Generation (NG) Accountable Care Organization (ACO) Indicator Code Table

    0 = Base record (no enhancements)
    1 = Population Based Payments (PBP)
    2 = Telehealth
    3 = Post Discharge Home Health Visits
    4 = 3-Day SNF Waiver
    5 = Capitation
    6 = CEC Telehealth
    7 = Care Management Home Visits


PMT_EDIT_RIC_TB                         Payment And Edit Record Identification Code Table

    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


PRVDR_NUM_TB                            Provider Number Table

    -   First two positions are the GEO SSA State Code.

    -   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):

-    A 'V' in the 5th position identifies a VA demo.

    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) - eff. 7/00 changed
                 to Religious Nonmedical Health Care
                 Institutions (RNHCI)
    2000-2299   Long-term hospitals
    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
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)
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
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) - eff. 7/00 Numbers
            Reserved (formerly CS)
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)
9000-9799   Continuation of 8000-8499 series (HHA)
```

```
                         (eff. 10/95)
       9800-9899   Transplant Centers (eff. 10/1/07)
       9900-9999   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:

    M = Psychiatric Unit in Critical Access Hospital
    R = Rehabilitation Unit in Critical Access Hospital
    S = Psychiatric unit (excluded from PPS)
    T = Rehabilitation unit (excluded from PPS)
    U = Swing-Bed Hospital Designation for Short-
        Term Hospitals
    V = Alcohol drug unit (prior to 10/87 only)
    W = Swing-Bed Hospital Designation for Long
        Term Care Hospitals
    Y = Swing-Bed Hospital Designation for
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            Rehabilitation Hospitals
    Z = Swing Bed Designation for Critical Access
        Hospitals

  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
```

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) with Medicare
         certification in anticipation of covered
         skilled care -- (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 a facility that
         provides custodial or supportive care (includes
         intermediate care facilities (ICF).  Also used
         to designate patients that are dischared/trans-
         ferred to a nursing facility with neither
         Medicare nor Medicaid certification and for
         discharges/transfers to Assisted Living Facilities.
    05 = Discharged/transferred to a designated cancer
         center or children's hospital (eff. 10/09). Prior
         to 10/1/09, discharged/transferred to another type
         of institution for inpatient care (including
         distinct parts).  NOTE:  Effective 1/2005,
         psychiatric hospital or psychiatric distinct
         part unit of a hospital will no longer be
         identified by this code.  New code is '65'.
    06 = Discharged/transferred to home care of
         organized home health service organization
         in anticipation of covered skilled care.
```

```
07 = Left against medical advice or discontinued
     care.
08 = Discharged/transferred to home under
     care of a home IV drug therapy provider.
     (discontinued effective 10/1/05)
09 = Admitted as an inpatient to this
     hospital (effective 3/1/91).  In situa-
     tions  where a patient is admitted before
     midnight of the third day following the
     day of an outpatient service, the out-
     patient services are considered inpatient.
20 = Expired
21 = Discharged/transferred to Court/Law
     Enforcement.
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)
43 = Discharged/transferred to a federal hospital
     (eff. 10/1/03). Discharges and transfers to a
     government operated health facility such as a
     Department of Defense hospital, a Veteran's
     Administration hospital or a Veteran's Administration
     nursing facility. To be used whenever the destination
     at discharge is a federal health care facility,
     whether the patient lives there or not.
50 = Hospice - home (eff. 10/96)
51 = Hospice - medical facility (certified) providing
     hospice level of care
61 = Discharged/transferred within this insti-
     tution to a hospital-based Medicare
     approved swing bed (eff. 9/01)
62 = Discharged/transferred to an inpatient
     rehabilitation facility including distinct
     parts units of a hospital.
     (eff. 1/2002)
63 = Discharged/transferred to a Medicare certified
     long term care hospital. (eff. 1/2002)
64 = Discharged/transferred to a nursing facility
     certified under Medicaid but not certified under
     Medicare (eff. 10/2002)
65 = Discharged/Transferred to a psychiatric
     hospital or psychiatric distinct unit of a
     hospital (these types of hospitals were
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              pulled from patient/discharge status code
              '05' and given their own code). (eff. 1/2005).
      66 = Discharged/transferred to a Critical Access
           Hospital (CAH) (eff. 1/1/06)
      69 = Discharge/transfers to a Designated Disaster
           Alternative Care site (eff. 10/2013)
      70 = Discharged/transferred to another type of health
           care institution not defined elsewhere in code
           list.
      71 = Discharged/transferred/referred to another
           institution for outpatient services as
           specified by the discharge plan of care
           (eff. 9/01) (discontinued effective 10/1/05)
      72 = Discharged/transferred/referred to this
           institution for outpatient services as
           specified by the discharge plan of care
           (eff. 9/01) (discontinued effective 10/1/05)
      81 = Discharged to home or self-care with a planned
           acute care hospital inpatient (eff. 10/2013)
      82 = Discharged/transferred to a short term general hospital
           for inpatient care readmission (eff. 10/2013)
      83 = Discharged/transferred to a skilled nursing facility
           (SNF) with Medicare (eff. 10/2013)
      84 = Discharged/transferred to a facility that provides
           custodial supportive care with a planned acute
           care hospital inpatient readmission certification
           with a planned acute care hospital inpatient readmission
           (eff. 10/2013)
      85 = Discharged/transferred to a designated cancer center or
           children's hospital with a planned acute care hospital
           inpatient readmission (eff. 10/2013)
      86 = Discharged/transferred to home under care of organized
           home health service organization with a planned acute
           care hospital inpatient readmission (eff. 10/2013)
      87 = Discharged/transferred to court/law enforcement with a
           planned acute care hospital inpatient readmission (eff.
           10/2013)
      88 = Discharged/transferred to a Federal health care facility
           with a planned acute care hospital inpatient readmission
           (eff. 10/2013)
      89 = Discharged/transferred to a hospital-based Medicare approved
           swing bed with a planned acute care hosptial inpatient
           readmission (eff. 10/2013)
      90 = Discharged/transferred to an inpatient rehabilitation
           facility (IRF) including rehabilitation distinct units of
           a hospital with a planned acute care hospital inpatient
           readmission (eff. 10/2013)
```

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     91 = Discharged/transferred to a Medicare certified Long Term
          Care Hospital (LTCH) with a planned acute care hospital
          inpatient readmission (eff. 10/2013)
     92 = Discharged/transferred to a nursing facility certified
          under Medicaid but not certified under Medicare with a
          planned acute care hospital inpatient readmission (eff.
          10/2013)
     93 = Discharged/transferred to a psychiatric hospital or
          psychiatric distinct part unit of a hospital with a
          planned acute care hospital inpatient readmission
          (eff. 10/2013)
     94 = Discharged/transferred to a critical access hospital (CAH)
          with a planned acute care hospital inpatient readmission
          (eff. 10/2013)
     95 = Discharged/transferred to another type of health care
          institution not defined elsewhere in this code list with a
          planned acute care hospital inpatient readmission. (eff. 10/2013)
```

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, re-
     sulted in an adjustment.  Generally, these adjust-
     ments 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 adjust-
     ment 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 auth-
orization number is missing, invalid, or does not
apply to the billed services or provider.
16 = Claim/service lacks information which is needed for
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 Com-
pensation 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-certi-
fication 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 arrange-
ment.
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 conjunc-
tion with a routine exam.
50 = These are non-covered services because this is not
deemed a 'medical necessity' by the payer.
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.
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.
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, Assess-
ments, 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 alter-
native services were available, and should have
been utilized.
B9 = Services not covered because the patient is en-
rolled in a Hospice.
B10 = Allowed amount has been reduced because a com-
ponent 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 re-
cords.
B13 = Previously paid. Payment for this claim/service
may have been provided in a previous payment.
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

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          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.



REV_CNTR_APC_BUFR_TB                          Revenue Center Ambulatory Payment Classification (APC) Buffer Code Table


      00 = No composite group assigned
      01 = First composite group on claim
      02 = Second composite group on claim
      NN = nth composite group on claim
        ---------------------------------
      00    =      N/A in this case
      01-99 =     1st composite - 99th composite
      A1-A9 =  100th composite - 108th composite
      B1-B9 =  109th composite - 117th composite
      C1-C9 =  118th composite - 126th composite
      D1-D9 =  127th composite - 135th composite
      E1-E9 =  136th composite - 144th composite
      F1-F9 =  145th composite - 153rd composite
      G1-G9 =  154th composite - 162nd composite
      H1-H9 =  163rd composite - 171st composite
      I1-I9 =  172nd composite - 180th composite
      J1-J9 =  181st composite - 189th composite
      K1-K9 =  190th composite - 198th composite
      L1-L9 =  199th composite - 207th composite
      M1-M9 =  208th composite - 216th composite
      N1-N9 =  217th composite - 225th composite
      O1-O9 =  226th composite - 234th composite
      P1-P9 =  235th composite - 243rd composite
      Q1-Q9 =  244th composite - 252nd composite
      R1-R9 =  253rd composite - 261st composite
      S1-S9 =  262nd composite - 270th composite
      T1-T9 =  271st composite - 279th composite
      U1-U9 =  280th composite - 288th composite
      V1-V9 =  289th composite - 297th composite
      W1-W9 =  298th composite - 306th composite
      X1-X9 =  307th composite - 315th composite
      Y1-Y9 =  316th composite - 324th composite
      Z1-Z9 =  325th composite - 333rd composite

      AA-AZ =  334th composite - 359th composite
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      BA-BZ =  360th composite - 385th composite
      CA-CZ =  386th composite - 411th composite
      DA-DZ =  412th composite - 437th composite
      EA-EZ =  438th composite - 463rd composite
      FA-FZ =  464th composite - 489th composite
      GA-GZ =  490th composite - 515th composite
      HA-HZ =  516th composite - 541st composite
      IA-IZ =  542nd composite - 567th composite
      JA-JZ =  568th composite - 593rd composite
      KA-KZ =  594th composite - 619th composite
      LA-LZ =  620th composite - 645th composite
      MA-MZ =  646th composite - 671st composite
      NA-NZ =  672nd composite - 697th composite
      OA-OZ =  698th composite - 723rd composite
      PA-PZ =  724th composite - 749th composite
      QA-QZ =  750th composite - 775th composite
      RA-RZ =  776th composite - 801st composite
      SA-SZ =  802nd composite - 827th composite
      TA-TZ =  828th composite - 853rd composite
      UA-UZ =  854th composite - 879th composite
      VA-VZ =  880th composite - 905th composite
      WA-WZ =  906th composite - 931st composite
      XA-XZ =  932nd composite - 957th composite
      ZA-ZZ =  958th composite - 983rd composite


REV_CNTR_APC_TB                          Revenue Center Ambulatory Payment Classification (APC)

      0000 = Code used when Payment Method Indicator
      equals 'N9'
      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
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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
0028 = Level I Incision/Excision Breast
0029 = Incision/Excision Breast (obsolete 12/00);
Level II Incision/Excision Breast (effective 1/01)
0030 = Breast Reconstruction/Mastectomy
0031 = Hyperbaric Oxygen (obsolete 1/01)
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
0058 = Level I Strapping and Cast Application
0059 = Level II Strapping and Cast Application
0060 = Manipulation Therapy
0070 = Thoracentesis/Lavage Procedures
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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 (obsolete 12/00);
Insertion/Replacement of Permanent Pacemaker and
Electrodes (eff. 1/01)
0090 = Level II Implantation/Removal/Revision of
Pacemaker AICD Vascular Device (obsolete 12/00);
Insertion/Replacement of Permanent Pacemaker
and Pulse Generator
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 (obsolete 12/00);
Cardiac Monitoring for 30 days (eff. 1/01)
0098 = Injection of Sclerosing Solution
0099 = Continuous Cardiac Monitoring (obsolete 12/00);
Electrocardiograms (eff. 1/01)
0100 = Stress test and continuous ECG
0101 = Tilt Table Evaluation
0102 = Electronic Analysis of Pacemakers/other Devices
0103 = Miscellaneous Vascular Procedures (eff. 1/01)
0104 = Transcatheter Placement of Intracoronary Stents
(eff. 1/01)
0105 = Revision/Removal of Pacemakers, AICD or Vascular
(eff. 1/01)
0106 = Insertion/Replacement/Repair of Pacemaker
Electrode (eff. 1/01)
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0107 = Insertion of Cardioverter-Defibrillator
(eff. 1/01)
0108 = Insertion/Replacement/Repair of Cardioverter-
Defibrillator Leads (eff. 1/01)
0109 = Bone Marrow Harvesting and Bone Marrow/Stem Cell
Transplant (obsolete 12/00); Removal of Implanted
Devices (eff. 1/01)
0110 = Transfusion
0111 = Blood PRODuct Exchange
0112 = Extracorporeal Photopheresis
0113 = Excision Lymphatic System
0114 = Thyroid/Lymphadenectomy Procedures
0115 = Cannula/Access Device Procedures
(eff. 1/01)
0116 = Chemotherapy Administration by Other Technique
Except Infusion
0117 = Chemotherapy Administration by Infusion Only
0118 = Chemotherapy Administration by Both Infusion and
Other Technique
0119 = Implantation of Devices (eff. 1/01)
0120 = Infusion Therapy Except Chemotherapy
0121 = Level I Tube changes and Repositioning
0122 = Level II Tube changes and Repositioning
0123 = Bone Marrow Harvesting and Bone Marrow/Stem
Cell Transplant
0124 = Revision of Implanted Infusion Pump
(eff. 1/01)
0130 = Level I Laparoscopy
0131 = Level II Laparoscopy
0132 = Level III Laparoscopy
0140 = Esophageal Dilation without Endoscopy
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)
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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
0210 = Spinal Tap
0211 = Level I Nervous System Injections
0212 = Level II Nervous System Injections
0213 = Extended EEG Studies and Sleep Studies
0214 = Electroencephalogram
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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
(obsolete 12/00); Implantation of Pain
Management Device (eff. 1/01)
0224 = Level II Revision/Removal Neurological Device
(obsolete 12/00); Implantation of Reservoir/
Pump/Shunt (eff. 1/01)
0225 = Implantation of Neurostimulator Electrodes
0226 = Implantation of Drug Infusion Reservior
(eff. 1/01)
0227 = Implantation of Drug Infusion Device
(eff. 1/01)
0228 = Creation of Lumbar Subarachnoid Shunt
(eff. 1/01)
0229 = Transcatherter Placement of Intravascular Shunts
(eff. 1/01)
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 (obsolete 1/01)
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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
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
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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
0345 = Transfusion Laboratory Procedures Level I
(eff. 1/01)
0346 = Transfusion Laboratory Procedures Level II
(eff. 1/01)
0347 = Transfusion Laboratory Procedures Level III
(eff. 1/01)
0348 = Fertility Laboratory Procedures
(eff. 1/01)
0349 = Miscellaneous Laboratory Procedures
(eff. 1/01)
0354 = Administration of Influenza Vaccine (Not
subject to national coinsurance)
0355 = Level I Immunizations
0356 = Level II Immunizations
0357 = Level III Immunizations (obsolete 1/01)
0358 = Level IV Immunizations (obsolete 1/01)
0359 = Injections
0360 = Level I Alimentary Tests
0361 = Level II Alimentary Tests
0362 = Fitting of Vision Aids
0363 = Otorhinolaryngologic Function Tests
0364 = Level I Audiometry
0365 = Level II Audiometry
0366 = Electrocardiogram (ECG) (obsolete 1/01)
0367 = Level I Pulmonary Test
0368 = Level II Pulmonary Test
0369 = Level III Pulmonary Test
0370 = Allergy Tests

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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 (obsolete 1/01)
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)
(obsolete 12/00); SR 89 chloride, per mCi
(eff. 1/01)
0702 = Samariam (eligible for pass-through payments)
(obsolete 12/00); SM 153 lexidronam, 50 mCi
(eff. 1/01)
0704 = IN 111 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 = Non-ESRD 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
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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)

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)

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0824 = Etoposide 10 mg (eligible for pass-through
payments)
0826 = Methotrexate Oral 2.5 mg (eligible for pass-through
payments)
0827 = Floxuridine injection 500mg
0828 = Gemcitabine HCL 200 mg (eligibile for pass-
through payments)
0830 = Irinotecan 20 mg (eligible for pass-through
payments)
0831 = Ifosfamide injection 1 gm (eligible for pass-through
payments)
0832 = Idarubicin HCL injection 5 mg (eligible for pass-
through payments)
0833 = Interferon Alfacon-1, 1 mcg
(eligible for pass-through payments)
0834 = Interferon,  Alfa-2A, Recombinant 3 million units
(eligible for pass-through payments)
0836 = Interferon,  Alfa-2B, Recombinant, 1 million units
(eligible for pass-through payments)
0838 = Interferon, Gamma 1-B injection, 3 million units
(eligible for pass-through payments)
0839 = Mechlorethamine HCL injection 10 mg
(eligible for pass-through payments)
0840 = Melphalan HCL 50 mg (eligible for pass-
through payments)
0841 = Methotrexate sodium injection 5 mg (eligible for
pass-through payments)
0842 = Fludarabine Phosphate injection 50 mg (eligible for
pass-through payments)
0843 = Pegaspargase, single dose vial (eligible for
pass-through payments)
0844 = Pentostatin injection, 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 injection, 1 gm (eligible for pass-
through payments)
0851 = Thiotepa injection, 15 mg (eligible for pass-through
payments)
0852 = Topotecan 4 mg (eligible for pass-through payments)
0853 = Vinblastine Sulfate injection, 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-
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through payments)
0856 = Porfimer Sodium 75 mg (eligible for pass-through
payments)
0857 = Bleomycin Sulfate injection 15 units (eligible for
pass-through payments)
0858 = Cladribine, 1mg (eligible for pass-through payments)
0859 = Fluorouracil injection 500 mg
0860 = Plicamycin (mithramycin) injection, 2.5 mg
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 250 mg
(Not subject to national coinsurance)
0891 = Tacrolimus per 1 mg oral
(Not subject to national coinsurance)
0892 = Daclizumab, Parenteral, 25 mg (obsolete 1/01)
(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 (obsolete 12/00);
Cytomegalovirus imm IV, vial
(eligible for pass-through payments) (eff. 1/01)
0905 = Immune Globulin per 500 mg
(eligible for pass-through payments)
0906 = RSV-ivig 50 mg
(eligible for pass-through payments)
0907 = Ganciclovir Sodium 500 mg injection
(Not subject to national coinsurance)

0908 = Tetanus Immune Globulin, injection 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 long act implant 4.5 mg (eligible for
pass-through payments)
0914 = Reteplase, 37.6 mg
(Not subject to national coinsurance)
0915 = Alteplase injection,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) (obsolete 1/01)
Pharmalogic stresses (eff. 1/01)
0918 = Brachytherapy Seeds, Any type, Each (eligible
for pass-through payments) (obsolete 4/01)
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) (obsolete 1/01)
Anti-inhibitor per iu (eff. 1/01)
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)
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)
0987 = New Device Technology - Level I ($0 - $250)
(eff. 1/01)
0988 = New Device Technology - Level II ($250 - $500)

(eff. 1/01)
0989 = New Device Technology - Level III ($500 - $750)
(eff. 1/01)
0990 = New Device Technology - Level IV ($750 - $1000)
(eff. 1/01)
0991 = New Device Technology - Level V ($1000 - $1500)
(eff. 1/01)
0992 = New Device Technology - Level VI ($1500 - $2000)
(eff. 1/01)
0993 = New Device Technology - Level VII ($2000 - $3000)
(eff. 1/01)
0994 = New Device Technology - Level VIII ($3000 - $4000)
(eff. 1/01)
0995 = New Device Technology - Level IX ($4000 - $5000)
(eff. 1/01)
0996 = New Device Technology - Level X ($5000 - $7000)
(eff. 1/01)
0997 = New Device Technology - Level XI ($7000 - $9000)
(eff. 1/01)
1000 = Perclose Closer Prostar Arterial Vascular
Closure (eff. 1/01)
1001 = AcuNav-diagnostic ultrasound ca (eff. 1/01)
1002 = Cochlear Implant System (eff. 1/01)
1003 = Cath, ablation, livewire TC (eff. 1/01)
1004 = Fast-Cath, Swartz, SAFL, CSTA (eff. 1/01)
1006 = ARRAY post chamb IOL (eff. 1/01)
1007 = Ams 700 penile prosthesis (eff. 1/01)
1008 = Urolume-implant urethral stent (eff. 1/01)
1009 = Plasma, cryoprecipitate-reduced, unit
(eff. 1/01)
1010 = Blood, L/R CMV-neg (eff. 1/01)
1011 = Platelets, L/R, CMV-neg (eff. 1/01)
1012 = Platelet concentrate, L/R, irradiated, unit
(eff. 1/01)
1013 = Platelet concentrate, L/R, unit (eff. 1/01)
1014 = Platelets, aph/pher, L/R, unit (eff. 1/01)
1016 = Blood, L/R, froz/deglycerol/washed (eff. 1/01)
1017 = Platelets, aph/pher, L/R CMV-neg, unit
(eff. 1/01)
1018 = Blood, L/R, irradiated (eff. 1/01)
1019 = Platelets, aph/pher, L/R, irradiated, unit
(eff. 1/01)
1024 = Quinupristin 150 mg/dalfopriston 350 mg
(eff. 1/01)
1025 = Marinr CS catheter (eff. 1/01)
1026 = RF Perfrmr cath 5F RF Marinr (eff. 1/01)
1027 = Magic x/short, radius 14m (eff. 1/01)

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1028 = Prcis Twst trnsvg anch sys (eff. 1/01)
1029 = CRE guided balloon dil cath (eff. 1/01)
1030 = Cthtr:Mrshal, Blu Max Utr Dmnd (eff. 1/01)
1033 = Sonicath mdl 37-410 (eff. 1/01)
1034 = SURPASS, Long30 SURPASS-cath (eff. 1/01)
1035 = Cath, Ultra ICE (eff. 1/01)
1036 = R port/reservior impl dev (eff. 1/01)
1037 = Vaxcelchronic dialysis cath (eff. 1/01)
1038 = UltraCross Imaging Cath (eff. 1/01)
1039 = Wallstent/RP:Trach (eff. 1/01)
1040 = Wallstent/RP TIPS -- 20/40/60 (eff. 1/01)
1042 = Wallstent, UltraFlex: Bil (eff. 1/01)
1045 = I-131 MIBG (ioben-sulfate) 0.5mCi
(eff. 1/01)
1047 = Navi-Star, Noga-Star cath (eff. 1/01)
1048 = NeuroCyberneticPros: gen (eff. 1/01)
1051 = Oasis Thrombectomy Cath (eff. 1/01)
1053 = EnSite 3000 catheter (eff. 1/01)
1054 = Hydrolyser Thromb Cath 6/7F (eff. 1/01)
1055 = Transesoph 210, 210-S Cath (eff. 1/01)
1056 = Thermachoice II Cath (eff. 1/01)
1057 = Micromark Tissue Marker (eff. 1/01)
1059 = Carticel, auto cult-chndr cyte (eff. 1/01)
1060 = ACS multi-link tristor stent (eff. 1/01)
1061 = ACS Viking Guiding cath (eff. 1/01)
1063 = EndoTak Endurance EZ,RX leads (eff. 1/01)
1067 = Megalink biliary stent (eff. 1/01)
1068 = Pulsar DDD pmkr (eff. 1/01)
1069 = Discovery DR, pmaker
1071 = Pulsar Max, Pulsar SR pmkr (eff. 1/01)
1072 = Guidant: blln dil cath (eff. 1/01)
1073 = Gynecare Morcellator (eff. 1/01)
1074 = RX/OTW Viatrac-peri dil cath (eff. 1/01)
1075 = Guidant: lead (eff. 1/01)
1076 = Ventak minisc defib (eff. 1/01)
1077 = Ventak VR Prizm VR, sc defib (eff. 1/01)
1078 = Ventak: Prizm, AVIIIDR defib
1079 = CO 57/58 0.5 mCi (eff. 1/01)
1084 = Denileukin diftitox, 300 mcg (eff. 1/01)
1086 = Temozolomide, 5 mg (eff. 1/01)
1087 = I-123 per uCi capsule (eff. 1/01)
1089 = CO 57, 0.5 mCi (eff. 1/01)
1090 = IN 111 Chloride, per mCi (eff. 1/01)
1091 = IN 111 Oxyquinoline, per 5 mCi (eff. 1/01)
1092 = IN 111 Pentetate, per 1.5 mCi (eff. 1/01)
1094 = TC 99M Albumin aggr, per vial
1095 = TC 99M Depreotide, per vial (eff. 1/01)
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1096 = TC 99M Exametazime, per dose (eff. 1/01)
1097 = TC 99M Mebrofenin, per vial (eff. 1/01)
1098 = TC 99M Pentetate, per vial (eff. 1/01)
1099 = TC 99M Pyrophosphate, per vial (eff. 1/01)
1100 = Medtronic AVE GT1 guidewire (eff. 1/01)
1101 = Medtronic AVE, AVE Z2 cath (eff. 1/01)
1102 = Synergy Neurostim Genrtr (eff. 1/01)
1103 = Micro Jewell Defibrillator (eff. 1/01)
1104 = RF ConductorAblative Cath (eff. 1/01)
1105 = Sigman 300VDD pacmkr (eff. 1/01)
1106 = SynergyEZ Pt Progmr (eff. 1/01)
1107 = Torqr, Solist cath (eff. 1/01)
1108 = Reveal Cardiac Recorder (eff. 1/01)
1109 = Implantable anchor: Ethicon (eff. 1/01)
1110 = Stable Mapper, cath electrd (eff. 1/01)
1111 = AneuRxAort-Uni-llicstnt & cath (eff. 1/01)
1112 = AneuRx Stent graft/del cath (eff. 1/01)
1113 = Tlnt Endo Sprng Stnt Grft Sys (eff. 1/01)
1114 = TalntSprgStnt + Graf endo pros (eff. 1/01)
1115 = 5038S, 5038, 5038L pace lead (eff. 1/01)
1116 = CapSureSP pacing lead (eff. 1/01)
1117 = Ancure Endograft Del Sys (eff. 1/01)
1118 = Sigma300DR LegIIDR, pacemkr (eff. 1/01)
1119 = Sprint6932, 6943 defib lead (eff. 1/01)
1120 = Sprint6942, 6945 defi lead (eff. 1/01)
1121 = Gem defibrillator (eff. 1/01)
1122 = TC 99M arcitumomab per dose (eff. 1/01)
1123 = Gem II VR defibrillator (eff. 1/01)
1124 = InterStim Test Stim Kit (eff. 1/01)
1125 = Kappa 400SR, Ttopaz II SR pmkr (eff. 1/01)
1126 = Kappa 700 DR pacemkr (eff. 1/01)
1127 = Kappa 700SR, pmkr sgl chamber (eff. 1/01)
1128 = Kappa 700D, Ruby IID pmkr (eff. 1/01)
1129 = Kappa 700VDD, pacmkr (eff. 1/01)
1130 = Sigma 200D, LGCY IID sc pmkr (eff. 1/01)
1131 = Sigma 200DR pmker (eff. 1/01)
1132 = Sigma 200SR Leg II:sc pac (eff. 1/01)
1133 = Sigma SR, Vita SR, pmaker (eff. 1/01)
1134 = Sigma 300D pmker (eff. 1/01)
1135 = Entity DR 5326L/R, DC, pmkr (eff. 1/01)
1136 = Affinity DR 5330L/R, DC, pmkr (eff. 1/01)
1137 = CardioSEAL implant syst (eff. 1/01)
1143 = AddVent mod 2060BL, VDD (eff. 1/01)
1144 = Afnty SP 5130, Integrity SR, pmkr (eff. 1/01)
1145 = Angio-Seal 6fr, 8fr (eff. 1/01)
1147 = AV Plus DX 1368: lead (eff. 1/01)
1148 = Contour MD sc defib (eff. 1/01)
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1149 = Entity DC 5226R-pmker (eff. 1/01)
1151 = Passiveplus DXlead, 10mdls (eff. 1/01)
1152 = LifeSite Access System (eff. 1/01)
1153 = Regency SC+ 2402L pmkr (eff. 1/01)
1154 = SPL:SPOI, 0204- defib lead (eff. 1/01)
1155 = Repliform 8 sq cm (eff. 1/01)
1156 = Tr 1102TrSR+ 2260L, 2264L, 5131 (eff. 1/01)
1157 = Trilogy DCT 23/8L pmkr (eff. 1/01)
1158 = TVL lead SV01, SV02, SV04 (eff. 1/01)
1159 = TVL RV02, RV06, RV07: lead (eff. 1/01)
1160 = TVL-ADX 1559: lead (eff. 1/01)
1161 = Tendril DX, 1338 pacing lead (eff. 1/01)
1162 = TempoDr, TrilogyDR+ DC pmkr (eff. 1/01)
1163 = Tendril SDX, 1488T pacing lead (eff. 1/01)
1164 = Iodine-125 brachytx seed (eff. 1/01)
1166 = Cytarabine liposomal, 10 mg (eff. 1/01)
1167 = Epirubicin hcl, 2 mg (eff. 1/01)
1171 = Autosuture site marker stple (eff. 1/01)
1172 = Spacemaker dissect ballon (eff. 1/01)
1173 = Cor stntS540, S670, o-wire stn (eff. 1/01)
1174 = Bard brachytx needle (eff. 1/01)
1178 = Busulfan IV, 6 mg (eff. 1/01)
1180 = Vigor SR, SC, pmkr (eff. 1/01)
1181 = Meridian SSI, SC pmkr (eff. 1/01)
1182 = Pulsar SSI, SC, pmkr (eff. 1/01)
1183 = Jade IIS, Sigma 300S, SC, pmkr (eff. 1/01)
1184 = Sigma 200S, SC, pmkr (eff. 1/01)
1188 = I 131, per mCi (eff. 1/01)
1200 = TC 99M Sodium Clucoheptonate, per vial
(eff. 1/01)
1201 = TC 99M succimer, per vial (eff. 1/01)
1202 = TC 99M Sulfur Colloid, per dose (eff. 1/01)
1203 = Verteporfin for Injection (eff. 1/01)
1205 = TC 99M Disofenin, per vial (eff. 1/01)
1207 = Octreotide acetate depot 1 mg (eff. 1/01)
1302 = SQ01:lead (eff. 1/01)
1303 = CapSure Fix 6940/4068-110, lead (eff. 1/01)
1304 = Sonicath mdl 37-416,-418 (eff. 1/01)
1305 = Apligraf (eff. 1/01)
1306 = NeuroCyberneticsPros: lead (eff. 1/01)
1311 = Trilogy DR + DAO pmkr (eff. 1/01)
1312 = Magic WALLSTENT stent-mini (eff. 1/01)
1313 = Magic medium, radius 31mm (eff. 1/01)
1314 = Magic WALLSTENT stent-Long (eff. 1/01)
1315 = Vigor DR, Meridian DR pmkr (eff. 1/01)
1316 = Meridian DDD pmkr (eff. 1/01)
1317 = Discovery SR, pmkr (eff. 1/01)
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1318 = Meridian SR pmkr (eff. 1/01)
1319 = Wallstent/RP Enteral--60mm (eff. 1/01)
1320 = Wallstent/RP lliac Del Sys (eff. 1/01)
1325 = Pallidium - 103 seed (eff. 1/01)
1326 = Angio-jet rheolytic thromb cath (eff. 1/01)
1328 = ANS Renew NS trnsmtr (eff. 1/01)
1333 = PALMZA Corinthian bill stent (eff. 1/01)
1334 = Crown, Mini-crown,CrossLC (eff. 1/01)
1335 = Mesh, Prolene (eff. 1/01)
1336 = Constant Flow Imp Pump (eff. 1/01)
1337 = IsoMed 8472-20/35/60 (eff. 1/01)
1348 = I 131 per mCi solution (eff. 1/01)
1350 = Prosta/OncoSeed, RAPID strand, I-125 (eff. 1/01)
1351 = CapSure (Fix) pacing lead (eff. 1/01)
1352 = Gem II defib (eff. 1/01)
1353 = Itrel Interstm neurostim + ext (eff. 1/01)
1354 = Kappa 400DR, Diamond II 820 DR (eff. 1/01)
1355 = Kappa 600 DR, Vita DR (eff. 1/01)
1356 = Profile MD V-186HV3 sc defib (eff. 1/01)
1357 = Angstrom MD V-190HV3 sc defib (eff. 1/01)
1358 = Affinity DC 5230R-Pacemaker (eff. 1/01)
1359 = Pulsar, Pulsar Max DR, pmkr  (eff. 1/01)
1363 = Gem DR, DC, defib (eff. 1/01)
1364 = Photon DR V-230HV3 DC defib (eff. 1/01)
1365 = Guidewire, Hi-Torque 14/18/35 (eff. 1/01)
1366 = Guidewire, PTCA, Hi-Torque (eff. 1/01)
1367 = Guidewire, Hi-Torque Crosslt (eff. 1/01)
1369 = ANS Renew Stim Sys recvr (eff. 1/01)
1370 = Tension-Free Vaginal Tape (eff. 1/01)
1371 = Symp Nitinol Transhep Bil Sys (eff. 1/01)
1372 = Cordis Nitinol bil Stent (eff. 1/01)
1375 = Stent, corornary, NIR (eff. 1/01)
1376 = ANS Renew Stim Sys lead (eff. 1/01)
1377 = Specify 3988 neuro lead (eff. 1/01)
1378 = InterStim Tx 3080/3886 lead (eff. 1/01)
1379 = Pisces-Quad 3887 lead (eff. 1/01)
1400 = Diphenhydramine hcl 50 mg (eff. 1/01)
1401 = Prochlorperazine maleate 5 mg (eff. 1/01)
1402 = Promethazine hcl 12.5 mg oral (eff. 1/01)
1403 = Chlorpromazine hcl 10mg oral (eff. 1/01)
1404 = Trimethobenzamide hcl 250mg (eff. 1/01)
1405 = Thiethylperazine maleate 10 mg (eff. 1/01)
1406 = Perphenazine 4 mg oral (eff. 1/01)
1407 = Hydroxyzine pamoate 25 mg (eff. 1/01)
1409 = Factor via recombinant, per 1.2 mg (eff. 1/01)
1410 = Prosorba column (eff. 1/01)
1411 = Herculink, OTW SDS bil stent (eff. 1/01)
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1420 = StapleTac2 Bone w/Dermis (eff. 1/01)
1421 = StapleTac2 Bone w/o Dermis (eff. 1/01)
1450 = Orthosphere Arthroplasty (eff. 1/01)
1451 = Orthosphere Arthroplasty Kity (eff. 1/01)
1500 = Atherectomy sys, peripheral (eff. 1/01)
1600 = TC 99M sestamibi, per syringe (eff. 1/01)
1601 = TC 99M medronate, per dose (eff. 1/01)
1602 = TC 99M apcitide, per vial (eff. 1/01)
1603 = TL 201, mCi (eff. 1/01)
1604 = IN 111 capromab pendetide, per dose (eff. 1/01)
1605 = Abciximab injection, 10 mg (eff. 1/01)
1606 = Anistreplase, 30 u (eff. 1/01)
1607 = Eptifibatide injection, 5 mg (eff. 1/01)
1608 = Etanercept injection, 25 mg (eff. 1/01)
1609 = Rho(D) Immune globulin h, sd 100 iu (eff. 1/01)
1611 = Hylan G-F 20 injection, 16 mg (eff. 1/01)
1612 = Daclizumab, parenteral, 25 mg (eff. 1/01)
1613 = Trastuzumab, 10 mg (eff. 1/01)
1614 = Valrubicin, 200 mg (eff. 1/01)
1615 = Basiliximab, 20 mg (eff. 1/01)
1616 = Histrelin Acetate, 0.5 mg (eff. 1/01)
1617 = Lepirdin, 50 mg (eff. 1/01)
1618 = Von Willebrand factor, per iu (eff. 1/01)
1619 = Ga 67, per mCi (eff. 1/01)
1620 = TC 99M Bicisate, per vial (eff. 1/01)
1621 = Xe 133, per mCi (eff. 1/01)
1622 = TC 99M Mertiatide, per vial (eff. 1/01)
1623 = TC 99M Gluceptate (eff. 1/01)
1624 = P32 sodium, per mCi (eff. 1/01)
1625 = IN 111 Pentetreotide, per mCi (eff. 1/01)
1626 = TC 99M Oxidronate, per vial (eff. 1/01)
1627 = TC-99 labeled red blood cell, per test (eff. 1/01)
1628 = P32 phosphate chromic,per mCi (eff. 1/01)
1700 = Authen Mick TP brachy needle (eff. 1/01)
(obsolete 4/01)
1701 = Medtec MT-BT-5201-25 ndl (eff. 1/01)
(obsolete 4/01)
1702 = WWMT brachytx needle (eff. 1/01)
(obsolete 4/01)
1703 = Mentor Prostate Brachy (eff. 1/01)
(obsolete 4/01)
1704 = MT-BT-5001-25/5051-25 (eff. 1/01)
(obsolete 4/01)
1705 = Best Flexi Brachy Needle (eff. 1/01)
(obsolete 4/01)
1706 = Indigo Prostate Seeding Ndl (eff. 1/01)
(obsolete 4/01)
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1707 = Varisource Implt Ndl (eff. 1/01)
(obsolete 4/01)
1708 = UroMed Prostate Seed Ndl (eff. 1/01)
(obsolete 4/01)
1709 = Remington Brachytx Needle (eff. 1/01)
(obsolete 4/01)
1710 = US Biopsy Prostate Needle (eff. 1/01)
(obsolete 4/01)
1711 = MD Tech brachytx needle (eff. 1/01)
(obsolete 4/01)
1712 = Imagyn brachytx needle (eff. 1/01)
(obsolete 4/01)
1713 = Anchor/screw bn/bn,tis/bn (eff. 4/01)
1714 = Cath, trans atherectomy, dir (eff. 4/01)
1715 = Brachytherapy needle (eff. 4/01)
1716 = Brachytx seed, Gold 198 (eff. 4/01)
1717 = Brachytx seed, HDR Ir-192 (eff. 4/01)
1718 = Brachytx seed, Iodine 125 (eff. 4/01)
1719 = Brachytx seed, Non-HDR Ir-192 (eff. 4/01)
1720 = Brachytx, Palladium 103 (eff. 4/01)
1721 = AICD, dual chamber (eff. 4/01)
1722 = AICD, single chamber (eff. 4/01)
1723 = Cath, ablation, non-cardiac (eff. 4/01)
1724 = Cath, trans atherec, rotation (eff. 4/01)
1725 = Cath, translumin non-laser (eff. 4/01)
1726 = Cath, bal dil, non-vascular (eff. 4/01)
1727 = Cath, bal tis, dis, nonvas (eff. 4/01)
1728 = Cath, brachytx seed adm (eff. 4/01)
1729 = Cath, drainage, biliary (eff. 4/01)
1730 = Cath, EP, 19 or fewer elect (eff. 4/01)
1731 = Cath, EP, 20 or more elect (eff. 4/01)
1732 = Cath, EP, diag/abl, 3D/vect (eff. 4/01)
1733 = Cath, EP, other than temp (eff. 4/01)
1750 = Cath, hemodialysis, long-term (eff. 4/01)
1751 = Cath, inf pr/cent/midline (eff. 4/01)
1752 = Cath, hemodialysis, short-term (eff. 4/01)
1753 = Cath, intravas ultrasound (eff. 4/01)
1754 = Catheter, intradiscal (eff. 4/01)
1755 = Catheter, intraspinal (eff. 4/01)
1756 = Cath, pacing, transesoph (eff. 4/01)
1757 = Cath, thrombectomy/embolect (eff. 4/01)
1758 = Cath, ureteral (eff. 4/01)
1759 = Cath, intra echocardiography (eff. 4/01)
1760 = Closure dev, vasc, imp/insert (eff. 4/01)
1762 = Conn tiss, human (inc fascia) (eff. 4/01)
1763 = Conn tiss, non-human (eff. 4/01)
1764 = Event recorder, cardiac (eff. 4/01)
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1767 = Generator, neurostim, imp (eff. 4/01)
1768 = Graft, vascular (eff. 4/01)
1769 = Guide wire (eff. 4/01)
1770 = Imaging coil, MR insertable (eff. 4/01)
1771 = Rep dev, urinary , w/sling (eff. 4/01)
1772 = Infusion pump, programmable (eff. 4/01)
1773 = Retrieval dev, insert (eff. 4/01)
1776 = Joint device (implantable) (eff. 4/01)
1777 = Lead, AICD, endo single coil (eff. 4/01)
1778 = Lead, neurostimulator (eff. 4/01)
1779 = Lead, pmkr, transvenous VDD (eff. 4/01)
1780 = Lens, intraocular (eff. 4/01)
1781 = Mesh (implantable) (eff. 4/01)
1782 = Morcellator (eff. 4/01)
1784 = Ocular dev, intraop, det ret (eff. 4/01)
1785 = Pmkr, dual, rate-resp (eff. 4/01)
1786 = Pmkr, single, rate-resp (eff. 4/01)
1787 = Patient progr, neurostim (eff. 4/01)
1788 = Port, indwelling, imp (eff. 4/01)
1789 = Prosthesis, breast, imp. (eff. 4/01)
1790 = Iridium 192 HDR (eff. 1/01)
(obsolete 4/01)
1791 = OncoSeed, Rapid Strand I-125 (eff. 1/01)
(obsolete 4/01)
1792 = UroMed I-125 Brachy seed (eff. 1/01)
(obsolete 4/01)
1793 = Bard InterSource P-103 seed (eff. 1/01)
(obsolete 4/01)
1794 = Bard IsoSeed P-103 seed (eff. 1/01)
(obsolete 4/01)
1795 = Bard BrachySource I-125 (eff. 1/01)
(obsolete 4/01)
1796 = Source Tech Med I-125 (eff. 1/01)
(obsolete 4/01)
1797 = Draximage I-125 seed (eff. 1/01)
(obsolete 4/01)
1798 = Syncor I-125 PharmaSeed (eff. 1/01)
(obsolete 4/01)
1799 = I-Plant I-125 Brachytx seed (eff. 1/01)
(obsolete 4/01)
1800 = Pd-103 brachytx seed (eff. 1/01)
(obsolete 4/01)
1801 = IoGold I-125 brachytx seed (eff. 1/01)
(obsolete 4/01)
1802 = Iridium 192 brachytx seed (eff. 1/01)
(obsolete 4/01)
1803 = Best Iodine 125 brachytx seeds (eff. 1/01)
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(obsolete 4/01)
1804 = Best Palladium 103 seeds (eff. 1/01)
(obsolete 4/01)
1805 = IsoStar Iodine-125 seeds (eff. 1/01)
(obsolete 4/01)
1806 = Gold 198 (eff. 1/01)
(obsolete 4/01)
1810 = D114S Dilatation Cath (eff. 1/01)
(obsolete 4/01)
1811 = Surgical Dynamics Anchors (eff. 1/01)
(obsolete 4/01)
1812 = OBL Anchors (eff. 1/01)
(obsolete 4/01)
1813 = Prosthesis, penile, inflatab (eff. 4/01)
1815 = Pros, urinary sph, imp (eff. 4/01)
1816 = Receiver/transmitter, neuro (eff. 4/01)
1817 = Septal defect imp sys (eff. 4/01)
1850 = Repliform 14/21 sq cm (eff. 1/01)
(obsolete 4/01)
1851 = Repliform 24/28 sq cm (eff. 1/01)
(obsolete 4/01)
1852 = TransCyte, per 247 sq cm (eff. 1/01)
(obsolete 4/01)
1853 = Suspend, per 8/14 sq cm (eff. 1/01)
(obsolete 4/01)
1854 = Suspend, per 24/28 sq cm (eff. 1/01)
(obsolete 4/01)
1855 = Suspend, per 36 sq cm (eff. 1/01)
(obsolete 4/01)
1856 = Suspend, per 48 sq cm (eff. 1/01)
(obsolete 4/01)
1857 = Suspend, per 84 sq cm (eff. 1/01)
(obsolete 4/01)
1858 = DuraDerm, per 8/14 sq cm (eff. 1/01)
(obsolete 4/01)
1859 = DuraDerm, per 21/24 sq cm (eff. 1/01)
(obsolete 4/01)
1860 = DuraDerm, per 48 sq cm (eff. 1/01)
(obsolete 4/01)
1861 = DuraDerm, per 36 sq cm (eff. 1/01)
(obsolete 4/01)
1862 = DuraDerm, per 72 sq cm (eff. 1/01)
(obsolete 4/01)
1863 = DuraDerm, per 84 sq cm (eff. 1/01)
(obsolete 4/01)
1864 = SpermaTex, per 13/44 sq cm (eff. 1/01)
(obsolete 4/01)
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1865 = FasLata, per 8/14 sq cm (eff. 1/01)
(obsolete 4/01)
1866 = FasLata, per 24/28 sq cm (eff. 1/01)
(obsolete 4/01)
1867 = FasLata, per 36/48 sq cm (eff. 1/01)
(obsolete 4/01)
1868 = FasLata, per 96 sq cm (eff. 1/01)
(obsolete 4/01)
1869 = Gore Thyroplasty Dev (eff. 1/01)
(obsolete 4/01)
1870 = DermMatrix, per 16 sq cm (eff. 1/01)
(obsolete 4/01)
1871 = DermMatrix, 32 or 64 sq cm (eff. 1/01)
(obsolete 4/01)
1872 = Dermagraft, per 37.5 sq cm (eff. 1/01)
(obsolete 4/01)
1873 = Bard 3DMax Mesh (eff. 1/01)
(obsolete 4/01)
1874 = Stent, coated/cov w/del sys (eff. 4/01)
1875 = Stent, coated/cov w/o del sys (eff. 4/01)
1876 = Stent, non-coated/no-cov w/del (eff. 4/01)
1877 = Stent, non-coated/cov w/o del (eff. 4/01)
1878 = Martl for vocal cord (eff. 4/01)
1879 = Tissue marker, imp (eff. 4/01)
1880 = Vena cava filter (eff. 4/01)
1881 = Dialysis access system (eff. 4/01)
1882 = AICD, other than sing/dual (eff. 4/01)
1883 = Adapt/ext, pacing/neuro lead (eff. 4/01)
1885 = Cath, translumin angio laser (eff. 4/01)
1887 = Catheter, guiding (eff. 4/01)
1891 = Infusion pump, non-prog, perm (eff. 4/01)
1892 = Intro/sheath , fixed, peel-away (eff. 4/01)
1893 = Intro/sheath, fixed, non-peel (eff. 4/01)
1894 = Intro/sheath, non-laser (eff. 4/01)
1895 = Lead, AICD, endo dual coil (eff. 4/01)
1896 = Lead, AICD, non sing/dual (eff. 4/01)
1897 = Lead, neurostim test kit (eff. 4/01)
1898 = Lead, pmkr, other than trans (eff. 4/01)
1899 = Lead, pmkr/AICD combination (eff. 4/01)
1929 = Maverick PTCA Cath (eff. 1/01) (obsolete 4/01)
1930 = Coyote Dil Cath, 20/30/40mm (eff. 1/01)
(obsolete 4/01)
1931 = Talon Dil Cath (eff. 1/01) (obsolete 4/01)
1932 = Scimed remedy Dil Cath (eff. 1/01)
(obsolete 4/01)
1933 = Opti-Plast XL/Centurion Cath (eff. 1/01)
(obsolete 4/01)
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1934 = Ultraverse 3.5F Bal Dil Cath (eff. 1/01)
(obsolete 4/01)
1935 = Workhorse PTA Bal Cath (eff. 1/01)
(obsolete 4/01)
1936 = Uromax Ultra Bal Dil Cath (eff. 1/01)
(obsolete 4/01)
1937 = Synergy Balloon Dil Cath (eff. 1/01)
(obsolete 4/01)
1938 = Uroforce Bal Dil Cath (eff. 1/01) (obsolete 4/01)
1939 = Raptur, Ninja PTCA Dil Cath (eff. 1/01)
(obsolete 4/01)
1940 = PowerFlex, OPTA 5/LP Bal Cath (eff. 1/01)
(obsolete 4/01)
1941 = Jupiter PTA Dil Cath (eff. 1/01)
(obsolete 4/01)
1942 = Cordis Maxi LD PTA Bal Cath (eff. 1/01)
(obsolete 4/01)
1943 = RXCrossSail OTW OpenSail (eff. 1/01)
(obsolete 4/01)
1944 = Rapid Exchange Bil Dil Cath (eff. 1/01)
(obsolete 4/01)
1945 = Savvy PTA Dil Cath (eff. 1/01)
(obsolete 4/01)
1946 = R1s Rapid Dil Cath (eff. 1/01)
(obsolete 4/01)
1947 = Gazelle Bal Dil Cath (eff. 1/01)
(obsolete 4/01)
1948 = Pursuit Balloon Cath (eff. 1/01)
(obsolete 4/01)
1949 = Oracle Megasonics Cath (eff. 1/01)
(obsolete 4/01)
1979 = Visions PV/Avanar US Cath (eff. 1/01)
(obsolete 4/01)
1980 = Atlantis SR Coronary Cath (eff. 1/01)
(obsolete 4/01)
1981 = PTCA Catheters (eff. 1/01)
(obsolete 4/01)
2000 = Orbiter ST Steerable Cath (eff. 1/01)
(obsolete 4/01)
2001 = Constellation Diag Cath (eff. 1/01)
(obsolete 4/01)
2002 = Irvine 5F Inquiry Diag EP Cath (eff. 1/01)
(obsolete 4/01)
2003 = Irvine 6F Inquiry Diag EP Cath (eff. 1/01)
(obsolete 4/01)
2004 = Biosense EP Cath -- Octapolar (eff. 1/01)
(obsolete 4/01)
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2005 = Biosense EP Cath -- Hexapolar (eff. 1/01)
(obsolete 4/01)
2006 = Biosense EP Cath -- Decapolar (eff. 1/01)
(obsolete 4/01)
2007 = Irvine 6F Luma-Cath EP Cath (eff. 1/01)
(obsolete 4/01)
2008 = 7F Luma-Cath EP Cath 81910-15 (eff. 1/01)
(obsolete 4/01)
2009 = Irvine 7F Luma-Cath EP Cath (eff. 1/01)
(obsolete 4/01)
2010 = Fixed Curve EP Cath (eff. 1/01)
(obsolete 4/01)
2011 = Deflectable Tip Cath--Quad (eff. 1/01)
(obsolete 4/01)
2012 = Celsius Abln Cath (eff. 1/01)
(obsolete 4/01)
2013 = Celsius Large Abln Cath (eff. 1/01)
(obsolete 4/01)
2014 = Celsius II Asym Abln Cath (eff. 1/01)
(obsolete 4/01)
2015 = Celsius II Sym Abln Cath (eff. 1/01)
(obsolete 4/01)
2016 = Navi-Star DS, Navi-Star Ther (eff. 1/01)
(obsolete 4/01)
2017 = Navi-Star Abln Cath (eff. 1/01)
(obsolete 4/01)
2018 = Polaris T Ablation Cath (eff. 1/01)
(obsolete 4/01)
2019 = EP Deflectable Cath (eff. 1/01)
(obsolete 4/01)
2020 = Blazer II XP Abln Cath (eff. 1/01)
(obsolete 4/01)
2021 = SilverFlex EP Cath (eff. 1/01)
(obsolete 4/01)
2022 = CP Chilli Cooled Abln Cath (eff. 1/01)
(obsolete 4/01)
2023 = Chilli Cld AblnCath-std, lg (eff. 1/01)
(obsolete 4/01)
2100 = CP CS Reference Cath (eff. 1/01)
(obsolete 4/01)
2102 = CP Radii 7F EP Cath (eff. 1/01)
(obsolete 4/01)
2103 = CP Radii 7F EP Cath w/Track (eff. 1/01)
(obsolete 4/01)
2104 = Lasso Deflectable Cath (eff. 1/01)
(obsolete 4/01)
2151 = Veripath Guiding Cath (eff. 1/01)
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(obsolete 4/01)
2152 = Cordis Vista Brite Tip Cath (eff. 1/01)
(obsolete 4/01)
2153 = Bard Viking Cath (eff. 1/01)
(obsolete 4/01)
2200 = Arrow-Trerotola PTD Cath (eff. 1/01)
(obsolete 4/01)
2300 = Varisource Stnd Catheters (eff. 1/01)
(obsolete 4/01)
2597 = Clinicath/kit 16/18 sgl/dbl (eff. 1/01)
(obsolete 4/01)
2598 = Clinicath 18/20/24-G single (eff. 1/01)
(obsolete 4/01)
2599 = Clinicath 16/18-G-double (eff. 1/01)
(obsolete 4/01)
2601 = Bard DL Ureteral Cath (eff. 1/01)
(obsolete 4/01)
2602 = Vitesse Laser Cath 1.4/1.7mm (eff. 1/01)
(obsolete 4/01)
2603 = Vitesse Laser Cath 2.0mm (eff. 1/01)
(obsolete 4/01)
2604 = Vitesse E Laser Cath 2.0mm (eff. 1/01)
(obsolete 4/01)
2605 = Extreme Laser Catheter (eff. 1/01)
(obsolete 4/01)
2606 = SpineCath XL Catheter (eff. 1/01)
(obsolete 4/01)
2607 = SpineCath Intradiscal Cath (eff. 1/01)
(obsolete 4/01)
2608 = Scimed 6F Wiseguide Cath (eff. 1/01)
(obsolete 4/01)
2609 = Flexima Bil Draingage Cath (eff. 1/01)
(obsolete 4/01)
2610 = FlexTipPlus Intraspinal Cath (eff. 1/01)
(obsolete 4/01)
2611 = AlgoLine Intraspinal Cath (eff. 1/01)
(obsolete 4/01)
2612 = InDura Catheter (eff. 1/01)
(obsolete 4/01)
2615 = Sealant, pulmonary, liquid (eff. 4/01)
2616 = Brachytx seed, Yttrium-90 (eff. 4/01)
2617 = Stent, non-cor, tem w/o del (eff. 4/01)
2618 = Probe, cryoablation (eff. 4/01)
2619 = Pmkr, dual, non rate-resp (eff. 4/01)
2620 = Pmkr, single, non rate-resp (eff. 4/01)
2621 = Pmkr, other than single/dual (eff. 4/01)
2622 = Prosthesis, penile, non-inf (eff. 4/01)

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2625 = Stent, non-cor , tem w/del sys (eff. 4/01)
2626 = Infusion pump, non-prog, temp (eff. 4/01)
2627 = Cath, suprapubic/cystoscopic (eff. 4/01)
2628 = Catheter, occlusion (eff. 4/01)
2629 = Intro/sheath, laser (eff. 4/01)
2630 = Cath, EP, temp-controlled (eff. 4/01)
2631 = Rep dev, urinary, w/o sling (eff. 4/01)
2700 = MycroPhylax Plus CS defib (eff. 1/01)
(obsolete 4/01)
2701 = Phylax XM SC defib (eff. 1/01)
(obsolete 4/01)
2702 = Ventak Prizm 2VR Defib (eff. 1/01)
(obsolete 4/01)
2703 = Ventak Prizm VR HE Defib (eff. 1/01)
(obsolete 4/01)
2704 = Ventak Mini IV + Defib (eff. 1/01)
(obsolete 4/01)
2801 = Defender IV DR 612 DC defib (eff. 1/01)
(obsolete 4/01)
2802 = Phylax AV DC defib (eff. 1/01)
(obsolete 4/01)
2803 = Ventak Prizm DR HE Defib (eff. 1/01)
(obsolete 4/01)
2804 = Ventak Prizm 2 DR Defib (eff. 1/01)
(obsolete 4/01)
2805 = Jewel AF 7250 Defib (eff. 1/01)
(obsolete 4/01)
2806 = GEM VR 7227 Defib (eff. 1/01)
(obsolete 4/01)
2807 = Contak CD 1823 (eff. 1/01)
(obsolete 4/01)
2808 = Contak TR 1241 (eff. 1/01)
(obsolete 4/01)
3001 = Kainox SL/RV defib lead (eff. 1/01)
(obsolete 4/01)
3002 = EasyTrak Defib Lead (eff. 1/01)
(obsolete 4/01)
3003 = Endotak SQ Array XP lead (eff. 1/01)
(obsolete 4/01)
3004 = Intervene Defib lead (eff. 1/01)
(obsolete 4/01)
3400 = Siltex Spectrum, Contour Prof (eff. 1/01)
(obsolete 4/01)
3401 = Saline-Filled Spectrum (eff. 1/01)
(obsolete 4/01)
3500 = Mentor alpha I Inf Penile Pros (eff. 1/01)
(obsolete 4/01)
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3510 = AMS 800 Urinary Pros (eff. 1/01)
(obsolete 4/01)
3551 = Choice/PT Graphix/Luge/Trooper (eff. 1/01)
(obsolete 4/01)
3552 = Hi-Torque Whisper (eff. 1/01)
(obsolete 4/01)
3553 = Cordis guidewires (eff. 1/01)
(obsolete 4/01)
3554 = Jindo guidewire (eff. 1/01)
(obsolete 4/01)
3555 = Wholey Hi-Torque Plus GW (eff. 1/01)
(obsolete 4/01)
3556 = Wave/FlowWire Guidewire (eff. 1/01)
(obsolete 4/01)
3557 = HyTek guidewire (eff. 1/01)
(obsolete 4/01)
3800 = SynchroMed EL infusion pump (eff. 1/01)
(obsolete 4/01)
3801 = Arrow/Microject PCAQ Sys (eff. 1/01)
(obsolete 4/01)
3851 = Elastic UV IOL AA-4203T/TF/TL (eff. 1/01)
(obsolete 4/01)
4000 = Opus G 4621, 4624 SC pmkr (eff. 1/01)
(obsolete 4/01)
4001 = Opus S 4121/4124 SC pmkr (eff. 1/01)
(obsolete 4/01)
4002 = Talent 113 SC pmkr (eff. 1/01)
(obsolete 4/01)
4003 = Kairos SR SC pmkr (eff. 1/01)
(obsolete 4/01)
4004 = Actros SR, Actros SLR SC pmkr (eff. 1/01)
(obsolete 4/01)
4005 = Philos SR/SR-B SC pmkr (eff. 1/01)
(obsolete 4/01)
4006 = Pulsar Max II SR pmkr (eff. 1/01)
(obsolete 4/01)
4007 = Marathon SR pmkr (eff. 1/01)
(obsolete 4/01)
4008 = Discovery II SSI pmkr (eff. 1/01)
(obsolete 4/01)
4009 = Discovery II SR pmkr (eff. 1/01)
(obsolete 4/01)
4300 = Integrity AFx DR 5342 pmkr (eff. 1/01)
(obsolete 4/01)
4301 = Integrity AFx DR 5346 pmkr (eff. 1/01)
(obsolete 4/01)
4302 = Affinity VDR 5430 DR (eff. 1/01)
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(obsolete 4/01)
4303 = Brio 112 DC pmkr (eff. 1/01)
(obsolete 4/01)
4304 = Brio 212, Talent 213/223 DC pmkr (eff. 1/01)
(obsolete 4/01)
4305 = Brio 222 DC pmkr (eff. 1/01)
(obsolete 4/01)
4306 = Brio 220 DC pmkr (eff. 1/01)
(obsolete 4/01)
4307 = Kairos DR DC pmkr (eff. 1/01)
(obsolete 4/01)
4308 = Inos2, Inos2+ DC pmkr (eff. 1/01)
(obsolete 4/01)
4309 = Actros DR,D,DR-A, SLR DC pmkr (eff. 1/01)
(obsolete 4/01)
4310 = Actros DR-B DC pmkr (eff. 1/01)
(obsolete 4/01)
4311 = Philos DR/DR-B/SLR DC (eff. 1/01)
(obsolete 4/01)
4312 = Pulsar Max II DR pmkr (eff. 1/01)
(obsolete 4/01)
4313 = Marathon DR pmkr (eff. 1/01)
(obsolete 4/01)
4314 = Momentum DR pmkr (eff. 1/01)
(obsolete 4/01)
4315 = Selection AFm pmkr (eff. 1/01)
(obsolete 4/01)
4316 = Discovery II DR (eff. 1/01)
(obsolete 4/01)
4317 = Discovery II DDD (eff. 1/01)
(obsolete 4/01)
4600 = Snynox, Polyrox, Elox, Retrox (eff. 1/01)
(obsolete 4/01)
4602 = Tendril SDX, 1488K pmkr lead (eff. 1/01)
(obsolete 4/01)
4603 = Oscor/Flexion pmkr lead (eff. 1/01)
(obsolete 4/01)
4604 = CrystallineActFix, CapsureFix (eff. 1/01)
(obsolete 4/01)
4605 = CapSure Epi pmkr lead (eff. 1/01)
(obsolete 4/01)
4606 = Flextend pmkr lead (eff. 1/01)
(obsolete 4/01)
4607 = FinelineII/EZ, ThinlineII/EZ (eff. 1/01)
(obsolete 4/01)
5000 = BX Velocity w/Hepacoat (eff. 1/01)
(obsolete 4/01)

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5001 = Memotherm Bil Stent, sm, med (eff. 1/01)
(obsolete 4/01)
5002 = Memotherm Bil Stent, large (eff. 1/01)
(obsolete 4/01)
5003 = Memotherm Bil Stent, x-large (eff. 1/01)
(obsolete 4/01)
5004 = PalmazCorinthian IQ Bil Stent (eff. 1/01)
(obsolete 4/01)
5005 = PalmazCorinthian IQ Trans/Bil (eff. 1/01)
(obsolete 4/01)
5006 = PalmazTran Bil Stent Sys-Med (eff. 1/01)
(obsolete 4/01)
5007 = PalmazTran XL Bil Stent--40mm (eff. 1/01)
(obsolete 4/01)
5008 = PalmazTran XL Bil Stent--50mm (eff. 1/01)
(obsolete 4/01)
5009 = VistaFlex Biliary Stent (eff. 1/01)
(obsolete 4/01)
5010 = Rapid Exchange Bil Stent Sys (eff. 1/01)
(obsolete 4/01)
5011 = IntraStent, IntraStent LP (eff. 1/01)
(obsolete 4/01)
5012 = IntraStent DoubleStrut LD (eff. 1/01)
(obsolete 4/01)
5013 = IntraStent DoubleStrut XS (eff. 1/01)
(obsolete 4/01)
5014 = AVE Bridge Stent Sys-10/17/28 (eff. 1/01)
(obsolete 4/01)
5015 = AVE/X3 Bridge Sys, 40-100 (eff. 1/010
(obsolete 4/01)
5016 = Biliary stent single use cov (eff. 1/01)
(obsolete 4/01)
5017 = WallstentRP Bil--20/40/60/68mm (eff. 1/01)
(obsolete 4/01)
5018 = WallstentRP Bil--80/94mm (eff. 1/01)
(obsolete 4/01)
5019 = Flexima Bil Stent Sys (eff. 1/01)
(obsolete 4/01)
5020 = Smart Nitinol Stent--20mm (eff. 1/01)
(obsolete 4/01)
5021 = Smart Nitinol Stent--40/60mm (eff. 1/01)
(obsolete 4/01)
5022 = Smart Nitinol Stent--80mm (eff. 1/01)
(obsolete 4/01)
5023 = BX Velocity Stent--8/13mm (eff. 1/01)
(obsolete 4/01)
5024 = BX Velocity Stent 18mm (eff. 1/01)
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(obsolete 4/01)
5025 = BX Velocity Stent 23 mm (eff. 1/01)
(obsolete 4/01)
5026 = BX Velocity Stent 28/33mm (eff. 1/01)
(obsolete 4/01)
5027 = BX Velocity Stent w/Hep--8/13mm (eff. 1/01)
(obsolete 4/01)
5028 = BX Velocity Stent w/Hep--18mm (eff. 1/01)
(obsolete 4/01)
5029 = BX Velocity Stent w/Hep--23mm (eff. 1/01)
(obsolete 4/01)
5030 = Stent, coronary, S660 9/12mm (eff. 1/01)
(obsolete 4/01)
5031 = Stent, coronary, S660 15/18mm (eff. 1/01)
(obsolete 4/01)
5032 = Stent, coronary, S660 24/30mm (eff. 1/01)
(obsolete 4/01)
5033 = Niroyal Stent Sys, 9mm (eff. 1/01)
(obsolete 4/01)
5034 = Niroyal Stent Sys, 12/15mm (eff. 1/01)
(obsolete 4/01)
5035 = Niroyal Stent Sys, 18mm (eff. 1/01)
(obsolete 4/01)
5036 = Niroyal Stent Sys, 25mm (eff. 1/01)
(obsolete 4/01)
5037 = Niroyal Stent Sys, 31mm (eff. 1/01)
(obsolete 4/01)
5038 = BX Velocity Stent w/Raptor (eff. 1/01)
(obsolete 4/01)
5039 = IntraCoil Periph Stent--40mm (eff. 1/01)
(obsolete 4/01)
5040 = IntraCoil Periph Stent--60mm (eff. 1/01)
(obsolete 4/01)
5041 = BeStent Over-the-Wire 24/30mm (eff. 1/01)
(obsolete 4/01)
5042 = BeStent Over-the-Wire 18mm (eff. 1/01)
(obsolete 4/01)
5043 = BeStent Over-the-Wire 15mm (eff. 1/01)
(obsolete 4/01)
5044 = BeStent Over-the-Wire 9/12mm (eff. 1/01)
(obsolete 4/01)
5045 = Multilink Tetra Cor Stent Sys (eff. 1/01)
(obsolete 4/01)
5046 = Radius 20mm cor stent (eff. 1/01)
(obsolete 4/01)
5047 = Niroyal Elite Cor Stent Sys (eff. 1/01)
(obsolete 4/01)

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5048 = GR II Coronary Stent (eff. 1/01)
(obsolete 4/01)
5130 = Wilson-Cook Colonic Z-Stent (eff. 1/01)
(obsolete 4/01)
5131 = Bard Colorectal Stent-60mm (eff. 1/01)
(obsolete 4/01)
5132 = Bard Colorectal Stent-80mm (eff. 1/01)
(obsolete 4/01)
5133 = Bard Colorectal Stent-100mm (eff. 1/01)
(obsolete 4/01)
5134 = Enteral Wallstent-90mm (eff. 1/01)
(obsolete 4/01)
5279 = Contour/Percuflex Stent (eff. 1/01)
(obsolete 4/01)
5280 = Inlay Dbl Ureteral Stent (eff. 1/01)
(obsolete 4/01)
5281 = Wallgraft Trach Sys 70mm (eff. 1/01)
(obsolete 4/01)
5282 = Wallgraft Trach Sys 20/30/50 (eff. 1/01)
(obsolete 4/01)
5283 = Wallstent/RP TIPS--80mm (eff. 1/01)
(obsolete 4/01)
5284 = Wallstent TrachUltraFlex (eff. 1/01)
(obsolete 4/01)
5600 = Closure dev, VasoSeal ES (eff. 1/01)
(obsolete 4/01)
5601 = VasoSeal Model 1000 (eff. 1/01)
(obsolete 4/01)
6001 = Composix Mesh 8/21 in (eff. 1/01)
(obsolete 4/01)
6002 = Composix Mesh 32 in (eff. 1/01)
(obsolete 4/01)
6003 = Composix Mesh 48 in (eff. 1/01)
(obsolete 4/01)
6004 = Composix Mesh 80 in (eff. 1/01)
(obsolete 4/01)
6005 = Composix Mesh 140 in (eff. 1/01)
(obsolete 4/01)
6006 = Composix Mesh 144 in (eff. 1/01)
(obsolete 4/01)
6012 = Pelvicol Collagen 8/14 sq cm (eff. 1/01)
(obsolete 4/01)
6013 = Pelvicol Collagen 21/24/28 sq cm (eff. 1/01)
(obsolete 4/01)
6014 = Pelvicol Collagen 36 sq cm (eff. 1/01)
(obsolete 4/01)
6015 = Pelvicol Collagen 48 sq cm (eff. 1/01)
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(obsolete 4/01)
6016 = Pelvicol Collagen 96 sq cm (eff. 1/01)
(obsolete 4/01)
6017 = Gore-Tex DualMesh 75/96 sq cm (eff. 1/01)
(obsolete 4/01)
6018 = Gore-Tex DualMesh 150 sq cm (eff. 1/01)
(obsolete 4/01)
6019 = Gore-Tex DualMesh 285 sq cm (eff. 1/01)
(obsolete 4/01)
6020 = Gore-Tex DualMesh 432 sq cm (eff. 1/01)
(obsolete 4/01)
6021 = Gore-Tex DualMesh 600 sq cm (eff. 1/01)
(obsolete 4/01)
6022 = Gore-Tex DualMesh 884 sq cm (eff. 1/01)
(obsolete 4/01)
6023 = Gore-TexPlus 1mm, 75/96 sq cm (eff. 1/01)
(obsolete 4/01)
6024 = Gore-TexPlus 1mm, 150 sq cm (eff. 1/01)
(obsolete 4/01)
6025 = Gore-TexPlus 1mm, 285 sq cm (eff. 1/01)
(obsolete 4/01)
6026 = Gore-TexPlus 1mm, 432 sq cm (eff. 1/01)
(obsolete 4/01)
6027 = Gore-TexPlus 1mm, 600 sq cm (eff. 1/01)
(obsolete 4/01)
6028 = Gore-TexPlus 1mm, 884 sq cm (eff. 1/01)
(obsolete 4/01)
6029 = Gore-TexPlus 2mm, 150 sq cm (eff. 1/01)
(obsolete 4/01)
6030 = Gore-TexPlus 2mm, 285 sq cm (eff. 1/01)
(obsolete 4/01)
6031 = Gore-TexPlus 2mm, 432 sq cm (eff. 1/01)
(obsolete 4/01)
6032 = Gore-TexPlus 2mm, 600 sq cm (eff. 1/01)
(obsolete 4/01)
6033 = Gore-TexPlus 2mm, 884 sq cm (eff. 1/01)
(obsolete 4/01)
6034 = Bard ePTFE: 150 sq cm-2mm
(obsolete 4/01)
6035 = Bard ePTFE: 150sqcm-1mm,75-2mm (eff. 1/01)
(obsolete 4/01)
6036 = Bard ePTFE: 50/75sqcm-1,2mm (eff. 1/01)
(obsolete 4/01)
6037 = Bard ePTFE: 300 sq cm-1,2mm (eff. 1/01)
(obsolete 4/01)
6038 = Bard ePTFE: 600 sq cm-1mm (eff. 1/01)
(obsolete 4/01)
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6039 = Bard ePTFE: 884sq cm-1mm (eff. 1/01)
(obsolete 4/01)
6040 = Bard ePTFE: 600sq cm-2mm (eff. 1/01)
(obsolete 4/01)
6041 = Bard ePTFE: 884sq cm -2mm (eff. 1/01)
(obsolete 4/01)
6050 = Female Sling Sys w/wo Matrl (eff. 1/01)
(obsolete 4/01)
6051 = Stratasis Sling, 20/40 cm (eff. 1/01)
(obsolete 4/01)
6052 = Stratasis Sling, 60 cm (eff. 1/01)
(obsolete 4/01)
6053 = Surgisis Soft Graft (eff. 1/01)
(obsolete 4/01)
6054 = Surgisis Enhanced Graft (eff. 1/01)
(obsolete 4/01)
6055 = Surgisis Enhanced Tissue (eff. 1/01)
(obsolete 4/01)
6056 = Surgisis Soft Tissue Graft (eff. 1/01)
(obsolete 4/01)
6057 = Surgisis Hernia Graft (eff. 1/01)
(obsolete 4/01)
6058 = SurgiPro Hernia Plug, med/lg (eff. 1/01)
(obsolete 4/01)
6080 = Male Sling Sys w/wo Matrial (eff. 1/01)
(obsolete 4/01)
6200 = Exxcel Soft ePTFE vas graft (ef. 1/01)
(obsolete 4/01)
6201 = Impra Venaflo--10/20cm (eff. 1/01)
(obsolete 4/01)
6202 = Impra Venaflo--30/40 cm (eff. 1/01)
(obsolete 4/01)
6203 = Impra Venaflo--50 cm, vt45 (eff. 1/01)
(obsolete 4/01)
6204 = Impra Venaflo--stepped (eff. 1/01)
(obsolete 4/01)
6205 = Impra Carboflo--10cm (eff. 1/01)
(obsolete 4/01)
6206 = Impra Carboflo--20 cm (eff. 1/01)
(obsolete 4/01)
6207 = Impra Carboflo--30/35/40cm (eff. 1/01)
(obsolete 4/01)
6208 = Impra Carboflo--40/50cm (eff. 1/01)
(obsolete 4/01)
6209 = Impra Carboflo--ctrflex (eff. 1/01)
(obsolete 4/01)
6210 = Exxcel ePTFE vas graft (eff. 1/01)
```

(obsolete 4/01)
6300 = Vanguard III Endovas Graft (eff. 1/01)
(obsolete 4/01)
6500 = Preface Guiding Sheath (eff. 1/01)
(obsolete 4/01)
6501 = Soft Tip Sheaths (eff. 1/01)
(obsolete 4/01)
6502 = Perry Exchange Dilator (eff. 1/01)
(obsolete 4/01)
6525 = Spectranetics Laser Sheath (eff. 1/01)
(obsolete 4/01)
6600 = Micro Litho Flex Probes (eff. 1/01)
(obsolete 4/01)
6650 = Fast-Cath Guiding Introducer (eff. 1/01)
(obsolete 4/01)
6651 = Seal-Away Guding Introducer (eff. 1/01)
(obsolete 4/01)
6652 = Bard Excalibur Introducer (eff. 1/01)
(obsolete 4/01)
6700 = Focal Seal-L (eff. 1/01)
(obsolete 4/01)
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) (obsolete 1/01)
7003 = Epoprostenol, 0.5 MG, inj (eligible for pass-
through payments)
7004 = Immune globulin intravenous human 5g, inj
(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) (obsolete 1/01)
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) (obsolete 1/01)
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 (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)
7047 = Droperidol/fentanyl inj (eff. 1/01)
7048 = Alteplase, 1 mg (eff. 1/01)
7049 = Filgrastim 480 mcg injection (eff. 1/01)
7315 = Sodium hyaluronate, 20 mg (eff. 1/01)
8099 = Spectranetics Lead Lock Dev (eff. 1/01)
(obsolete 4/01)
8100 = Adhesion barrier, ADCON-L (eff. 1/01)
(obsolete 4/01)
8102 = SurgiVision Esoph Coil (eff. 1/01)
(obsolete 4/01)
9000 = Na chromate Cr51, per 0.25mCi (eff. 1/01)
9001 = Linezolid inj, 200mg (eff. 1/01)
9002 = Tenecteplase, 50mg/vial (eff. 1/01)
9003 = Palivizumab, per 50 mg (eff. 1/01)
9004 = Gemtuzumab ozogamicin inj, 5mg (eff. 1/01)
9005 = Reteplase inj, half-kit, 18.8 mg/vial (eff. 1/01)
9006 = Tacrolimus inj, per 5 mg (1 amp) (eff. 1/01)
9007 = Baclofen Intrathecal kit-1amp (eff. 1/01)
9008 = Baclofen Refill Kit--500mcg (eff. 1/01)
9009 = Baclofen Refill Kit--2000mcg (eff. 1/01)
9010 = Baclofen Refill Kit--4000mcg (eff. 1/01)
9011 = Caffeine Citrate, inj, 1ml (eff. 1/01)
9012 = Arsenic Trioxide, 1mg/kg (eff. 4/01)
9013 = Co 57 Cobaltous Cl, 1 ml (eff. 4/01)
9100 = Iodinated I-131 Albumin (eff. 1/01)
9102 = 51 Na chromate, 50mCi (eff. 1/01)
9103 = Na lothalamate I-125, 10uCi (eff. 1/01)
9104 = Anti-thymocyte globin, 25 mg (eff. 1/01)
9105 = Hep B immun glob, per 1 ml (eff. 1/01)
9106 = Sirolimus 1 mg/ml (eff. 1/01)
9107 = Tinzaparin sodium, 2ml vial (eff. 1/01)
9108 = Thyrotropin Alfa, 1.1 mg (eff. 1/01)
9109 = Tirofiban hydrachloride 6.25 mg (eff. 1/01)
9217 = Leuprolide acetate for depot suspension,
7.5 mg (eff. 1/01)
9500 = Platelets, irrad, ea unit (eff. 1/01)
9501 = Platelets, pheresis, ea unit (eff. 1/01)
9502 = Platelets, pher/irrad, ea unit (eff. 1/01)
9503 = Fresh frozen plasma, ea unit (eff. 1/01)
9504 = RBC, deglycerolized, ea unit (eff. 1/01)
9505 = RBC, irradiated, ea unit (eff. 1/01)
9998 = Enoxaparin (eff. 1/01)

```
REV_CNTR_CNSLDTD_BLG_TB                 Revenue Center Consolidated Billing Table


    1 = Home Health Consolidated Billing Override Code
    2 = SNF Consolidated Billing Override Code



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)



REV_CNTR_DSCNT_IND_TB                   Revenue Center Discount Indicator Table

    *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
```

```
      NOTE:  VALUES D, U & T REPRESENT THE FOLLOWING:
      D = Discounting fraction (currently 0.5)
      U = Number of units
      T = Terminated procedure discount (currently 0.5)
```

REV_CNTR_DUP_CLM_CHK_IND_TB   Revenue Center Duplicate Claim Check Indcator Table

      1 = Suspect duplicate review performed

REV_CNTR_NDC_QTY_QLFR_TB   Revenue Center NDC Qualifier Code Table

      Valid Values:
      F2 = International Unit
      GR = Gram
      ML = Milliliter
      UN = Unit

REV_CNTR_PACKG_IND_TB   Revenue Center Packaging Indicator Table

      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
      3 = Artificial charges for surgical procedure
          (eff. 7/2004)

REV_CNTR_PMT_MTHD_IND_TB   Revenue Center Payment Method Indicator Table

      NOTE: Prior to 10/2005, this table contained the
      valid values for both the payment indicator and
      status indicator. Effective 10/2005, the payment
      indicator codes will remain in this table and the
      status indicator code values will be reflected in
      the new table: REV_CNTR_STUS_IND_TB. Both the
      payment indicator and status indicator values have
      been expanded to 2-btyes.

      1 = Paid standard hospital OPPS amount

```
          (status indicators K, S,T,V,X)
2 = Services not paid under OPPS (status
      indicator A, or no HCPCS code and not
      certain revenue center codes)
3 = Not paid (status indicator M,W,Y,E) or not
      paid under OPPS (status indicator B,C & Z)
4 = Paid at reasonable cost (status  indica-
      tor F,L)
5 = Additional payment for drug or biological
      (status indicator G)
6 = Additional payment for device (status
      indicator H)
7 = Additional payment for new drug or new
      biological (status indicator J)
8 = Paid partial hospitalization per diem
      (status indicator P)
9 = No additional payment, payment included
      in line items with APCs (status indicator
      N, or no HCPCS code and certain revenue
      center codes, or HCPCS codes G0176
      (activity therapy), G0129 (occupational
      therapy) or G0177 (partial hospitalization
      program services)

*********VALUES PRIOR TO 10/3/2005**************

**********Service Indicator**************
********** 1st position ****************
A = Services not paid under OPPS
C = Inpatient procedure
E = Noncovered items or services
F = Corneal tissue 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)
```

```
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.
    for the provider billed charges. NOTE: There is an excep-
    tion for Critical Access Hospitals (provider numbers
    XX1300-XX1399) with reimbursement method 'J' (all-
    inclusive method) and dates of service on or after
    7/1/01.  In these situations, reimbursement for pro-
    fessional services (revenue codes 96X, 97X, 98X) is
    always at the fee schedule amount of logic is not
    applicable.

    C = Unlisted Rehabilitation Carrier Priced HCPCS

    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 treats this
```

HCPCS as a non-covered service. Reimbursement is cal-
culated 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 re-
ported 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.

NOTE: The ESRD Pricing Indicator is used when process-
ing the ESRD claim. The non-ESRD pricing indicator
is used only for Inpatient claims as follows: valid
Hemophilia HCPCS for inpatient claim only and code is
summed to parameter rate.

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. Reim-
bursement is calculated either on a fee schedule, pro-
vider submitted charges or the lesser of provider
submitted, or the fee schedule depending on the cate-
gory of DME.

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. This

code will be automatically set by the system.

M = A valid TENS HCPCS, Medical Review has approved the
rental charge in excess of five months. This must be
set by Medical Review. This must be set by Medical
Review when approved for payment.

N = Paid based on the fee amount for non ESRD TOB's.
    NOTE: Fee amount is paid regardless of charges.

Q = Manual pricing

R = A valid radiology HCPCS code and is subject to
APC. 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
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.

U = Valid ambulance HCPCS. A fee amount is present.
The amount payable is a blended amount based on a
percentage of the fee schedule and a percentage of
the reasonable cost. The fee amount is subject to
coinsurance and deductible.

X = Unclassified drug as subject to manual pricing.

REV_CNTR_PRIOR_AUTHRZTN_TB   Revenue Center Prior Authorization Indicator Table

    A = Part A
    B = Part B
    D = DME
    H = Home Health and Hospice
    + 3 digit number

```
REV_CNTR_PWK_TB                          Revenue Center Paperwork Table


     P1 = one iteration is present
     P2 = two iterations are present
     P3 = three iterations are present
     P4 = four iterations are present
     P5 = five iterations are present
     P6 = six iterations are present
     P7 = seven iterations are present
     P8 = eight iterations are present
     P9 = nine iterations are present
     P0 = ten iterations are present




REV_CNTR_STUS_IND_TB                      Revenue Center Status Indicator Table

     A = Services not paid under OPPS
     B = Non-allowed item or service for OPPS
     C = Inpatient procedure
     E = Non-allowed item or service
     F = Corneal tissue acquisition and certain CRNA
         services
     G = Drug/bilogical pass-through
     H = Device pass-through
     J = New drug or new biological pass-through
     K = Non pass-through drug/biological, radio-
         pharmaceutical agent, certain brachytherapy
         sources
     L = Flu/PPV vaccines
     M = Service not billable to FI
     N = Packaged incidental service
     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
     W = Invalid HCPCS or invalid revenue code with blank
         HCPCS
     X = Ancillary service
     Y = Non-implantable DME, Therapeutic shoes
     Z = Valid revenue with blank HCPCS and no other SI
         assigned
```

```
     0001 = Total charge
     0022 = SNF claim paid under PPS submitted as TOB 21X,
            effective for cost reporting periods begin-
            ning 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).
     0024 = Inpatient Rehabilitation Facility services paid
            under PPS submitted as TOB 11X, effective for
            cost reporting periods beginning on or after
            1/1/2002 (dates of service after 12/31/01).
            This code may appear only once on a claim.
     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
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
       (obsolete)
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
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
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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
0343 = Nuclear medicine-diagnostic radiopharmaceuticals
0344 = Nuclear medicine-therapeutic radiopharmaceuticals
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
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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
0392 = Blood storage and processing - storage
       and processing
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
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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
0499 = Ambulatory surgical care-other
0500 = Outpatient services-general classification
0509 = Outpatient services-other
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-Clinic visit by a
       member to RHC/FQHC (eff. 7/1/06). Prior to
       7/1/06 - Rural Health-Clinic
0522 = Free-standing clinic-Home visit by RHC/FQHC
       practitioner (eff. 7/1/06).  Prior to
       7/1/06 - Rural Health-Home
0523 = Free-standing clinic-family practice
0524 = Free-standing clinic - visit by RHC/FQHC
       practitioner to a member in a covered Part
       A stay at the SNF. (eff. 7/1/06)
0525 = Free-standing clinic - visit by RHC/FQHC
       practitioner to a member in a SNF (not in
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             a covered Part A stay) or NF or ICF MR or
             other residential facility. (eff. 7/1/06)
0526 = Free-standing clinic-urgent care (eff 10/96)
0527 = Free-standing clinic-RHC/FQHC visiting nurse
       service(s) to a member's home when in a home
       health shortage area. (eff. 7/1/06)
0528 = Free-standing clinic-visit by RHC/FQHC
       practitioner to other non RHC/FQHC site
       (e.g. scene of accident).  (eff. 7/1/06)
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)
0583 = Other visits (home health) - assessments
       (under HHPPS, not allow as covered charges)
0589 = Other visits (home health)-other
       (under HHPPS, not allowed as covered charges)
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0590 = Units of service (home health)-general
       classification (under HHPPS, not allowed
       as covered charges)
0599 = Units of service (home health)-other
       (under HHPPS, not allowed as covered charges)
       (obsolete)
0600 = Oxygen/Home Health-general classification
0601 = Oxygen/Home Health-stat or port equip/supply
       or count
0602 = Oxygen/Home Health-stat/equip/under 1 LPM
0603 = Oxygen/Home Health-stat/equip/over 4 LPM
0604 = Oxygen/Home Health-stat/equip/portable add-on
0609 = Oxygen/Home Health - Other (Obsolete)
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 MRT
0620 = Reserved (Use 0270 for general classification)
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 = Reserved (eff. 1/98)
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
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              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)
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
0658 = Hospice services-Hospice Room & Board -
       Nursing Facility
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)
0663 = Respite care-daily respite care
0669 = Respite care-other respite care
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
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0680 = Trauma Response-not used
0681 = Trauma response-Level I Trauma
0682 = Trauma response-Level II Trauma
0683 = Trauma response-Level III Trauma
0684 = Trauma response-Level IV Trauma
0689 = Trauma response-Other trauma response
0690 = Pre-hospice/Palliative Care Services - general
       (eff. 7/1/17)
0691 = Pre-hospice/Palliative Care Services - visit
       (eff. 7/1/17)
0692 = Pre-hospice/Palliative Care Services - hourly
       (eff. 7/1/17)
0693 = Pre-hospice/Palliative Care Services - evaluation
       (eff. 7/1/17)
0694 = Pre-hospice/Palliative Care Services - consultation &
       education (eff. 7/1/17)
0695 = Pre-hospice/Palliative Care Services - Inpatient
       (eff. 7/1/17)
0696 = Pre-hospice/Palliative Care Services - Physician
       (eff. 7/1/17)
0699 = Pre-hospice/Palliative Care Services - Other
       (eff. 7/1/17)
0700 = Cast room-general classification
0709 = Cast room-other (obsolete)
0710 = Recovery room-general classification
0719 = Recovery room-other (obsolete)
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 (Obsolete)
0750 = Gastro-intestinal services-general classification
0759 = Gastro-intestinal services-other (Obsolete)
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)
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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) (Obsolete)
0780 = Telemedicine - general classification
       (eff 10/97)
0789 = Telemedicine - telemedicine (eff 10/97) (Obsolete)
0790 = Extra-Corporeal Shock Wave Therapy (ESWT) - general
       classification - formerly Lithotripsy
0799 = Lithotripsy-other (Obsolete)
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 = Allogeneic Stem Cell Acquisition/Donor Services
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
0826 = Hemodialysis OP or home dialysis- Hemo short
       (eff. 7/1/17)
0829 = Hemodialysis OP or home dialysis-other
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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
0860 = Magnetoencephalography (MEG) - general
       classification
0861 = Magnetoencephalography (MEG) - MEG
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 = Behavior Health Treatment/Services - general
       classification (eff. 10/2004); prior to
       10/2004 defined as Psychiatric/psychological
       treatments-general classification
0901 = Behavior Health Treatment/Services - electroshock
       treatment (eff. 10/2004); prior to 10/2004
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                    defined as Psychiatric/psychological
                    treatments-electroshock treatment
0902 = Behavior Health Treatment/Services - milieu
       therapy (eff. 10/2004); prior to 10/2004
       defined as Psychiatric/psychological
       treatments-milieu therapy
0903 = Behavior Health Treatment/Services - play
       therapy (eff. 10/2004); prior to 10/2004
       defined as Psychiatric/psychological
       treatments-play therapy
0904 = Behavior Health Treatment/Services - activity
       therapy (eff. 10/2004); prior to 10/2004
       defined as Psychiatric/psychological
       treatments-activity therapy
0905 = Behavior Health Treatment/Services - intensive
       outpatient services-psychiatric (eff. 10/2004)
0906 = Behavior Health Treatment/Services - intensive
       outpatient services-chemical dependency
       (eff. 10/2004)
0907 = Behavior Health Treatment/Services - community
       behavioral health program-day treatment
       (eff. 10/2004)
0909 = Reserved for National Use (eff. 10/2004); prior
       to 10/2004 defined as Psychiatric/psychological
       treatments-other
0910 = Behavioral Health Treatment/Services-Reserved for
       National Assignment (eff. 10/2004); prior to
       10/2004 defined as Psychiatric/psychological
       services-general classification
0911 = Behavioral Health Treatment/Services-rehabilitation
       (eff. 10/2004); prior to 10/2004 defined as
       Psychiatric/psychological services-rehabilitation
0912 = Behavioral Health Treatment/Services-partial
       hospitalization-less intensive (eff. 10/2004);
       prior to 10/2004 defined as Psychiatric/
       psychological services-less intensive
0913 = Behavioral Health Treatment/Services-partial
       hospitalization-intensive (eff. 10/2004);
       prior to 10/2004 defined as Psychiatric/
       psychological services-intensive
0914 = Behavioral Health Treatment/Services-indivi-
       dual therapy (eff. 10/2004); prior to
       10/2004 defined as Psychiatric/psychological
       services-individual therapy
0915 = Behavioral Health Treatment/Services-group
       therapy (eff. 10/2004); prior to 10/2004
       defined as Psychiatric/psychological services-
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              group therapy
0916 = Behavioral Health Treatment/Services-family
       therapy (eff. 10/2004); prior to 10/2004
       defined as Psychiatric/psychological services-
       family therapy
0917 = Behavioral Health Treatment/Services-bio
       feedback (eff. 10/2004); prior to 10/2004
       defined as Psychiatric/psychological services-
       bio feedback
0918 = Behavioral Health Treatment/Services-testing
       (eff. 10/2004); prior to 10/2004 defined as
       Psychiatric/psychological services-testing
0919 = Behavioral Health Treatment/Services-other
       (eff. 10/2004); prior to 10/2004 defined as
       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
0931 = Medical Rehabilitation Day Program - Half Day
0932 = Medical Rehabilitation Day Program - Full Day
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
0947 = Other therapeutic services-ancillary complex
       medical equipment (eff 3/92)
0948 = Other therapeutic services- pulmonary rehab
0949 = Other therapeutic services-other
0951 = Professional Fees-athletic training (extension
       of 094X)
0952 = Professional Fees-kinesiotherapy (extension
       of 094X)
0953 = Chemical Dependency (eff. 4/2013)
0960 = Professional fees-general classification
0961 = Professional fees-psychiatric
0962 = Professional fees-ophthalmology
0963 = Professional fees-anesthesiologist (MD)
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0964 = Professional fees-anesthetist (CRNA)
0969 = Professional fees-other
       NOTE:  097X is an extension of 096X
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
       NOTE:  098X is an extension of 096X & 097X
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/telecom
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
1000 = Behavioral Health Accommodations -
       general classification
1001 = Behavioral Health Accommodations -
       residential treatment -Psychiatric
1002 = Behavioral Health Accommodations -
       residential treatment - chemical
       dependency
1003 = Behavioral Health Accommodations -
       supervised living
1004 = Behavioral Health Accommodations -
       halfway house
1005 = Behavioral Health Accommodations -
       group home
2100 = Alternative Therapy Services - general
       classification
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2101 = Alternative Therapy Services -
       Acupuncture
2102 = Alternative Therapy Services -
       Acupressure
2103 = Alternative Therapy Services -
       massage
2104 = Alternative Therapy Services -
       reflexology
2105 = Alternative Therapy Services -
       biofeedback
2106 = Alternative Therapy Services -
       hypnosis
2109 = Alternative Therapy Services -
       other alternative therapy service
3100 = Adult Care - Reserved
3101 = Adult Care - adult day care, medical
       and social hourly
3102 = Adult Care - adult day care, social-
       hourly
3103 = Adult Care - adult day care, medical
       and social - daily
3104 = Adult Care - adult day care, social -
       daily
3105 = Adult Care - adult foster care daily
3109 = Adult Care - other adult care

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
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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-
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        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-
            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
```

REV_CNTR_THRPY_CAP_IND_CD_TB   Revenue Center Therapy CAP Indicator Code Table

```
     A = Hospital outpatient claims are subject to the
         therapy cap for this date of service (this indicator
         will be used on institutional claims only).

     B = Critical Access Hospital outpatient claims are
         subject to the therapy cap for this date of service
         (this indicator will be used on institutional claims
         only).  Note:  Currently, Critical Access Hospital
```

claims are not subject to any therapy cap policies.
                        Indicator B is created here to prepare for possible
                        future legislation to include these claims.

          C = The therapy cap exceptions process, as indicated
              by the submission of the KX modifier, no longer
              applies for this date of service (this indicator
              will be used on both institutional and professional
              claims).

          D = The $3700 threshold for review therapy services
              no longer applies for this date of service (this
              indicator will be used on both institutional and
              professional claims).

 RP_IND_TB   Claim Representative Payee (RP) Indicator Code Table

       R = bypass representative payee
       Space

 RSDL_PMT_IND_TB   Claim Residual Payment Indicator Code Table

       X = Residual Payment
       Space

                                          QUERY: RIFQQ11, RIFQQ21 ON DB2T
                        *******END OF TOC APPENDIX FOR RECORD: FI_IP_SNF_CLM_REC*******

1
 LIMITATIONS APPENDIX FOR RECORD: FI_IP_SNF_CLM_REC, STATUS: PROD, VERSION: 19068
  PRINTED: 07/10/2019, USER: A4KJ, DATA SOURCE: CA REPOSITORY ON DB2T

  CHOICES_DEMO_LIM
                                 FULL NAME: Choices Demonstration Limitation
                                 DESCRIPTION :
                                   A programming error created an 'INVALID' indication
                                   in the demo text field for CHOICES claims.
                                 BACKGROUND   :
                                   In 6/00, the CWFMQA front-end editing revealed that some

```
                        CHOICES demo claims were coming in with a valid 'H'
                        number in the fixed portion of the claims, but in the
                        first occurrence MCO trailer a numeric packed field
                        (value hex '0100000C') was moved to the MCO Contract
                        Number/Option Code fields.   This created an invalid
                        period check of number/code to MCO effective date,
                        resulting in an INVALID indication in the demo info
                        text field.
                      CORRECTIVE ACTION :
                        The problem was forwarded to the CWF BSOG staff
                        for further investigation.
                      SOURCE:
                        CONTACT            :  OIS/EDG/DMUDD

CLM_ACNT_NUM_LIM
                      FULL NAME: Beneficiary Claim Account Number Limitation
                      DESCRIPTION :
                        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.
                      SOURCE:

CLM_POA_IND_CD_LIM
                      FULL NAME: Claim Present on Admission Indicator Code Limitation
                      DESCRIPTION :
                        DESCRIPTION:
                        Missing present on admission (POA) indicators on the NCH claims.
                      BACKGROUND     :
                        A problem has been discovered with the Inpatient claims received
                        from CWF from July 6, 2009 through October 4, 2009. The
                        claims received during this timeperiod have no POA indicators.
                        The problem was a result of a defect in the conversion code
                        used by CWF to convert the new 5010 record format back to the
                        4010 format for the NCH. The reason CWF was converting the
                        claims to the 4010 format was because they implemented the 5010
                        format beginning in July 2009 but the NCH is still using
                        the 4010 until 1/3/2011.
                      CORRECTIVE ACTION :
                        CORRECTIVE ACTION:
                        CWF will be sending in adjustment claims to correct the
                        problem.  The claims will come into the NCH the week of
                        December 19, 2009.  There were approximately 3 million
                        claims missing the POA indicator.
                      SOURCE:
                      ADMINISTRATIVE DATA:
                        START DATE      : 7/6/09
                        END DATE        : 10/5/09
                        CONTACT
```

```
                                    CONTACT        act:  OIS/EDG/DIDPM

CLM_PRCDR_PRFRM_DT_LIM
                                    FULL NAME: Claim Procedure Perform Date Limitation
                                    DESCRIPTION :
                                      The principal procedure perform date is missing from all
                                      Inpatient/SNF claims processed from January 1/2012
                                      through March 31, 2012.  Service years involved are 2011
                                      and 2012.
                                    BACKGROUND    :
                                      Back in February 2012, a data user of our NCH 100% Monthly
                                      TAP file noticed that the principal procedure perform
                                      date was missing on the Inpatient/SNF claims starting in
                                      January 2012.  After further investigation by CWF, it
                                      was discovered the problem originated from a coding
                                      change in the CWF January 2012 Quarterly Release.

                                      In March 2013, another data user realized the date was
                                      missing from the claims.  The principal procedure date
                                      is a critical data element for this data user and
                                      their Value Based Purchasing Project.  They asked
                                      if we could have CWF send in adjustments to correct
                                      those erroneous claims.
                                    CORRECTIVE ACTION :
                                      This issue is being resolved in two Phases:
                                      (1) Because CWF accidently stripped the principal
                                      procedure date from the claims, FISS will need to
                                      provide the date to data user.  The data user pulled
                                      claims information (HICN, from/thru date, etc.) from
                                      the NCH SAF to create a "trigger" file for FISS to
                                      use to pull the claims from their system to capture
                                      the principal procedure date.   FISS will update the
                                      trigger file with the missing date so the user can
                                      include the date in their algorithms to produce their
                                      payment measures.

                                      (2) FISS will provide the "trigger" file to CWF so they
                                      can create credit/debit claims for the NCH.  NCH will
                                      update the 2011 and 2012 SAF to include those adjustments.
                                    SOURCE:
                                    ADMINISTRATIVE DATA:
                                      START DATE       : 01/01/2012
                                      END DATE         : 03/31/2012
                                      CONTACT          : OIS/EDG/DDOM

CLM_SNF_VRSN_I_REC_LIM
                                    FULL NAME: Claim SNF Version 'I' Record Limitation
                                    DESCRIPTION :
                                      SNF Version 'I' claims were incorrectly identified in
```

the NCH Nearline as Inpatient encounter claims.
BACKGROUND   :
  SNF claims matching the Inpatient encounter data criteria
  were incorrectly identified as Inpatient encounters (NCH
  Claim Type Code is '61', rather than '20' or '30').
  If the SNF claims were identified as Inpatient encounters,
  the MCO Paid Switch was set to '1'.
CORRECTIVE ACTION :
  The problem was corrected during the NCH quarterly
  update in March 2001. The NCH Claim Type was correctly
  identified as '20' or '30'.   The MCO Paid Switch was
  changed to '0'. A patch code trailer was added to the
  record: Patch Code '14' and a patch apply date of
  '20010330'.
SOURCE:
ADMINISTRATIVE DATA:
  START DATE   : 07/07/00
  END DATE   : 01/26/01
  CONTACT   : OIS/EDG/DMUDD

CLM_TRANS_CD_LIM

FULL NAME: Claim Transaction Code Limitation
DESCRIPTION :
  Claim Transaction Code missing from 1999 inpatient
  records and there was also a problem identified
  in the May and June 2000 data.
BACKGROUND   :
  Users of the data discovered taht the claim trans-
  action code was missing values 2 & 3 for service year
  1999 and for the months of May and June, 2000. This
  information was confirmed and OIS/BSOG was notified.
CORRECTIVE ACTION :
  In July 2000 the problem was fixed and the claim
  transaction code contained the correct values.
SOURCE:
  CONTACT   : OIS/EDG/DMUDD

CNCL_CLM_LIM

FULL NAME: Cancel Claim Limitation
DESCRIPTION :
  It was brought to our attention in May 2012, that the
  expected volume of cancel claims (query code '0') was
  drastically reduced in the Inpatient claims files sent
  from CWF to NCH from April 2nd to May 8th.
BACKGROUND   :
  It was our understanding at the time the issue was first
  raised, in May, there were missing cancel claims on the
  April files.

In November 2012, we were notified by another data user
that it appeared not all of the cancel claims were sent
in the "special" file (received in May) so the problem
still remained. After further investigation, we deter-
mined from CWF that the cancel claims were not truly
missing from the April - May files, but the query code
on those claims was incorrectly set for claims with an
Action code of 4 or 6 which caused the appearance of
a decrease in cancel claims.   Claims with an action
code of 4 or 6 should only have a query code of '0'.

It was determined that the CWF Spell Rewrite changes
implemented with the CWF April 2012 Quarterly release
was creating query codes of '0', '1', '3' and '5' for
action codes 4 and 6.

When CWF created the utility to fix the problem re-
ported in May, they pulled all claims processed from
the timeframe of 4/2/12 - 5/8/12 that had an action
code of 4 or 6 and changed the query code to a '0'.
Not knowing that the issue with the original files
was the claims were there but the query code was set
incorrectly, we processed the special file through
our systems and loaded the data into our repositories.
This means we have the claims with the incorrect
query code and the same claims (from the special
file) with the correct query code.

This issue caused a problem for users who were trying
to create debit/credit pairs instead of using the
standard final action routine. OIS/EDG/DDOM ran
a subset of the problem claims through our final
action algorithm and it appears that the claim are
falling out correctly during SAF processing.

CORRECTIVE ACTION :
  Once the original issue was brought to our attention in
  May, we notified CWF of the "missing" cancel claims. CWF
  put in an emergency fix on May 8th to correct the
  problem going forward. They also ran a utility to create
  the "special" file of the cancel claims and sent the file
  to the NCH on Saturday, May 12th. The special file pro-
  cessed through the NCH with the May data load.

  As for the 2nd data user notification in November 2012, we
  notified CWF of the miscommunication of the exact problem
  with the original data. It was determined that CWF could
  unable to create adjustments to back out the incorrect

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                        claims sent in the original files.  CWF no longer had
                        the special file they created, so they had no way of
                        identifying the claims that needed to be adjusted.
                        It was determined that users who were doing debit/credit
                        pairing instead of using the NCH SAFs could remove the
                        incorrect claims by using the following criteria:

                        Pull any claims with an NCH Weekly Process Date of April
                        6th, April 13, April 20th, April 27th, May 4th, May 11th
                        or May 18th that has an Action Code of 4 or 6 and Claim
                        Query Codes of '1', '3' or '5'.
                      SOURCE:
                      ADMINISTRATIVE DATA:
                        START DATE       : 04/02/2012
                        END DATE         : 05/08/2012
                        CONTACT          :  OIS/EDG/DDOM

HHA_HCPCS_LIM
                      FULL NAME: Home Health HCPCS Limitation
                      DESCRIPTION :
                        It was determined that providers were not complying with
                        the 15-minute increment billing instructions for using
                        the 'G' HCPCS codes.
                      BACKGROUND     :
                        The instructions state that providers are to use the
                        newly created 'G' codes to identify services of the six
                        home health disciplines during an HH episode of care.
                        These 'G' codes (G0151, G0152, G0153, G0154, G0155,
                        G0156) are subject to 15-minute interval billing.  As
                        a result the user can not trust the 'G' codes for visit
                        counting.  For a more accurate accounting of services
                        the user should rely on the revenue center codes rather
                        than the HCPCS.

                        Currently there is a check that if the 15-minute incre-
                        ment 'G' codes appear, the revenue center code must be
                        the corresponding HH discipline; however, there is no
                        check to see if the discipline revenue center code
                        appears and that the HCPCS contains the corresponding
                        'G' code.
                      CORRECTIVE ACTION :
                        The Standard Systems has put a fix in to correct this
                        problem.
                      SOURCE:
                        CONTACT          :  OIS/EDG/DMUDD

IP_IME_GME_LIM
                      FULL NAME: Inpatient IME/GME Limitation
                      DESCRIPTION :
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                          Special payment records to reimburse teaching hos-
                          pitals for direct/indirect graduate medical educa-
                          tion costs (IME/GME payment records) were mistakenly
                          put into the NCH.
                        BACKGROUND     :
                          During the recovery from CWF history of NCH dropped
                          claims, we were unaware that the files contained
                          the IME/GME payment records.  Normally, these claims
                          are received in separate transmittals from the FFS
                          claims and full UB-92 encounters; and are not stored
                          in the NCH.  The total number of IME/GMEs inserted
                          was 181,693, representing $57.76 million in reim-
                          bursement; involving service years 1998 and 1999.

                          To identify these claims, look for service years
                          1998 and 1999 inpatient claims with claim related
                          condition codes 04 and 69.  Condition code '69' is
                          the identifying characteristic.

                          NOTE:  There could be identical full inpatient en-
                          counter claims in history that match to these
                          erroneous IME/GME records, except that they will
                          not contain a condition code '69'.  If the IME/GMEs
                          are not deleted, it is possible when running the
                          final action algorithm that the IME/GME record
                          will remain and the full inpatient encounter claim
                          could be dropped.
                        CORRECTIVE ACTION :
                          The IME/GME claims were not removed from the NCH,
                          due to the impact it would have on the balancing
                          counts. They were removed from the 1999 service
                          year SAFs.   The 1998 finalized SAFs were not
                          rerun to incorporate the relevant dropped claims
                          (only missing receipts for 6/18/99 and 6/25/99
                          weeks); the IME/GMEs are not in the 1998 SAFs.
                        SOURCE: NCH
                          CONTACT          :   OIS/EDG/DMUDD

MCO_PD_SW_LIM
                        FULL NAME: Claim MCO Paid Switch Limitation
                        DESCRIPTION :
                          The MCO paid switch made consistent with criteria
                          used to identify an inpatient encounter claim.
                        BACKGROUND     :
                          During the NCH Version 'I' conversion, history was
                          populated with an NCH Claim Type Code that will
                          identify the record as an inpatient encounter claim.
                          When applying the CWF logic to identify an inpatient
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                             encounter claim, it was discovered that when all
                             the criteria was met the MCO paid switch was some-
                             times a blank or '0' (reflecting that the MCO did
                             not pay the provider).
                           CORRECTIVE ACTION :
                             With the inception of the Version 'I' processing
                             (7/00), if all the criteria for identifying an
                             inpatient encounter claim is met but the MCO paid
                             switch is a blank or '0' it is changed to a '1'.

                             A patch code = '13' was applied to all claims back
                             to 7/1/97 service year thru date.
                           SOURCE:
                             CONTACT          :  OIS/EDG/DMUDD
MLTPL_REV_CNTR_0001_CD_LIM
                           FULL NAME: Multiple Revenue Center '0001' Code Limitation
                           DESCRIPTION :
                             Multiple total charge '0001' revenue center codes appearing
                             on outpatient, hospice and home health claim records.
                           BACKGROUND     :
                             On outpatient, home health and hospice it appears that
                             more than one '0001' revenue center code is showing
                             up on the claims.   The first total charge line adds
                             the revenue center codes above it correctly; the
                             problem exists below the first total charge line
                             where garbage may be present due to the FI Standard
                             System not clearing out fields before processing the
                             next claim.  We believe the error began with the change-
                             over to a different claims processing contractor in
                             1/98.
                           CORRECTIVE ACTION :
                             CWF created an edit to reject mulitple '0001' revenue
                             center codes, effective 6/28/99.  EDG's CWFMQA process
                             implemented an edit to drop any revenue center line
                             items below the first total charge line.  The NCH
                             Nearline File, as well as the 1998 Standard Analytic
                             Files (SAFs), have been patched/corrected to delete
                             the multiple '0001' codes where present on any of the
                             institutional claim types.  Also, HCIS will be cor-
                             recting the revenue center summaries during the next
                             refresh.

                             The NCH_PATCH_CD field will reflect a value '10'.
                           SOURCE:
                             CONTACT          :  OIS/EDG/DMUDD
NCH_CLM_TYPE_CD_LIM
                           FULL NAME: NCH Claim Type Code Limitation
```

DESCRIPTION :
  As of the implementation of Version 'J', the NCH claim
  type codes '62' and '64' were not correctly being set.
BACKGROUND   :
  With the implementation of Version'J', we added three
  new claim type codes ('62', '63' and '64') to identify
  Medicare Advantage claims.

  It appears that the conversion code we used to convert
  all of our history files (claims prior to start of Version
  'J') set the 62 and 64 correctly but that same code was not
  used in our normal monthly claims processing (claims
  received January 1, 2011 and after). The error was with
  the MCO-PD-SW logic used to derive the claim type code.
CORRECTIVE ACTION :
  This anamoly was handled in two phases:

  Phase 1 -- a fix was put into the NCH code to use
  the correct MCO-PD-SW logic. The fix was imple-
  mented prior to our October 2012 NCH monthly
  load. This fix corrected the claims received
  October 1st and forward.

  Phase 2 -- History files (January 1, 2011 thru
  September 28, 2012) were corrected during our
  NCH Version 'K' conversion, which was implemented
  April 2013.
SOURCE:
ADMINISTRATIVE DATA:
  START DATE   : 01/01/2011
  END DATE   : 10/01/2012

NCH_DAILY_PROC_DT_LIM

FULL NAME: NCH Daily Process Date Limitation
DESCRIPTION :
  The NCH Daily Process Date was mistakenly changed on
  all Version 'J' claims during the history conversion
  process.
BACKGROUND   :
  It was discovered during the process of modifying the
  conversion code used during Version 'J' processing that
  the NCH Daily Process Date was mistakenly changed in the
  Version 'J' conversion code. When preparing the specs for
  the Version 'J' conversion code, we were told to change the
  NCH Daily Process Date to reflect the date the history files
  were converted.

  This change impacts the linkage of Part A claims that have

multiple segments (claims with more than 45 revenue center
lines) on the Version 'J' claim files. The NCH Daily
Process Date is used in conjuction with the NCH Segment
Link Number to keep records/segments belonging to a
specific claim together.

There is the possibility that two different claims could
now have the same NCH Daily Process Date and NCH Segment
Link Number. This could cause users of the data to
match claim records/segments together that should not
be paired.   We believe the chances of this occurring to
be minimal.

CORRECTIVE ACTION :
  Because the Version 'I' files were converted and the
  date changed, we have no way of going back and retrieving
  the original NCH Daily Process Date so no fix/patch
  will be applied.
SOURCE:
  CONTACT   : OIS/EDG/DDOM

PMT_AMT_EXCEDG_CHRG_AMT_LIM

FULL NAME: Claim Payment Amount Exceeding Total Charge Amount Limitation
DESCRIPTION :
  Approximately 75 Inpatient claims had a reimbursement
  amount exceed $500,000 which was at least 25 times
  the total charge amount. There were also claims where
  the reimbursement was less than $500,000 but greater
  than the total charges.

  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.
SQL_INFO: NUMBER(11,2)
BACKGROUND   :
  In November of 1999, it was brought to the attention
  of the HDUG that large reimbursement amounts were
  being paid in Pennsylvania. There were 75 inpatient
  claims provided where the reimbursement amount was
  over $500,000 and at least 25 times the total charge
  amount. These claims were processed between 9/29/98
  and 10/1/98. There were also claims identified with
  reimbursement less than $500,000 but greater than

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                              total charge.  It was later discovered that the
                              source of the problem was an error in entering an
                              MSA; the decimal point was off by 2 positions.

                              Because there were no changes in utilization, the
                              claims were corrected and the correct payments dis-
                              tributed, but the new payment amounts were never
                              sent to CWF (not in NCH).  There is currently
                              no requirement that FIs and carriers update CWF with
                              final payment information by submitting payment only
                              adjustments. It was noted that there is no expectation
                              that CWF wll have final payment information for claims.
                            CORRECTIVE ACTION :
                              According to Veritus (FI), the problem was caught
                              in their system using a pre-payment edit prior to
                              sending out the payments.  The erroneous MSA value
                              was corrected and the claims were then sent to
                              PRICER again and paid correctly.

                              The claims were corrected and correct payments were
                              made but these new payment amounts were never sent
                              to CWF and are not reflected in the NCH.
                            SOURCE:
                              CONTACT          :  OIS/EDG/DMUDD
PPS_CPTL_DRG_WT_NUM_LIM

                            FULL NAME: Claim PPS Capital DRG Weight Number Limitation
                            DESCRIPTION :
                              Field erroneously blanked out on segments 2-10.
                            BACKGROUND     :
                              During the Version 'I' conversion of all service years
                              (1991-6/30/00) the following field was erroneously
                              blanked out on segments 2-10.

                              During the Version 'I' planning process, it was decided
                              that all codes, dates, numbers, names and percent fields
                              would be populated on all segments of a claim; but
                              amount, counts, and quantities would be zeroed out on
                              segments 2-10 to eliminate the risk of overstating values.
                            CORRECTIVE ACTION :
                              This data can not be recovered.
                            SOURCE:
                              CONTACT          :  OIS/EDG/DMUDD
PPS_CPTL_DSCHRG_FRCTN_PCT_LIM

                            FULL NAME: Claim PPS Capital Discharge Fraction Percent Limitation
                            DESCRIPTION :
                              Field erroneously blanked out on segments 2-10.
                            BACKGROUND     :
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                                     During the Version 'I' conversion of all service years
                                     (1991 through 6/30/00) the following field was erro-
                                     neously blanked out on segments 2-10.

                                     During the Version 'I' planning process, it was decided
                                     that all codes, dates, numbers, names and percent fields
                                     would be populated on all segments of a claim; but
                                     amount, counts, and quantities would be zeroed out on
                                     segments 2-10 to eliminate the risk of overstating values.
                                   CORRECTIVE ACTION :
                                     This data can not be recovered.
                                   SOURCE:
                                     CONTACT          :  OIS/EDG/DMUDD

REV_CNTR_IDE_NDC_UPC_LIM
                                   FULL NAME: Revenue Center IDE, NDC, UPC Limitation
                                   DESCRIPTION :
                                     Missing data in the REV_CNTR_IDE_NDC_UPC_NUM
                                     field.
                                   BACKGROUND     :
                                     Prior to Version 'I', this field housed only the 7-position
                                     exemption number assigned by the FDA to an investigational
                                     device after a manufacturer has been approved to conduct
                                     a clinical trial on that device.  With Version 'I', this
                                     field expanded to 24 positions to accommodate the future
                                     receipt of the National Drug Code and the Uniform Product
                                     Code.  The CWFMQA editing process was moving the IDE to
                                     the expanded field, but then incorrectly blanked it out
                                     (positions 8-24 should be blank).
                                   CORRECTIVE ACTION :
                                     CWFMQA fixed the code and the problem was corrected with
                                     claims processed with NCH weekly process date 9/15/00.
                                   SOURCE:
                                   ADMINISTRATIVE DATA:
                                     START DATE      : 06/09/00
                                     END DATE        : 09/08/00
                                     CONTACT         :  OIS/EDG/DMUDD

REV_CNTR_RNDRNG_SPCLTY_CD_LIM
                                   FULL NAME: Revenue Center Rendering Specialty Code Limitation
                                   DESCRIPTION :
                                     It was discovered that the specialty code at the line
                                     level on Outpatient claims was erroneous due to the
                                     truncation of the the revenue center rendering physician
                                     NPI number.
                                   BACKGROUND     :
                                     In March 2013, it was discovered that since January 2013
                                     FISS was sending CWF/NCH truncated revenue center ren-
                                     dering physician NPI numbers.  Because the NPI was being
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                      truncated this also caused erroneous data in the
                      specialty code field.  This issue only impacts outpatient
                      claims.

                      After further investigation, it was determined that the
                      correct outpatient copybook was not being used with the
                      implementation of the January release.
                    CORRECTIVE ACTION :
                      The fix for this anomaly is being handled in two phases:

                      Phase 1 -- a fix was put in the FISS system on 4/22/2013 to
                      correct the issue going forward.

                      Phase 2 -- the second fix will be to send debit/credit
                      adjustmentss to correct the data in the NCH/SAF.
                    SOURCE:
                    ADMINISTRATIVE DATA:
                      START DATE       : 01/01/2013
                      END DATE         : 04/22/2013
                      CONTACT          :  OIS/EDG/DDOM

REV_CNTR_TOT_CHRG_AMT_LIM

                    FULL NAME: Revenue Center Total Charge Amount Limitation
                    DESCRIPTION :
                      Revenue center total charge amount field being
                      populated on segments 2-10 of the Version 'I'
                      record.
                    BACKGROUND     :
                      Under Version 'I', a decision was made that any
                      amount, count and quantity field would be zeroed
                      out to eliminate the risk of overstating values
                      during an accumulation.
                    CORRECTIVE ACTION :
                      The CWFMQA front-end process was modified to zero
                      out the total charge amount field in segments 2-10.
                    SOURCE:
                    ADMINISTRATIVE DATA:
                      START DATE       : 07/01/00
                      END DATE         : 02/02/01
                      CONTACT          :  OIS/EDG/DMUDD

REV_RNDRNG_PHYSN_NPI_NUM_LIM

                    FULL NAME: Revenue Center Rendering Physician NPI Number Limitation
                    DESCRIPTION :
                      It was discovered that the NPI at the line level on
                      Outpatient claims was being truncated since January
                      2013.
                    BACKGROUND     :
                      In March 2013, it was discovered that since January 2013
```

FISS was sending CWF/NCH truncated revenue center ren-
dering physician NPI numbers (REV-CNTR-RNDRNG-PHYSN-NPI-
NUM). The NPIs were coming in as 8 bytes instead of 10
bytes. Because the NPI is truncated it is also causing
erroneous data in the specialty code (REV-CNTR-RNDRNG-
SPCLTY-CD) field. The issue only impacts outpatient
claims.

After further investigation, it was determined that the
correct outpatient copybook was not being used with the
implementation of the January release.
CORRECTIVE ACTION :
The fix for this anamoly is being handled in two phases:

Phase 1 -- a fix was put in the FISS system on 4/22/13 to
correct the issue going forward.

Phase 2 -- A second fix will be to send in debit/credit
adjustments to correct the data in the NCH/SAF.
SOURCE:
ADMINISTRATIVE DATA:
START DATE   : 01/01/2013
END DATE   : 04/22/2013
CONTACT   : OIS/EDG/DDOM

TOT_CHRG_AMT_LIM

FULL NAME: Claim Total Charge Amount Limitation
DESCRIPTION :
The total charge amount field in the fixed portion was
truncated on outpatient, hospice and home health claims.
BACKGROUND   :
For outpatient, hospice and home health claims, the
total charge amount field in the fixed portion was
truncated (the cents were dropped off; the decimal
point was moved, making cents out of dollars) in the
CWFMQA process beginning with data received from CWF
1/4/99 through 5/14/99. The problem occurred when
CWF increased the size of the field.
CORRECTIVE ACTION :
The CWFMQA front-end was fixed. The Nearline was patched
during the quarterly merge in 7/99 for service years
1998 and 1999. The NCH_PACTCH_CD field will be pop-
ulated with a value '11'. The 1998 and 1999 SAFs were
corrected when finalized in 7/99.

The patch involved moving the total charge amount in
the revenue center trailer to the total charge amount
field in the fixed portion, for records with NCH Daily

Process Date 1/4/99 - 5/14/99.
              SOURCE:
              ADMINISTRATIVE DATA:
                START DATE   : 01/04/99
                END DATE   : 05/14/99
                CONTACT   : OIS/EDG/DMUDD

                          QUERY: RIFQQ41 ON DB2T
          *******END OF LIMITATION APPENDIX FOR RECORD: FI_IP_SNF_CLM_REC*******