1

FI HHA Claim Record -- 08/2002

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

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

5 DIGITS SIGNED

DB2 ALIAS: REC_LENGTH_CNT
SAS ALIAS: REC_LEN
STANDARD ALIAS: REC_LENGTH_CNT

SOURCE:
NCH

---

FI HHA Claim Record -- 08/2002

<p>| POSITIONS |
|---------------------------|----|------|---------|------------------------------------------------------------|</p>
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. NCH Near-Line Record</td>
<td>CHAR</td>
<td>1</td>
<td>54</td>
<td>54</td>
<td>The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored.</td>
</tr>
</tbody>
</table>

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

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

**COMMENT:**
Prior to Version H this field was named:
6. NCH Near Line Record Identification Code

CHAR  1  55  55  A code defining the type of claim record being processed.

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

CODES:
REFER TO: NCH_NEAR_LINE_RIC_TB
IN THE CODES APPENDIX

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

SOURCE:
NCH

7. NCH MQA RIC Code

CHAR  1  56  56  Effective with Version H, the code used (for internal editing purposes) to identify the record being processed through HCFA's CWFMQA system.

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

1

FI HHA Claim Record -- 08/2002

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

DB2 ALIAS: NCH_MQA_RIC_CD
SAS ALIAS: MQA_RIC
STANDARD ALIAS: NCH_MQA_RIC_CD
TITLE ALIAS: MQA_RIC
CODES:
1  =  Inpatient
2  =  SNF
3  =  Hospice
4  =  Outpatient
5  =  Home Health Agency
6  =  Physician/Supplier
7  =  Durable Medical Equipment

SOURCE:
NCH QA PROCESS

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

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

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

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

DERIVATION:
FFS CLAIM TYPE CODES DERIVED FROM:
  NCH_CLM_NEAR_LINE_RIC_CD
  NCH_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
INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(HDC processing -- AVAILABLE IN NMUD)
FI_NUM

<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Length</th>
<th>BEG</th>
<th>END</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>... inpatient encounter claims are not available in NCH or NMUD.</td>
</tr>
<tr>
<td>PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DERIVATION RULES:

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

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

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

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

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

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

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

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

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

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

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_TYPE_CD = '1'; CLM_FREQ_CD = '2'
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>WHERE THE FOLLOWING CONDITIONS ARE MET:</td>
</tr>
<tr>
<td>1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. HCPCS_CD not on DMEPOS table</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>WHERE THE FOLLOWING CONDITIONS ARE MET:</td>
</tr>
<tr>
<td>1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. CARR_NUM = 808882 AND</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. CLM_DEMO_ID_NUM = 38</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>WHERE THE FOLLOWING CONDITIONS ARE MET:</td>
</tr>
<tr>
<td>1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. HCPCS_CD not on DMEPOS table</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>WHERE THE FOLLOWING CONDITIONS ARE MET:</td>
</tr>
<tr>
<td>1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CODES:
REFER TO: NCH_CLM_TYPE_TB IN THE CODES APPENDIX

SOURCE:
NCH

**** Fiscal Intermediary Claim GROUP 125 59 183 Effective with Version 'I', this group
Link Group contains those fields necessary to keep records/segments together (a claim may have up to 10 records/segments due to the increase in number of revenue center trailers (up to 450). It is also used to house fields necessary for sorting and final action processing.

STANDARD ALIAS: FI_CLM_LINK_GRP

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

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

FI NHA Claim Record -- 08/2002

<table>
<thead>
<tr>
<th>POSITION</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td>Beneficiary Claim Account</td>
<td>CHAR</td>
<td>9</td>
<td>59</td>
<td>67</td>
<td>The number identifying the primary beneficiary under the SSA or RRB programs submitted.</td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>COMMON ALIAS: CAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>DA3 ALIAS: CLAIM_ACCOUNT_NUMBER</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: BENE_CLM_ACNT_NUM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: CAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: BENE_CLM_ACNT_NUM</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: CAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SOURCE: SSA, RRB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LIMITATIONS: RRB-issued numbers contain an overpunch in the first position that may appear as a plus zero or A-G. RRB-formatted numbers may cause matching problems on non-IBM machines.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>NCH Category Equatable</td>
<td>CHAR</td>
<td>2</td>
<td>68</td>
<td>69</td>
<td>The code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner.</td>
</tr>
<tr>
<td></td>
<td>Beneficiary Identification</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Code</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The equitable BIC module electronically matches two records that contain different BICs where it is apparent that both are records for the same beneficiary. It validates the BIC and returns a base BIC under which to house the record in the National Claims History (NCH) databases. (All records for a beneficiary are stored under a single BIC.)

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

CODES:
REFER TO: CTGRY_EQTBL_BENE_IDENT_TB
IN THE CODES APPENDIX

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

SOURCE:
BIC EQUATE MODULE

11. Beneficiary Identification Code

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

1

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<table>
<thead>
<tr>
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<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMON ALIAS:</td>
<td>BIC</td>
<td>DA3 ALIAS:</td>
<td>BENE_IDENT_CODE</td>
<td>DB2 ALIAS:</td>
<td>BENE_IDENT_CD</td>
</tr>
<tr>
<td>DB2 ALIAS:</td>
<td>BENE_IDENT_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOURCE:</td>
<td>BIC EQUATE MODULE</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>COMMON ALIAS:</th>
<th>BIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>STANDARD ALIAS:</td>
<td>BENE_IDENT_CD</td>
</tr>
<tr>
<td>Field Description</td>
<td>Type</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>NCH State Segment Code</td>
<td>CHAR</td>
</tr>
</tbody>
</table>

**EDIT-RULES:**

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

**CODES:**

Refer to: NCH_STATE_SGMT_TB in the Codes Appendix

**SOURCE:**

NCH
OPTIONAL: MAY BE BLANK

CODES:
REFER TO: GEO_SSA_STATE_TB
IN THE CODES APPENDIX

14. Claim From Date

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NUM</td>
<td>8</td>
<td>75</td>
<td>82</td>
<td></td>
</tr>
</tbody>
</table>

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

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD
15. Claim Through Date  

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

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

8 DIGITS UNSIGNED  

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

EDIT-RULES:  
YYYYMMDD

16. NCH Weekly Claim Processing Date  

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

8 DIGITS UNSIGNED  

DB2 ALIAS: NCH_WKLY_PROC_DT  
SAS ALIAS: WKLY_DT  
STANDARD ALIAS: NCH_WKLY_PROC_DT  
TITLE ALIAS: NCH_PROCESS_DT
17. CWF Claim Accretion Date   NUM   8   99  106 The date the claim record is accreted (posted/processed) to the beneficiary master record at the CWF host site and authorization for payment is returned to the fiscal intermediary or carrier.

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

SOURCE: NCH

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

SOURCE: CWF

1 FI HHA Claim Record -- 08/2002

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


```plaintext
1
FI HHA Claim Record -- 08/2002

<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
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<tbody>
<tr>
<td>SOURCE:</td>
<td></td>
<td>CWF</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>22. Provider Number</td>
<td></td>
<td>CHAR</td>
<td>6</td>
<td>156</td>
<td>161</td>
<td>The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.</td>
</tr>
</tbody>
</table>

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

CODES:
REFER TO: PRVDR_NUM_TB
IN THE CODES APPENDIX

SOURCE: OSCAR

23. NCH Daily Process Date | NUM | 8  | 162 | 169 | Effective with Version H, the date the claim record was processed by HCFA's CWFMQA system (used for internal editing purposes). |
```

**CODES:**
- 0 = Credit adjustment
- 1 = Interim bill
- 2 = Home Health Agency (HHA) benefits exhausted (obsolete 7/98)
- 3 = Final bill
- 4 = Discharge notice (obsolete 7/98)
- 5 = Debit adjustment
Effective with Version I, this date is used in conjunction with the NCH Segment Link Number to keep claims with multiple records/segments together.

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

SOURCE:
NCH

24. NCH Segment Link Number  PACK  5 170 174 Effective with Version 'I', the system generated number used in conjunction with the NCH daily process date to keep records/segments belonging to a specific claim together. This field was added to ensure that records/segments that come in on the same batch with the same identifying information in the link group are not mixed with each other.

1

FI HHA Claim Record -- 08/2002

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

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

9 DIGITS SIGNED
25. Claim Total Segment Count  NUM  2  175  176

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

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

2 DIGITS UNSIGNED

26. Claim Segment Number  NUM  2  177  178

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

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

2 DIGITS UNSIGNED

<table>
<thead>
<tr>
<th>POSITIONS</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DB2 ALIAS: CLM_SGMT_NUM</td>
<td>NUM</td>
<td>3</td>
<td>179</td>
<td>181</td>
<td>Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim.</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: SGMT_NUM</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: CLM_SGMT_NUM</td>
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</tr>
<tr>
<td></td>
<td>TITLE ALIAS: SEGMENT_NUMBER</td>
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<td></td>
<td>SOURCE: CWF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

27. Claim Total Line Count  NUM 3 179 181 Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim.

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

3 DIGITS UNSIGNED

<table>
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<tr>
<th>POSITIONS</th>
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<th>TYPE</th>
<th>LENGTH</th>
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<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DB2 ALIAS: TOT_LINE_CNT</td>
<td>NUM</td>
<td>2</td>
<td>182</td>
<td>183</td>
<td>Effective with Version I, the count used to identify the number of revenue center lines on a record/segment.</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: LINECNT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: CLM_TOT_LINE_CNT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: TOTAL_LINE_COUNT</td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td></td>
<td>SOURCE: CWF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). The maximum line count per record/segment is 45.

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

SOURCE:
CWF

**** FI Claim Common Group        GROUP   359   184  542 Information common to fiscal intermediary (FI) claims (inpatient/SNF, outpatient, HHA & hospice), for version I of NCH Nearline file.

STANDARD ALIAS: FI_CLM_CMN_GRP1
SOURCE: CWF

1

FI HHA Claim Record -- 08/2002

NAME              TYPE  LENGTH  BEG  END  CONTENTS
---------------------------  ----  ------  ---------  ------------------------------------------------------------
29. NCH Payment and Edit Record Identification Code  CHAR  1   184   184  The code used for payment and editing purposes that indicates the type of institutional claim record.

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

CODES:
C = Inpatient hospital, SNF
D = Outpatient
E = Religious Nonmedical Health Care Institutions (eff. 8/00 Christian Science, prior to 7/00
F = Home Health Agency (HHA)
G = Discharge notice
(obsoleted 7/98)
I - Hospice

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

SOURCE:
WCH QA Process

30. Claim Transaction Code     CHAR     1   185 185  The code derived by CWF to indicate the type of claim submitted by an institutional provider.

DB2 ALIAS: CLM_TRANS_CD
SAS ALIAS: TRANS_CD
STANDARD ALIAS: CLM_TRANS_CD
SYSTEM ALIAS: LTCLTRAN
TITLE ALIAS: TRANSACTION_CODE

CODES:
REFER TO: CLM_TRANS_TB
IN THE CODES APPENDIX

SOURCE:
CWF

**** Claim Bill Type Group     GROUP     2   186 187  Effective with Version H, the claim facility type code plus the claim service classification type code. (The first two positions of the '{type of bill}'. During the Version H conversion, this grouping was created throughout history.

STANDARD ALIAS: CLM_BILL_TYPE_CD_GRP
SYSTEM ALIAS: LTBILLCD

CODES:
REFER TO: CLM_BILL_TYPE_TB
IN THE CODES APPENDIX

1
FI NHA Claim Record -- 08/2002

POSITIONS
NAME       TYPE LENGTH BEG END CONTENTS
---------------------- ---- ------ -------- -------------------------------


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<th>No.</th>
<th>Field Name</th>
<th>Data Type</th>
<th>Precision</th>
<th>Scale</th>
<th>Description</th>
<th>Common Alias</th>
<th>DB2 Alias</th>
<th>SAS Alias</th>
<th>Standard Alias</th>
<th>Title Alias</th>
<th>Codes Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>Claim Facility Type Code</td>
<td>CHAR</td>
<td>1</td>
<td>186</td>
<td>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.</td>
<td>TOB1</td>
<td>CLM_FAC_TYPE_CD</td>
<td>FAC_TYPE</td>
<td>CLM_FAC_TYPE_CD</td>
<td>TOB1</td>
<td>CWF</td>
</tr>
<tr>
<td>32</td>
<td>Claim Service Classification Type Code</td>
<td>CHAR</td>
<td>1</td>
<td>187</td>
<td>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.</td>
<td>TOB2</td>
<td>SRVC_CLSFCTN_CD</td>
<td>TYPESRVC</td>
<td>CLM_SRVC_CLSFCTN_TYPE_CD</td>
<td>TOB2</td>
<td>CWF</td>
</tr>
<tr>
<td>33</td>
<td>Claim Frequency Code</td>
<td>CHAR</td>
<td>1</td>
<td>188</td>
<td>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.</td>
<td>TOB3</td>
<td>CLM_FREQ_CD</td>
<td>FREQ_CD</td>
<td>CLM_FREQ_CD</td>
<td>LTFREQ</td>
<td>CWF</td>
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</table>
### 34. FILLER

**Source:** CWF

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<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FI HHA Claim Record -- 08/2002</td>
<td>CHAR</td>
<td>1</td>
<td>189</td>
<td>189</td>
<td></td>
</tr>
</tbody>
</table>

### 35. NCH MQA Query Patch Code

*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  

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
</table>
| NCH MQA Query Patch Code | CHAR | 1 | 190 | 190 | Effectively 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.  

### 36. Claim Disposition Code

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

**Source:** NCH QA Process
37. NCH Edit Disposition Code  CHAR  2  193  194  

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

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

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

SOURCE:
NCH QA Process
38. NCH Claim BIC Modify H Code  CHAR  1  195 195  Effective with Version H, the code used (for internal editing purposes) to identify a claim record that was submitted with an incorrect HA, HB, or HC BIC.

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

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

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

SOURCE:
NCH QA Process


Standard County Code

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

EDIT-RULES:
OPTIONAL: MAY BE BLANK

SOURCE:
SSA/EDB

40. FI Claim Receipt Date  NUM  8  199 206  The date the fiscal intermediary received the institutional claim from the provider.

8 DIGITS UNSIGNED

1

FI HHA Claim Record -- 08/2002

POSITIONS
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
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<th>END</th>
<th>CONTENTS</th>
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<td>TITLE ALIAS: RECEIPT_DT</td>
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<td>SOURCE:</td>
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<td></td>
<td></td>
<td></td>
<td>CWF</td>
</tr>
</tbody>
</table>

41. FI Claim Scheduled Payment Date
The scheduled date of payment to the institutional provider, as reflected on the claim record transmitted to the CWF host. Note: This date is considered to be the date paid since no additional information as to the actual payment date is available. 

8 DIGITS UNSIGNED

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
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<td>DB2 ALIAS: FI_SCHLD_PMT_DT</td>
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<tr>
<td>SAS ALIAS: SCHLD_DT</td>
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<tr>
<td>STANDARD ALIAS: FI_CLM_SCHLD_PMT_DT</td>
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<tr>
<td>TITLE ALIAS: SCHEDULED_PMT_DT</td>
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</table>

42. CWF Forwarded Date
Effective with Version H, the date CWF forwarded the claim

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
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<td>STANDARD ALIAS: FI_CLM_SCHLD_PMT_DT</td>
<td></td>
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<tr>
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<td>COMMENT:</td>
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<td>Prior to Version H this field was named: FICARR_CLM_PMT_DT.</td>
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<td>CWF</td>
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</tbody>
</table>
record to HCFA (used for internal editing purposes).

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

FI HHA Claim Record -- 08/2002

<table>
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<tr>
<th>POSITION</th>
<th>NAME</th>
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<th>LENGTH</th>
<th>BEG</th>
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<tbody>
<tr>
<td>43.</td>
<td>FI Number</td>
<td>CHAR</td>
<td>5</td>
<td>223</td>
<td>227</td>
<td>The identification number assigned by HCFA to a fiscal intermediary authorized to process institutional claim records.</td>
</tr>
</tbody>
</table>

SOURCE:
CWF

DB2 ALIAS: FI_NUM
SAS ALIAS: FI_NUM
STANDARD ALIAS: FI_NUM
SYSTEM ALIAS: LTFI
TITLE ALIAS: INTERMEDIARY

CODES:
REFER TO: FI_NUM_TB
IN THE CODES APPENDIX

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

SOURCE:
44. CWF Claim Assigned Number  CHAR  8  228  235
Effective with Version H, the number assigned to an institutional claim record by CWF (used for internal editing purposes).

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

DB2 ALIAS: CWF_CLM_ASGN_NUM
SAS ALIAS: ASGN_NUM
STANDARD ALIAS: CWF_CLM_ASGN_NUM
TITLE ALIAS: ASSIGNED_NUM

SOURCE: CWF

45. CWF Transmission Batch Number  CHAR  4  236  239
Effective with Version H, the number assigned to each batch of claims transactions sent from CWF (used for internal editing purposes).

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

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

SOURCE: CWF

<p>| POSITIONS |
|-----------|---------|</p>
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 46. Beneficiary Mailing Contact  CHAR  9  240  248
The ZIP code of the mailing address where the
47. Beneficiary Sex Identification Code

**CHAR** 1 249 249

The sex of a beneficiary.

**COMMON ALIAS:** SEX_CD
**DA3 ALIAS:** SEX_CODE
**DB2 ALIAS:** BENE_SEX_IDENT_CD
**SAS ALIAS:** SEX
**STANDARD ALIAS:** BENE_SEX_IDENT_CD
**SYSTEM ALIAS:** LTSEX
**TITLE ALIAS:** SEX_CD

**EDIT-RULES:**
**REQUIRED FIELD**

**CODES:**
1 = Male
2 = Female
0 = Unknown

**SOURCE:**
SSA, RRB, EDB

48. Beneficiary Race Code

**CHAR** 1 250 250

The race of a beneficiary.

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

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

FI HHA Claim Record -- 08/2002

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOURCE: SSA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**49. Beneficiary Birth Date**  
NUM 8 251 258  
The beneficiary's date of birth.  
8 DIGITS UNSIGNED  
DB2 ALIAS: BENE_BIRTH_DT  
SAS ALIAS: BENE_DOB  
STANDARD ALIAS: BENE_BIRTH_DT  
TITLE ALIAS: BENE_BIRTH_DATE  
EDIT-RULES: YYYYMMDD  
SOURCE: CWF

**50. CWF Beneficiary Medicare Status Code**  
CHAR 2 259 260  
The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM_THRU_DT).  
COBOL ALIAS: MSC  
COMMON ALIAS: MSC  
DB2 ALIAS: BENE_MDCR_STUS_CD  
SAS ALIAS: MS_CD  
STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD  
SYSTEM ALIAS: LTMSC  
TITLE ALIAS: MSC  
DERIVATION:
CWF derives MSC from the following:
1. Date of Birth
2. Claim Through Date
3. Original/Current Reasons for entitlement
4. ESRD Indicator
5. Beneficiary Claim Number

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

<table>
<thead>
<tr>
<th>MSC</th>
<th>OASI</th>
<th>DIB</th>
<th>ESRD</th>
<th>AGE</th>
<th>BIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>YES</td>
<td>N/A</td>
<td>NO</td>
<td>65 and over</td>
<td>N/A</td>
</tr>
<tr>
<td>11</td>
<td>YES</td>
<td>N/A</td>
<td>YES</td>
<td>65 and over</td>
<td>N/A</td>
</tr>
<tr>
<td>20</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>under 65</td>
<td>N/A</td>
</tr>
<tr>
<td>21</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>under 65</td>
<td>N/A</td>
</tr>
<tr>
<td>31</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>any age</td>
<td>T.</td>
</tr>
</tbody>
</table>

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

SOURCE:
CWF

FI HHA Claim Record -- 08/2002

POSITIONS

51. Claim Patient 6 Position  CHAR  6  261 266
Surname

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

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

SOURCE:
CWF
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>53. Claim Patient First Initial Middle Name</td>
<td>CHAR</td>
<td>1</td>
<td>268</td>
<td>268</td>
<td>The first initial of the Medicare patient's middle name as reported by the provider on the claim.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

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

SOURCE: CWF

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>54. Beneficiary CWF Location Code</td>
<td>CHAR</td>
<td>1</td>
<td>269</td>
<td>269</td>
<td>The code that identifies the Common Working File (CWF) location (the host site) where a beneficiary's Medicare utilization records are maintained.</td>
</tr>
</tbody>
</table>

COMMON ALIAS: CWF_HOST  
DB2 ALIAS: BENE_CWF_LOC_CD  
SAS ALIAS: CWFLOC人参  
STANDARD ALIAS: BENE_CWF_LOC_CD  
SYSTEM ALIAS: LTCHFLC  
TITLE ALIAS: CWF_HOST  

CODES:
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>55. Claim Principal Diagnosis Code</td>
<td>CHAR</td>
<td>5</td>
<td>270</td>
<td>274</td>
<td>The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.</td>
</tr>
<tr>
<td>NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DB2 ALIAS: PRNCPAL_DGNS_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: PDGNS_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: PRINCIPAL_DIAGNOSIS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDIT-RULES: ICD-9-CM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOURCE: CWF</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>56. FILLER</td>
<td>CHAR</td>
<td>1</td>
<td>275</td>
<td>275</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>57. Claim Medicare Non Payment Reason Code</td>
<td>CHAR</td>
<td>1</td>
<td>276</td>
<td>276</td>
<td>The reason that no Medicare payment is made for services on an institutional claim.</td>
</tr>
</tbody>
</table>
NOTE: Effective with Version I, this field was put on all institutional claim types. Prior to Version I, this field was present only on inpatient/SNF claims.

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

EDIT-RULES:
OPTIONAL

CODES:
REFER TO: CLM_MDCR_NPMT_RSN_TB
IN THE CODES APPENDIX

SOURCE:
CWF

58. Claim Excepted/Nonexcepted Medical Treatment Code

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DB2 ALIAS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EXCPTD_NEXCPTD_CD</td>
<td>CHAR</td>
<td>1</td>
<td>277</td>
<td>277</td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRTMT_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLM_EXCPTD_NEXCPTD_TRTMT_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SYSTEM ALIAS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTNPMT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EXCPTD_NEXCPTD_CD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CODES:
0 = No Entry
Claim Payment Amount

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 presented e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)

Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). It does NOT include the pass thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement.

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

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

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

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

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

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

For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

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

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

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

9.2 DIGITS SIGNED

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

EDIT-RULES:
$\text{CC}$

FI HHA Claim Record -- 08/2002

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

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

SOURCE:
CWF

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

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

9.2 DIGITS SIGNED
DB2 ALIAS: PRMRY_PYR_PD_AMT
SAS ALIAS: PRPAYAMT
STANDARD ALIAS: NCH_PRMRY_PYR_CLM_PD_AMT
TITLE ALIAS: PRIMARY_PAYER_AMOUNT
EDIT-RULES:
$$$$$$$$$CC
COMMENT:
Prior to Version H this field was named:
BENE_PRMRY_PYR_CLM_PMT_AMT and the field size
was S9(7)V99.

SOURCE:
NCH

61. NCH Primary Payer Code
CHAR 1 290 290
The code, on an institutional claim, specifying a federal
non-Medicare program or other source that has primary
responsibility for the payment of the Medicare beneficiary's
health insurance bills.

DB2 ALIAS: NCH_PRMRY_PYR_CD
SAS ALIAS: PRPAY_CD
STANDARD ALIAS: NCH_PRMRY_PYR_CD
TITLE ALIAS: PRIMARY_PAYER_CD
DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES

SET NCH_PRMRY_PYR_CD TO 'A' WHERE THE CLM_VAL_CD = '12'

SET NCH_PRMRY_PYR_CD TO 'B' WHERE THE CLM_VAL_CD = '13'

SET NCH_PRMRY_PYR_CD TO 'C' WHERE THE CLM_VAL_CD = '16' and CLM_VAL_AMT is zeroes

SET NCH_PRMRY_PYR_CD TO 'D' WHERE THE CLM_VAL_CD = '14'

SET NCH_PRMRY_PYR_CD TO 'E' WHERE THE CLM_VAL_CD = '15'

SET NCH_PRMRY_PYR_CD TO 'F' WHERE THE CLM_VAL_CD = '16' (CLM_VAL_AMT not equal to zeroes)

SET NCH_PRMRY_PYR_CD TO 'G' WHERE THE CLM_VAL_CD = '43'

SET NCH_PRMRY_PYR_CD TO 'H' WHERE THE CLM_VAL_CD = '41'

SET NCH_PRMRY_PYR_CD TO 'I' WHERE THE CLM_VAL_CD = '42'

SET NCH_PRMRY_PYR_CD TO 'L' (or prior to 4/97 set code to 'J') WHERE THE CLM_VAL_CD = '47'

CODES:
REFER TO: BENE_PRMRY_PYR_TB
            IN THE CODES APPENDIX
**FIELD: 62. FI Requested Claim Cancel**

**NAME:** Reason Code

**CHAR**

**LENGTH:** 1

**BEG:** 291

**END:** 291

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

<table>
<thead>
<tr>
<th>POSITIONS</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
<td>TYPE</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>DB2 ALIAS: RQST_CNCL_RSN_CD</td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: CANCELCNL</td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: FI_RQST_CLM_CNCL_RSN_CD</td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: CANCEL_CD</td>
<td></td>
</tr>
</tbody>
</table>

**CODES:**

REFER TO: FI_RQST_CLM_CNCL_RSN_TB

IN THE CODES APPENDIX

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

**SOURCE:** CWF

---

**FIELD: 63. FI Claim Action Code**

**CHAR**

**LENGTH:** 1

**BEG:** 292

**END:** 292

The type of action requested by the intermediary to be taken on an institutional claim.

<table>
<thead>
<tr>
<th>POSITIONS</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
<td>TYPE</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>DB2 ALIAS: FI_CLM_ACTN_CD</td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: ACTIONCD</td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: FI_CLM_ACTN_CD</td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: ACTION_CD</td>
<td></td>
</tr>
</tbody>
</table>

**CODES:**

REFER TO: FI_CLM_ACTN_TB

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

**SOURCE:** NCH
### 64. FI Claim Process Date

**NUM 8 293 300**

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

- **8 DIGITS UNSIGNED**
- **DB2 ALIAS:** FI_CLM_PROC_DT
- **SAS ALIAS:** APRVL_DT
- **STANDARD ALIAS:** FI_CLM_PROC_DT
- **TITLE ALIAS:** FI_PROCESS_DT

**SOURCE:** CWF

**EDIT-RULES:** YYYYMMDD

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

### 65. NCH Provider State Code

**CHAR 2 301 302**

Effective with Version H, the two position SSA state code where provider facility is located.

**SOURCE:** CWF

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

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

DERIVATION RULES:

SET NCH_PRVDR_STATE_CD TO PRVDR_NUM POS1-2.
FOR PRVDR_NUM POS1-2 EQUAL '55'
  SET NCH_PRVDR_STATE_CD TO '05'.
FOR PRVDR_NUM POS1-2 EQUAL '65'
  SET NCH_PRVDR_STATE_CD TO '65'.
FOR PRVDR_NUM POS1-2 EQUAL '68'
  SET NCH_PRVDR_STATE_CD TO '10'.

CODES:
REFER TO: GEO_SSA_STATE_TB IN THE CODES APPENDIX

SOURCE:
NCH

66. Organization NPI Number  CHAR  10  303  312 A placeholder field (effective with Version H) for storing
the NPI assigned to the institutional provider.
DB2 ALIAS: ORG_NPI_NUM
SAS ALIAS: ORGNFINM
STANDARD ALIAS: ORG_NPI_NUM
TITLE ALIAS: ORG_NPI
SOURCE:
NCH

**** Attending Physician ID GROUP 24 313 336 Name and identification numbers associated
Group with the primary care physician.
STANDARD ALIAS: ATNDG_PHYSN_ID_GRP

67. Claim Attending Physician UPIN Number CHAR 6 313 318 On an institutional claim, the unique physician
identification number (UPIN) of the physician
who would normally be expected to certify and
recertify the medical necessity of the services
rendered and/or who has primary responsibility for the beneficiary's medical care and treatment (attending physician).

### Positions

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
<th>POSITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMON ALIAS: ATTENDING_PHYSICIAN_UPIN</td>
<td>CHAR</td>
<td>10</td>
<td>319</td>
<td>328</td>
<td>A placeholder field (effective with Version H) for storing the NPI assigned to the attending physician.</td>
<td></td>
</tr>
<tr>
<td>DB2 ALIAS: ATNDG_UPIN</td>
<td>STANDARD ALIAS: CLM_ATNDG_PHYSN_UPIN_NUM</td>
<td>TITLE ALIAS: ATTENDING_PHYSICIAN</td>
<td>COMMENT: Prior to Version H this field was named: CLM_PRMRY_CARE_PHYSN_IDENT_NUM and contained 10 positions (6-position UPIN and 4-position physician surname).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOURCE: CWF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>68. Claim Attending Physician NPI Number</td>
<td>CHAR</td>
<td>6</td>
<td>329</td>
<td>334</td>
<td>Effective with Version H, the last name of the attending physician (used for internal editing purpose in HCFA's CWFMQA system.)</td>
<td></td>
</tr>
<tr>
<td>COMMON ALIAS: ATTENDING_PHYSICIAN_NPI</td>
<td>DB2 ALIAS: ATNDG_NPI</td>
<td>STANDARD ALIAS: CLM_ATNDG_PHYSN_NPI_NUM</td>
<td>TITLE ALIAS: ATNDG_NPI</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>SOURCE: CWF</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>69. Claim Attending Physician Surname</td>
<td>CHAR</td>
<td>10</td>
<td>319</td>
<td>328</td>
<td>A placeholder field (effective with Version H) for storing the NPI assigned to the attending physician.</td>
<td></td>
</tr>
<tr>
<td>COMMON ALIAS: ATTENDING_PHYSICIAN_NPI</td>
<td>DB2 ALIAS: ATNDG_NPI</td>
<td>STANDARD ALIAS: CLM_ATNDG_PHYSN_NPI_NUM</td>
<td>TITLE ALIAS: ATNDG_NPI</td>
<td></td>
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<tr>
<td>SOURCE: CWF</td>
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</tr>
</tbody>
</table>
10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS: ATNDG_SRNM
SAS ALIAS: AT_SRNM
STANDARD ALIAS: CLM_ATNDG_PHYSN_SRNM_NAME
TITLE ALIAS: ANDG_PHYSN_SURNAME

SOURCE: CWF

70. Claim Attending Physician

Given Name

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DB2 ALIAS: ATNDG_GVN_NAME</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: AT_GVNNM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: CLM_ATNDG_PHYSN_GVN_NAME</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: ATNDG_PHYSN_FIRSTNAME</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

SOURCE: CWF

71. Claim Attending Physician

Middle Initial Name

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DB2 ALIAS: ATNDG_GVN_NAME</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: AT_GVNNM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: CLM_ATNDG_PHYSN_GVN_NAME</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: ATNDG_PHYSN_FIRSTNAME</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SOURCE: CWF
**** Operating Physician ID Group

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

STANDARD ALIAS: OPRTG_PHYSN_ID_GRP

72. Claim Operating Physician UPIN Number CHAR 6 337 342

On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgical procedure.

DB2 ALIAS: OPRTG_UPIN
SAS ALIAS: OP_UPIN
STANDARD ALIAS: CLM_OPRTG_PHYSN_UPIN_NUM
TITLE ALIAS: OPRTG_UPIN

COMMENT:
Prior to Version H this field was named: CLM_PRINCIPAL_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.
73. Claim Operating Physician NPI Number

A placeholder field (effective with Version H) for storing the NPI assigned to the operating physician.

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

SOURCE: CWF

74. Claim Operating Physician Surname

Effective with Version H, the last name of the operating physician (used for internal editing purposes in HCFA's CWFMQA system.)

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

DB2 ALIAS: OPRTG_SRNM
SAS ALIAS: OP_SRNM
STANDARD ALIAS: CLM_OPRTG_PHYSN_SRNM_NAME
TITLE ALIAS: OPRTG_PHYSN_SURNAME

SOURCE: CWF

75. Claim Operating Physician Given Name

Effective with Version H, the first name of the operating physician (used for internal editing purposes in HCFA's CWFMQA system.)

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

DB2 ALIAS: OPRTG_GVN_NAME
SAS ALIAS: OP_GVN
STANDARD ALIAS: CLM_OPRTG_PHYSN_GVN_NAME
TITLE ALIAS: OPRTG_PHYSN_FIRSTNAME

SOURCE: CWF

** 76. Claim Operating Physician  Middle Initial Name  CHAR  1  360  360**

Effective with Version H, the middle initial of the operating physician (used for internal editing purposes in HCFA's CWFMQA system.)

```
NAME  TYPE  LENGTH  BEG  END  CONTENTS
-----------------------------------------------
NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS: OPRTG_MI_NAME
SAS ALIAS: OP_MDL
STANDARD ALIAS: CLM_OPRTG_PHYSN_MDL_INITL_NAME
TITLE ALIAS: OPRTG_PHYSN_MI

SOURCE: CWF
```

** 77. Claim Other Physician UPIN  Number  CHAR  6  361  366**

On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim.

```
DB2 ALIAS: OTHR_UPIN
SAS ALIAS: OT_UPIN
STANDARD ALIAS: CLM_OTHR_PHYSN_UPIN_NUM
```
TITLE ALIAS: OTH_PHYSN_UPIN

COMMENT:
Prior to Version H this field was named:
CLM_OTHR_PHYSN_IDENT_NUM and contained
10 positions (6-position UPIN and 4-position
other physician surname).

NOTE: For HHA and Hospice formats beginning
with NCH weekly process date 10/3/97 this field
was populated with data. HHA and Hospice claims
processed prior to 10/3/97 will contain spaces.

SOURCE: CWF

78. Claim Other Physician NPI Number
CHAR 10 367 376
A placeholder field (effective with Version H
for storing the NPI assigned to the other
physician.

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

SOURCE: CWF

79. Claim Other Physician Surname
CHAR 6 377 382
Effective with Version H, the last name of the
other physician (used for internal editing
purposes in HCFA's CWFMQA system.)

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

DB2 ALIAS: OTHR_SRNM
80. Claim Other Physician Given Name  

**CHAR** 1 383 383  

Effective with Version H, the first name of the other physician (used for internal editing purposes in HCFA's CWFMQA system.)

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

**SOURCE:** CWF

81. Claim Other Physician Middle Initial Name  

**CHAR** 1 384 384  

Effective with Version H, the middle initial of the other physician (used for internal editing purposes in HCFA's CWFMQA system.)

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

**SOURCE:** CWF
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
<th>DB2 ALIAS: MDCD_PRVDR_NUM</th>
<th>SAS ALIAS: MDCD_PRV</th>
<th>STANDARD ALIAS: MDCD_PRVDR_IDENT_NUM</th>
<th>TITLE ALIAS: MEDICAID_PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>82. Medicaid Provider</td>
<td>CHAR</td>
<td>13</td>
<td>385</td>
<td>397</td>
<td>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.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Identification Number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>COMMENT: Prior to Version H the field size was X(12).</td>
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<td></td>
<td>SOURCE: CWF</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>84. Claim MCO Paid Switch</td>
<td>CHAR</td>
<td>1</td>
<td>402</td>
<td>402</td>
<td>A switch indicating whether or not a Managed Care Organization (MCO) has paid the provider for an institutional claim.</td>
<td>COBOL ALIAS: MCO_PD_IND</td>
<td></td>
<td>STANDARD ALIAS: CLM_MCO_PD_SW</td>
<td>TITLE ALIAS: MCO_PAID_SW</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>SOURCE: CWF</td>
<td>DB2 ALIAS: CLM_MCO_PD_SW</td>
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<td></td>
<td></td>
<td></td>
<td>SOURCE: CWF</td>
<td>SAS ALIAS: MCO_PDSW</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>SOURCE: CWF</td>
<td>STANDARD ALIAS: CLM_MCO_PD_SW</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1 = MCO has paid the provider for a claim  
Blank or 0 = MCO has not paid the provider for a claim  

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

SOURCE:  
CWF  

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

provider to the institutional claim to facilitate retrieval of individual case records and posting of payments.

DB2 ALIAS: PTNT_CNTL_NUM  
SAS ALIAS: PTNT_CNTL  
STANDARD ALIAS: PTNT_CNTL_NUM  
TITLE ALIAS: PATIENT_CONTROL_NUM  
SOURCE:  
CWF

<table>
<thead>
<tr>
<th>87. Claim Medical Record Number</th>
<th>CHAR</th>
<th>17</th>
<th>441 457</th>
<th>The number assigned by the provider to the beneficiary's medical record to assist in record retrieval.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOURCE:</td>
<td>CWF</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>88. Claim PRO Control Number</th>
<th>CHAR</th>
<th>12</th>
<th>458 469</th>
<th>Effective with Version G, the unique identifier assigned by the Peer Review Organization (PRO) for control purposes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOURCE:</td>
<td>CWF</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 89. Claim PRO Process Date     | NUM  | 8  | 470 477 | Effective with Version H, the date the claim was  
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SOURCE:</td>
<td>CWF</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
used in the PRO review process.

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

<table>
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<tr>
<th>Field Name</th>
<th>Type</th>
<th>Start</th>
<th>End</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90. Patient Discharge Status Code</td>
<td>CHAR</td>
<td>2</td>
<td>478 479</td>
<td>The code used to identify the status of the patient as of the CLM_THRU_DT.</td>
</tr>
</tbody>
</table>

COMMON ALIAS: DISCHARGE_DESTINATION/PATIENT_STATUS
DB2 ALIAS: PTNT_DSCHRG_STUS
SAS ALIAS: STUS_CD
STANDARD ALIAS: PTNT_DSCHRG_STUS_CD
SYSTEM ALIAS: LTCLMST
TITLE ALIAS: PTNT_DSCHRG_STUS_CD

CODES:
REFER TO: PTNT_DSCHRG_STUS_TB
IN THE CODES APPENDIX

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

SOURCE:
CWF

91. Claim Diagnosis E Code | CHAR | 5 | 480 484 | Effective with Version H, the ICD-9-CM code used to identify the external cause of injury, poisoning, or other adverse affect. Redundantly
this field is also stored as the last occurrence of the diagnosis trailer.

1
Fi Hha Claim Record -- 08/2002

<table>
<thead>
<tr>
<th>POSITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
</tr>
<tr>
<td>TYPE</td>
</tr>
<tr>
<td>LENGTH</td>
</tr>
<tr>
<td>BEG</td>
</tr>
<tr>
<td>END</td>
</tr>
<tr>
<td>CONTENTS</td>
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<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>NOTE: During the Version H conversion, the data in the last occurrence of the diagnosis trailer was used to populate history.</td>
</tr>
<tr>
<td>DB2 ALIAS: CLM_DGNS_E_CD</td>
</tr>
<tr>
<td>SAS ALIAS: DGNS_E</td>
</tr>
<tr>
<td>STANDARD ALIAS: CLM_DGNS_E_CD</td>
</tr>
<tr>
<td>TITLE ALIAS: DGNS_E_CD</td>
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<tr>
<td>SOURCE: CWF</td>
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<table>
<thead>
<tr>
<th>92. Filler</th>
<th>CHAR</th>
<th>1 485 485</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>93. Claim PPS Indicator Code</th>
<th>CHAR</th>
<th>1 486 486</th>
</tr>
</thead>
</table>

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 populated with only the PPS indicator. Beginning with NCH weekly process date 6/5/98, this field was additionally populated with the deemed MQGE indicator. Claims processed prior to 10/3/97 will contain spaces.

| COBOL ALIAS: PPS_IND |
| DB2 ALIAS: CLM_PPS_IND_CD |
| SAS ALIAS: PPS_IND |
| STANDARD ALIAS: CLM_PPS_IND_CD |
| TITLE ALIAS: PPS_IND |
| CODES: |
94. Claim Total Charge Amount       PACK   6  487  492  Effective with Version G, the total charges for all services included on the institutional claim. This field is redundant with revenue center code 0001/total charges.

9.2 DIGITS SIGNED

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

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

FI HHA Claim Record -- 08/2002

95. FILLER                       CHAR    50  493  542

96. HHA NCH Edit Code Count      NUM    2  543  544  The count of the number of edit codes annotated to the HHA claim during the HCFA's CWFMQA process. The purpose of this count is to indicate how many claim edit trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: HHA_EDIT_CD_CNT
SAS ALIAS: HHEDCNT
STANDARD ALIAS: HHA_NCH_EDIT_CD_CNT
COMMENT:
Prior to Version H this field was named: CLM_EDIT_CD_CNT.

SOURCE:
NCH

97. HHA NCH Patch Code Count NUM 2 545 546
Effective with Version H, the count of the number of HCFA patch codes annotated to the home health claim during the Nearline maintenance process. The purpose of this count is to indicate how many NCH patch trailers are present.

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

NOTE2: Effective with Version 'I' the number of possible occurrences was reduced to 30. Prior to Version 'I' the number of possible occurrences was 99.

2 DIGITS UNSIGNED
DB2 ALIAS: HHA_PATCH_CD_CNT
SAS ALIAS: HHPATCNT
STANDARD ALIAS: HHA_NCH_PATCH_CD_I_CNT

SOURCE:
NCH

98. HHA MCO Period Count NUM 1 547 547
Effective with Version H, the count of the number of Managed Care Organization (MCO) periods reported on an home health agency claim. The purpose of this count is to indicate how many MCO period trailers are present.

SOURCE:
NCH

FI HHA Claim Record -- 08/2002

POSITIONS

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

CONTENTS

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

1 DIGIT UNSIGNED

DB2 ALIAS: HHA_MCO_PRD_CNT
SAS ALIAS: HHMCOCNT
STANDARD ALIAS: HHA_MCO_PRD_CNT

EDIT-RULES:
RANGE: 0 TO 2
SOURCE:
NCH

99. HHA Claim Health PlanID Count
NUM 1 548 548
A placeholder field (effective with Version H) for storing the count of the number of Health PlanIDs reported on the HHA claim. The purpose of this count is to indicate how many Health PlanID trailers are present. NOTE: Prior to Version 'I' this field was named: HHA_CLM_PAYERID_CNT.

1 DIGIT UNSIGNED

DB2 ALIAS: HHA_PLANID_CNT
SAS ALIAS: HHPLANNT
STANDARD ALIAS: HHA_CLM_HLTH_PLANID_CNT

EDIT-RULES:
RANGE: 0 TO 3
SOURCE:
NCH

100. HHA Claim Demonstration ID Count
NUM 1 549 549
Effective with Version H, the count of the number of claim demonstration IDs reported on an HHA claim. The purpose of this count is to indicate how many claim demonstration trailers are present.
NOTE: During the Version H conversion this field was populated with data where a demo was identifiable.

1 DIGIT UNSIGNED

DB2 ALIAS: HHA_DEMO_ID_CNT
SAS ALIAS: HHDEMCNT
STANDARD ALIAS: HHA_CLM_DEMO_ID_CNT

EDIT-RULES:
RANGE: 0 TO 5

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
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<tbody>
<tr>
<td>SOURCE: NCH</td>
<td></td>
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</tr>
</tbody>
</table>

101. HHA Claim Diagnosis Code Count

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

2 DIGITS UNSIGNED

DB2 ALIAS: HHA_DGNS_CD_CNT
SAS ALIAS: HHDGNCNT
STANDARD ALIAS: HHA_CLM_DGNS_CD_CNT

EDIT-RULES:
RANGE: 0 TO 10

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

SOURCE: NCH
### 102. FILLER

**CHAR** 2 552 553

### 103. HHA Claim Related Condition Code Count

**NUM** 2 554 555

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

2 DIGITS UNSIGNED

DB2 ALIAS: HHA_COND_CD_CNT  
SAS ALIAS: HHCONCNT  
STANDARD ALIAS: HHA_CLM_RLT_COND_CD_CNT

EDIT-RULES:  
RANGE: 0 TO 30

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

SOURCE:  
NCH

### 104. HHA Claim Related Occurrence Code Count

**NUM** 2 556 557

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

2 DIGITS UNSIGNED

DB2 ALIAS: HHA_RLT_OCRNC_CNT  
SAS ALIAS: HHOCRCNT  
STANDARD ALIAS: HHA_CLM_RLT_OCRNC_CD_CNT

EDIT-RULES:  
RANGE: 0 TO 30
105. HHA Claim Occurrence Span Code Count

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

2 DIGITS UNSIGNED

DB2 ALIAS: HHA_OCRNC_SPAN_CNT
SAS ALIAS: HHSPPCNT
STANDARD ALIAS: HHA_CLM_OCRNC_SPAN_CD_CNT

106. HHA Claim Value Code Count

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

2 DIGITS UNSIGNED

DB2 ALIAS: HHA_CLM_VAL_CD_CNT
SAS ALIAS: HHVACLNT
STANDARD ALIAS: HHA_CLM_VAL_CD_CNT

EDIT-RULES:
RANGE: 0 TO 36

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

SOURCE:
NCH
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>107. HHA Revenue Center Code</td>
<td>NUM</td>
<td>2</td>
<td>562</td>
<td>563</td>
<td>The count of the number of revenue codes reported on an HHA claim. The purpose of the count is to indicate how many revenue center trailers are present.</td>
</tr>
<tr>
<td></td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>2 DIGITS UNSIGNED</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DB2 ALIAS: HHA_REV_CNTR_CNT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SAS ALIAS: HHREVCNT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>STANDARD ALIAS: HHA_REV_CNTR_CD_I_CNT</td>
</tr>
<tr>
<td>EDIT-RULES:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RANGE: 0 TO 45</td>
</tr>
<tr>
<td>COMMENT:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prior to Version H this field was named: CLM_REV_CNTR_CD_CNT.</td>
</tr>
<tr>
<td>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.</td>
<td></td>
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</tr>
</tbody>
</table>

| 108. FILLER                        | CHAR | 4      | 564 | 567 |          |
|                                    |      |        |     |     |          |
| **** FI HHA Claim Specific Group   | GROUP| 52     | 568 | 619 | Data pertaining only to fiscal intermediary HHA claims. |
|                                    |      |        |     |     | STANDARD ALIAS: FI_HHA_CLM_SPECF_GRP |
| 109. Claim HHA Low Utilization     | CHAR | 1      | 568 | 568 | Effective with Version I, the code used |
Payment Adjustment (LUPA) Indicator Code  

to identify those Home Health PPS claims that have 4 visits or less in a 60-day episode. If an HHA provides 4 visits or less, they will be reimbursed based on a national standardized per visit rate instead of HHRGs.

NOTE: Beginning 10/1/00, this field will be populated with data. Claims processed prior to 10/1/00 will contain spaces.

DB2 ALIAS: HHA_LUPA_IND_CD  
SAS ALIAS: LUPAIND  
STANDARD ALIAS: CLM_HHA_LUPA_IND_CD  
TITLE ALIAS: HHA_TOT_VISITS  

CODES:
L = LUPA Claim  
blank = Not a LUPA claim

SOURCE:  
CWF

1  
FI HHA Claim Record -- 08/2002

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
</table>
| 110. Claim HHA Referral Code | CHAR | 1      | 569  | 569 | Effective with Version 'I', the code used to identify the means by which the beneficiary was referred for Home Health services.  

NOTE: Beginning 10/1/00, this field will be populated with data. Claims processed prior to 10/1/00 will contain spaces in this field.

DB2 ALIAS: CLM_HHA_RFRL_CD  
SAS ALIAS: HHA_RFRL  
STANDARD ALIAS: CLM_HHA_RFRL_CD  
SYSTEM ALIAS: LTHRFRL  
TITLE ALIAS: HHA_REFERRAL_CODE  

CODES:
Effective with Version H, the count of the number of HHA visits as derived by CWF.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991) using the CWF derivation rule (units associated with revenue center codes 042X, 043X, 044X, 055X, 056X, 057X, 058X and 059X. Value '999' will be displayed if the sum of the revenue center unit count equals or exceeds '999'.

NOTE2: Effective 7/1/99, all HHA claims received with service from dates 7/1/99 and after will be processed as if the units field contains the 15 minute interval count; and each visit revenue code line item will be counted as ONE visit. This field is calculated correctly; but those users who derive the count themselves they will have to revise their routine. NO LONGER IS THE COUNT DERIVED BY ADDING UP THE UNITS FIELDS ASSOCIATED WITH THE HHA VISIT REVENUE CODES.

3 DIGITS SIGNED

DB2 ALIAS: HHA_TOT_VISIT_CNT
SAS ALIAS: VISITCNT
STANDARD ALIAS: CLM_HHA_TOT_VISIT_CNT
TITLE ALIAS: HHA_TOT_VISITS

SOURCE:
CWF

<table>
<thead>
<tr>
<th>POSITION</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
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<tbody>
<tr>
<td>1</td>
<td>FI HHA Claim Record -- 08/2002</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
112. NCH Qualified Stay From Date 

Effective with Version H, the beginning date of the beneficiary's qualifying stay (used for internal CWFMQA editing purposes). For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization to benefits. For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission is other than 'A'.

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

8 DIGITS UNSIGNED

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

EDIT-RULES:

YYYYMMDD

DERIVATION:
DERIVED FROM:
  CLM_OCRNC_SPAN_CD
  CLM_OCRNC_SPAN_FROM_DT

DERIVATION RULES:
Based on the presence of occurrence code 70 move the related occurrence from date to NCH_QLFY_STAY_FROM_DT.

SOURCE:
NCH QA Process

113. NCH Qualify Stay Through Date 

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).

8 DIGITS UNSIGNED

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DB2 ALIAS: QLFY_STAY_THRU_DT</td>
<td>SAS ALIAS: QLFYTHRU</td>
<td>STANDARD ALIAS: NCH_QLFY_STAY_THRU_DT</td>
<td>TITLE ALIAS: QLFYG_STAY_THRU_DT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDIT-RULES:</td>
<td>YYMMDD</td>
<td>DERIVATION:</td>
<td>DERIVED FROM:</td>
<td>CLM_OCRNC_SPAN_CD CLM_OCRNC_SPAN_THRU_DT</td>
<td></td>
</tr>
<tr>
<td>DERIVATION RULES:</td>
<td>Based on the presence of occurrence code 70 move the related occurrence thru date to NCH_QLFY_STAY_THRU_DT.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOURCE:</td>
<td>NCH QA Process</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
EDI editing purposes.)

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

8 DIGITS UNSIGNED

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

EDIT-RULES: YYYYMMDD

DERIVATION:
DERIVED FROM:
   NCH_PTNT_STUS_IND_CD
   CLM_THRU_DT

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

SOURCE:
NCH QA Process

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>115. Claim HHA Care Start Date</td>
<td>NUM</td>
<td>8</td>
<td>596</td>
<td>603</td>
<td>Effective with Version H, the date care started for the HHA services reported on the institutional claim with a from date greater than 3/31/98. The Balanced Budget Act (BBA) required that this field be present on all HHA claims.</td>
</tr>
</tbody>
</table>

NOTE1: Beginning with NCH weekly process date 4/3/98, this field was populated with data.
Claims processed prior to 4/3/98 will contain zeroes in this field.

NOTE2: Effective with Version 'I', the start of care date will be moved from the 1st eight positions of the Claim Treatment Authorization Number. Prior to Version 'I' this date was moved from Occurrence Code 27 date field.

8 DIGITS UNSIGNED

DB2 ALIAS: HHA_CARE_STRT_DT
SAS ALIAS: HHSTRT_DT
STANDARD ALIAS: CLM_HHA_CARE_STRT_DT
TITLE ALIAS: HHA_CARE_START_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

116. FILLER

117. NCH Edit Trailer Indicator

Variable portion of the fiscal intermediary HHA claim record for version I of the NCH.

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

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).
CODES:
E = Edit code trailer present

SOURCE:
NCH QA Process

118. NCH Edit Code  CHAR  4
The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.

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

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

CODES:
REFER TO: NCH_EDIT_TB
IN THE CODES APPENDIX

SOURCE:
NCH QA EDIT PROCESS

**** NCH Patch Group  GROUP  11
OCCURS: UP TO 30 TIMES
DEPENDING ON HHA_NCH_PATCH_CD_I_CNT

STANDARD ALIAS: NCH_PATCH_GRP

119. NCH Patch Trailer Indicator  CHAR  1
Effective with Version H, the code indicating
the presence of an NCH patch trailer.

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

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

CODES:
P = Patch code trailer present

SOURCE:
NCH

120. NCH Patch Code

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CHAR</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

CODES:
REFER TO: NCH_PATCH_TB
IN THE CODES APPENDIX

SOURCE:
NCH
121. NCH Patch Applied Date     NUM 8  

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

SOURCE:
NCH

**** MCO Period Group     GROUP 37

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

OCCURS: UP TO 2 TIMES
DEPENDING ON HHA_MCO_PRD_CNT

STANDARD ALIAS: MCO_PRD_GRP

122. NCH MCO Trailer Indicator       CHAR 1

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

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

FI HHA Claim Record -- 08/2002

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<th>POSITIONS</th>
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<tbody>
<tr>
<td>NAME</td>
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<tr>
<td>--------------</td>
</tr>
</tbody>
</table>
CODES:
M = MCO trailer present

SOURCE:
NCH QA Process

123. MCO Contract Number  CHAR  5
Effective with Version H, this field represents the plan contract number of the Managed Care Organization (MCO).

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

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

SOURCE:
CWF

124. MCO Option Code  CHAR  1
Effective with Version H, the code indicating Managed Care Organization (MCO) lock-in enrollment status of the beneficiary.

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

DB2 ALIAS: MCO_OPTN_CD
SAS ALIAS: MCOOPTN
STANDARD ALIAS: MCO_OPTN_CD
TITLE ALIAS: MCO_OPTION_CD
CODES:
***** For lock-in beneficiaries****
A = HCFA to process all provider bills
B = MCO to process only in-plan
C = MCO to process all Part A and Part B bills

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

1
FI HHA Claim Record -- 08/2002

POSITIONS

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<th>TYPE</th>
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<tr>
<td>SOURCE:</td>
<td>CWF</td>
<td></td>
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</tbody>
</table>

125. MCO Period Effective Date  NUM  8

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

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

8 DIGITS UNSIGNED

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

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF
126. MCO Period Termination Date  NUM  8

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

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

8 DIGITS UNSIGNED
DB2 ALIAS: MCO_PRD_TRMNTN_DT
SAS ALIAS: MCO-caretmdt
STANDARD ALIAS: MCO_PRD_TRMNTN_DT
TITLE ALIAS: MCO_PERIOD_TERM_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

127. MCO Health PLANID Number  CHAR 14

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

1

FI HHA Claim Record -- 08/2002

<table>
<thead>
<tr>
<th>POSITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
</tr>
<tr>
<td>-----------</td>
</tr>
</tbody>
</table>

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

COMMENT:
Prior to Version I this field was named: MCO_PAYERID_NUM.
**** Claim Health PlanID Group

The number of Health PlanID data trailers is determined by the claim Health PlanID trailer count. Prior to Version 'I' this field was named: CLM_PAYERID_GRP.

OCCURS: UP TO 3 TIMES DEPENDING ON HHA_CLM_HLTH_PLANID_CNT

STANDARD ALIAS: CLM_HLTH_PLANID_GRP

128. NCH Health PlanID Trailer Indicator Code

A placeholder field (effective with Version H) for storing the code that indicates the presence of a Health PlanID trailer. NOTE: Prior to Version 'I' this field was named: NCH_PAYERID_TRLR_IND_CD.

DB2 ALIAS: PLANID_TRLR_CD
SAS ALIAS: PLANIDIN
STANDARD ALIAS: NCH_HLTH_PLANID_TRLR_IND_CD

CODES:
I = Health PlanID trailer present

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

SOURCE: NCH

129. Claim Health PlanID Code

A placeholder field (effective with Version H) for storing the code identifying the type of Health PlanID. Prior to Version 'I' this field was named: CLM_PAYERID_CD

DB2 ALIAS: CLM_PLANID_CD
SAS ALIAS: PLANIDCD
STANDARD ALIAS: CLM_HLTH_PLANID_CD
TITLE ALIAS: PLANID_TYPE
<table>
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<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
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<tr>
<td>124</td>
<td>CODES:</td>
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<td></td>
<td></td>
<td></td>
<td>CODES: Medicare Secondary Payer, Medicaid, Medigap, Supplemental Insurer, Managed Care Organization</td>
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<td></td>
<td>SOURCE:</td>
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<td></td>
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<td>CWF</td>
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<tr>
<td>130</td>
<td>Claim Health PlanID Number</td>
<td>CHAR</td>
<td>14</td>
<td></td>
<td></td>
<td>A placeholder field (effective with Version H) for storing the Health PlanID number. Prior to Version 'I' this field was named: CLM_PAYERID_NUM.</td>
</tr>
<tr>
<td></td>
<td>SOURCE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CWF</td>
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<tr>
<td></td>
<td>OCCURS: UP TO 5 TIMES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DEPENDING ON HHA_CLM_DEMO_ID_CNT</td>
</tr>
<tr>
<td>130</td>
<td>Claim Demonstration Identification Group</td>
<td>GROUP</td>
<td>18</td>
<td></td>
<td></td>
<td>The number of demonstration identification trailers present is determined by the claim demonstration identification trailer count.</td>
</tr>
<tr>
<td></td>
<td>SOURCE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CWF</td>
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<tr>
<td></td>
<td>OCCURS: UP TO 5 TIMES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DEPENDING ON HHA_CLM_DEMO_ID_CNT</td>
</tr>
</tbody>
</table>
STANDARD ALIAS: CLM_DEMO_ID_GRP

131. NCH Demonstration Trailer
    Indicator Code
    CHAR  1

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

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

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

CODES:
D = Demo trailer present

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-
priate 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

132. Claim Demonstration Identification Number
    CHAR  2

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

NOTE: Prior to Version H, Demo ID was stored in the
redefined Claim Edit Group, 4th occurrence, positions
3 and 4. During the H conversion, this field was
populated with data throughout history (as appro-
priate 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.

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

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

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

04 = United Mine Workers of America (UMWA) Managed Care Demo -- testing risk sharing for Part A services, paying special capitation rates for all UMWA beneficiaries residing in 13 designated counties in 3 states. Under the demo, UMWA will waive the 3-day qualifying hospital stay for a SNF admission. The claims contain TGB '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 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 #.

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').

<table>
<thead>
<tr>
<th>POSITIONS</th>
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<tbody>
<tr>
<td>NAME</td>
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</tbody>
</table>
| 06 = Coronary Artery Bypass Graft (CABG) Demo -- testing bundled payment (all-inclusive global pricing) for hospital + physician services related to CABG surgery in 7 hospitals in 7 states. The inpatient claims contain a DRG '106' or '107'.

NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit Date no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID '06' on the claim. The FI adds the ID to the claim based on the presence of DRG '106' or '107' from specific providers for specified time periods; the carrier adds the ID to the claim based on receiving 'Daily Census List' from participating hospitals. Demo ID '06' will end once Demo ID '07' is implemented.

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

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

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

1                            FI HHA Claim Record -- 08/2002

POSITIONS

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

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

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

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

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

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

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

<table>
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<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
</table>

1

FI NHA Claim Record -- 08/2002
37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries improve outcomes of care and reduce Medicare expenditures under Part A and Part B. There will be at least 9 Coordinated Care Entities (CCEs). The selected entities will be assigned a provider number specifically for the demonstration services.

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

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

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

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

NOTE: Effective October, 2000 for carrier claims.

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

133. Claim Demonstration CHAR 15 Effective with Version H, the text field that
Information Text contains related demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field.

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

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**DERIVATION:**

**DERIVATION RULES:**
- Demo ID = 01 (RUGS) -- the text field will contain a 2, 3 or 4 to denote the RUGS phase. If RUGS phase is blank or not one of the above the text field will reflect 'INVALID'. NOTE: In Version 'G', RUGS phase was stored in redefined Claim Edit Group, 3rd occurrence, 4th position.
- Demo ID = 02 (Home Health demo) -- the text field will contain PROV#. When demo number not equal to 02 then text will reflect 'INVALID'.
- Demo ID = 03 (Telemedicine demo) -- text field will contain the HCPCS code. If the required HCPCS is not shown then the text field will reflect 'INVALID'.
- Demo ID = 04 (UMWA) -- text field will contain W0 denoting that condition code W0 was present. If condition code W0 not present then the text field will reflect 'INVALID'.
Demo ID = 05 (CHOICES) -- the text field will contain the CHOICES plan number, if both of the following conditions are met: (1) CHOICES plan number present and PPS or Inpatient claim shows that 1st 3 positions of provider number as '210' and the admission date is within HMO effective/termination date; or non-PPS claim and the from date is within HMO effective/termination date and (2) CHOICES plan number matches the HMO plan number. If either condition is not met the text field will reflect 'INVALID CHOICES PLAN NUMBER'. When CHOICES plan number not present, text will reflect 'INVALID'.

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

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

1  
FI HHA Claim Record -- 08/2002

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<tr>
<th>POSITIONS</th>
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<td>NAME</td>
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</table>

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

SOURCE:
CWF

**** Claim Diagnosis Group    GROUP    7

The number of claim diagnosis trailers is determined by the claim diagnosis code count. The principal diagnosis is the first occurrence. The 'E' code (ICD-9-CM code for the external cause
of an injury, poisoning, or adverse affect) is stored as the last occurrence. The principal diagnosis and the 'E' code are also stored (redundantly) in the fixed portion of the record.

NOTE:
Prior to Version H this group was named: CLM_OTHR_DGNS_GRP and did not contain the CLM_PRNCPAL_DGNS_CD.

OCCURS: UP TO 10 TIMES DEPENDING ON HHA_CLM_DGNS_CD_CNT

STANDARD ALIAS: CLM_DGNS_GRP

134. NCH Diagnosis Trailer Indicator Code CHAR 1

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

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

DB2 ALIAS: DGNS_TRLR_IND_CD
SAS ALIAS: DGNSIND
STANDARD ALIAS: NCH_DGNS_TRLR_IND_CD

CODES:
Y = Diagnosis code trailer present

SOURCE:
NCH

135. Claim Diagnosis Code CHAR 5

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

SOURCE:
NCH

FI HHA Claim Record -- 08/2002

<table>
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<tr>
<th>POSITIONS</th>
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<tbody>
<tr>
<td>NAME</td>
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</table>


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

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

EDIT-RULES:
ICD-9-CM

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

136. FILLER
CHAR 1

**** Claim Related Condition Group

The number of claim related condition trailers is determined by the claim related condition code count. Effective 10/93, up to 30 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

OCCURS: UP TO 30 TIMES
DEPENDING ON HHA_CLM_RLT_COND_CD_CNT

STANDARD ALIAS: CLM_RLT_COND_GRP

137. NCH Condition Trailer Indicator Code
CHAR 1

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

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

DB2 ALIAS: COND_TRLR_IND_CD
SAS ALIAS: CONDIND
STANDARD ALIAS: NCH_COND_TRLR_IND_CD
### Codes

**C** = Condition code trailer present

**SOURCE:**

**NCH**

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<tr>
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<th>Begin</th>
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<th>Contents</th>
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<tbody>
<tr>
<td>138. Claim Related Condition</td>
<td>CHAR</td>
<td>2</td>
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<td></td>
<td>The code that indicates a condition relating to an institutional claim that may affect payer processing.</td>
</tr>
</tbody>
</table>

<table>
<thead>
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</tbody>
</table>

**Codes:**

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

**Codes:**

Refer To: CLM_RLT_COND_TB
In The Codes Appendix

**Source:**

**CWF**
Claim Related Occurrence Group

The number of claim related occurrence trailers is determined by the claim related occurrence code count. Effective 10/93, up to 30 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

OCCURS: UP TO 30 TIMES DEPENDING ON HHA_CLM_RLT_OCRNC_CD_CNT

STANDARD ALIAS: CLM_RLT_OCRNC_GRP

OCCURS: UP TO 30 TIMES DEPENDING ON HHA_CLM_RLT_OCRNC_CD_CNT

STANDARD ALIAS: CLM_RLT_OCRNC_GRP

139. NCH Occurrence Trailer Indicator Code

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

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

DB2 ALIAS: OCRNC_TRLR_IND_CD
SAS ALIAS: OCRNCIND
STANDARD ALIAS: NCH_OCRNC_TRLR_IND_CD

CODES:
O = Occurrence code trailer present

SOURCE:
NCH

1

FI HHA Claim Record -- 08/2002

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
141. Claim Related Occurrence  NUM  8
Date

The date associated with a significant event related to an institutional claim that may affect payer processing.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_RLT_OCRNC_DT
SAS ALIAS: OCRNCDT
STANDARD ALIAS: CLM_RLT_OCRNC_DT
TITLE ALIAS: RLT_OCRNC_DT

EDIT-RULES: YYYYMMDD

SOURCE: CWF

**** Claim Occurrence Span Group  GROUP  19

The number of claim occurrence span trailers is determined by the claim occurrence span code count. Up to 10 occurrences may be reported on an institutional claim.

OCCURS: UP TO 10 TIMES

DEPENDING ON HHA_CLM_OCRNC_SPAN_CD_CNTL

STANDARD ALIAS: CLM_OCRNC_SPAN_GRP
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<thead>
<tr>
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<td>142. NCH Span Trailer Indicator</td>
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<td>Effective with Version H, the code indicating the presence of a span code trailer.</td>
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<td>STANDARD ALIAS: NCH_SPAN_TRLR_IND_CD</td>
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<td>CODES:</td>
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<td>S = Span code trailer present</td>
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<td>SOURCE:</td>
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<td>NCH</td>
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<tr>
<td>143. Claim Occurrence Span Code</td>
<td>CHAR</td>
<td>2</td>
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<td>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).</td>
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<td>CWF</td>
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</tbody>
</table>

Refer to the CODES APPENDIX in the A8/A9 system manual for detailed information.
144. Claim Occurrence Span From
Date

The from date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.

8 DIGITS UNSIGNED

DB2 ALIAS: OCRNC_SPAN_FROM_DT
SAS ALIAS: SPANFROM
STANDARD ALIAS: CLM_OCRNC_SPAN_FROM_DT
TITLE ALIAS: SPAN_FROM_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

145. Claim Occurrence Span
Through Date

The thru date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.

8 DIGITS UNSIGNED

DB2 ALIAS: OCRNC_SPAN_THRU_DT
SAS ALIAS: SPANTHRU
STANDARD ALIAS: CLM_OCRNC_SPAN_THRU_DT
TITLE ALIAS: SPAN_THRU_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

**** Claim Value Group

The number of claim value data trailers present is
determined by the claim value code count. Effective 10/93, up to 36 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

**OCCURS: UP TO 36 TIMES DEPENDING ON HHA_CLM_VAL_CD_CNT**

**STANDARD ALIAS: CLM_VAL_GRP**

**CODES:**

V = Value code trailer present

**SOURCE:** NCH

146. **NCH Value Trailer Indicator** 

<table>
<thead>
<tr>
<th>CHAR</th>
<th>1</th>
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Effective with Version H, the code indicating the presence of a value code trailer.

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

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

**CODES:**

V = Value code trailer present

147. **Claim Value Code** 

| CHAR | 2 |

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

**DB2 ALIAS:** CLM_VAL_CD  
**SAS ALIAS:** VAL_CD  
**STANDARD ALIAS:** CLM_VAL_CD  
**SYSTEM ALIAS:** LVVALUE  
**TITLE ALIAS:** VALUE_CD

<table>
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<tr>
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<th>END</th>
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</table>

**CODES:**

...
REFER TO: CLM_VAL_TB
IN THE CODES APPENDIX

SOURCE:
CWF

148. Claim Value Amount           PACK      6
The amount related to the condition identified in the CLM_VAL_CD which was used by the intermediary to process the institutional claim.
9.2 DIGITS SIGNED
DB2 ALIAS: CLM_VAL_AMT
SAS ALIAS: VAL_AMT
STANDARD ALIAS: CLM_VAL_AMT
TITLE ALIAS: VALUE_AMOUNT
EDIT-RULES:
$$$$$$$$$CC
SOURCE:
CWF

**** Claim Revenue Center Group   GROUP 224
The number of claim revenue center data trailers is determined by the claim revenue center code count. Effective 7/7/00, up to 450 occurrences may be reported for an institutional claim. The increase in the number of revenue center lines causes each claim to be broken out into records/segments (up to 10). Each record can have up to 45 occurrences of revenue center lines. Prior to 7/7/00, up to 58 occurrences may be reported on an institutional claim. Claims submitted prior to 10/93, contained up to 28 occurrences.
OCCURS: UP TO 45 TIMES
    DEPENDING ON HHA_REV_CNTR_CD_I_CNT
STANDARD ALIAS: CLM_REV_CNTR_GRP
COMMENT:
****************** FOR SNF PPS ******************
The Balanced Budget Act modified how payment will be made for skilled nursing facility (SNF) services. Effective with cost reporting periods beginning on or after 7/1/98 (with all providers transitioning by 6/30/99, SNFs will be paid on a prospective payment system (PPS).

Payment for services under the OPPS system is calculated based on grouping outpatient services into ambulatory payment classifications (APC) groups.

SNFs will classify beneficiaries on the basis of residents' characteristics and resource needs, using the 44-group patient classification system known as Resource Utilization Groups (RUGS), Version III. Facilities will use information from the Minimum Data Set (MDS), Version 2.0, Resident Assessment Instrument (RAI) to classify residents into the RUG-III groups.

***************** FOR OUTPATIENT PPS ***************

The Balanced Budget Act modified how payment will be made for hospital outpatient services, certain PTB services furnished to inpatients who have no FTA coverage, CMHCs, and limited services provided by CORFs, Home Health Agencies or to hospice patients for the treatment of a non-terminal illness. Implementation for Outpatient PPS (OPPS) will be effective for claims with dates of service on or after July 1, 2000.

Payment for services under the OPPS system is calculated based on grouping outpatient services into ambulatory payment classifications (APC) groups.

***************** FOR HOME HEALTH PPS ***************

The Balanced Budget Act of 1997 mandated changes in payment and other provider requirements for home health. All home health agencies will be paid through a prospective payment system beginning October 1, 2000.
Under Home Health PPS (HH PPS) the unit of payment will be a 60-day episode. Home Health Resources Groups (HRGs), also called HRGs represented by HCFA HIPPS coding, will be the basis of payment for each episode; HRGs will be produced through publicly available Grouper software that will determine the appropriate HRG when results of comprehensive assessments of the beneficiary (made incorporating the OASIS data set) are input or grouped in this software.

149. NCH Revenue Center Trailer

Indicator Code

Effective with Version H, the code identifying the revenue center trailer.

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

DB2 ALIAS: REV_CNTR_TRLR_CD
SAS ALIAS: REVIND
STANDARD ALIAS: NCH_REV_CNTR_TRLR_IND_CD

CODES:
R = Revenue code trailer present

1

FI NHA Claim Record -- 08/2002

<table>
<thead>
<tr>
<th>POSITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOURCE: NCH</td>
</tr>
</tbody>
</table>

150. Revenue Center Code

The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology).

EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

COBOL ALIAS: REV_CD
DB2 ALIAS: REV_CNTR_CD
SAS ALIAS: REV_CNTR
STANDARD ALIAS: REV_CNTR_CD
SYSTEM ALIAS: LTRC
TITLE ALIAS: REVENUE_CENTER_CD

CODES:
   REFER TO: REV_CNTR_TB
   IN THE CODES APPENDIX

SOURCE:
CWF

151. Revenue Center Date

   Effective with Version H, the date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS.

NOTE1: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

NOTE2: When revenue center code equals '0022' (SNF PPS) and revenue center HCPCS code not equal to 'AAA00' (default for no assessment), date represents the MDS RAI assessment reference date.

NOTE3: When revenue center code equals '0023' (HHPPS), the date on the initial claim (RAP) must represent the first date of service in the episode. The final claim will match the '0023' information submitted on the initial claim. The SCIC (significant change in condition) claims may show additional '0023' revenue lines in which the date represents the date of the first service under the revised plan of treatment.

8 DIGITS UNSIGNED
<table>
<thead>
<tr>
<th>NAME</th>
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<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>152. Revenue Center 1st ANSI</td>
<td>CHAR</td>
<td>5</td>
<td></td>
<td></td>
<td>The first code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).</td>
</tr>
<tr>
<td>Code</td>
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<td>NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.</td>
</tr>
<tr>
<td>153. Revenue Center 2nd ANSI</td>
<td>CHAR</td>
<td>5</td>
<td></td>
<td></td>
<td>The second code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).</td>
</tr>
<tr>
<td>Code</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NOTE: Beginning with NCH weekly process date</td>
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7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

**DB2 ALIAS:** REV_CNTR_ANSI2_CD  
**SAS ALIAS:** REVANSI2  
**STANDARD ALIAS:** REV_CNTR_ANSI_2_CD  
**TITLE ALIAS:** ANSI_CD

**SOURCE:**  
CWF

### 154. Revenue Center 3rd ANSI  
<table>
<thead>
<tr>
<th>CHAR</th>
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</thead>
</table>

The third code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

**SOURCE:**  
CWF

### 155. Revenue Center 4th ANSI  
<table>
<thead>
<tr>
<th>CHAR</th>
<th>5</th>
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</thead>
</table>

The fourth code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

**SOURCE:**  
CWF
Effective with Outpatient PPS (OPPS), the Ambulatory Payment Classification (APC) code used to identify groupings of outpatient services. APC codes are used to calculate payment for services under OPPS.

Effective with Home Health PPS (HHPPS), this field will only be populated with a HIPPS code if the HIPPS code that is stored in the HCPCS field has been downcoded and the new code will be placed in this field.

NOTE1: Under SNF PPS and HHPPS, HIPPS codes are stored in the HCPCS field. **EXCEPTION: if a HHPPS HIPPS code is downcoded the downcoded HIPPS will be stored in this field.

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

CHAR 5

Revenue Center HCFA Common Code

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

DB2 ALIAS: REV_CNTR_HCPCS_CD
SAS ALIAS: HCPCS_CD
STANDARD ALIAS: REV_CNTR_HCPCS_CD
SYSTEM ALIAS: LTHIPPS
TITLE ALIAS: HCPCS_CD

CODES:
REFER TO: CLM_HIPPS_TB
IN THE CODES APPENDIX

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

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

The HIPPS code for Home Health PPS identifies

REV_CNTR_APC_TB
IN THE CODES APPENDIX

SOURCE:
CWF
The three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived.

The HHRGs, represented by the HIPPS coding, will be the basis of payment for each episode. For both SNF PPS & HH PPS HIPPS values see CLM_HIPPS_TB.

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

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

Level II
Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.
Level III
Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not represented in the level I or level II codes.

158. Revenue Center HCPCS Initial Modifier Code
CHAR 2
A first modifier to the procedure code to enable a more specific procedure identification for the claim.

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

EDIT-RULES:
Carrier Information File

159. Revenue Center HCPCS Second Modifier Code
CHAR 2
A second modifier to the procedure code to make it more specific than the first modifier code to identify the procedures performed on the beneficiary for the claim.

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

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.
161. Revenue Center HCPCS Fourth Modifier Code

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

DB2 ALIAS: REV_HCPCS_4TH_CD
SAS ALIAS: MDFR_CD4
STANDARD ALIAS: REV_CNTR_HCPCS_4TH_MDFR_CD
TITLE ALIAS: FOURTH_MODIFIER

EDIT-RULES:
CARRIER INFORMATION FILE

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

SOURCE:
CWF

162. Revenue Center HCPCS Fifth Modifier Code

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

DB2 ALIAS: REV_HCPCS_5TH_CD
SAS ALIAS: MDFR_CD5
STANDARD ALIAS: REV_CNTR_HCPCS_5TH_MDFR_CD
TITLE ALIAS: FIFTH_MODIFIER

EDIT-RULES:
CARRIER INFORMATION FILE

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

SOURCE:
CWF
### 163. Revenue Center Payment Method Indicator Code

**CHAR 2**

Effective with Version 'I', the code used to identify how the service is priced for payment. This field is made up of two pieces of data, 1st position being the service indicator and the 2nd position being the payment indicator.

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

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DB2 ALIAS: REV_PMT_MTHD_CD</td>
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</tr>
<tr>
<td>SAS ALIAS: PMT_MTHD</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: REV_CNTR_PMT_MTHD_IND_CD</td>
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<tr>
<td>SYSTEM ALIAS: LTPMTHD</td>
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<tr>
<td>TITLE ALIAS: PMT_MTHD</td>
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</tbody>
</table>

CODES:
- REFER TO: REV_CNTR_PMT_MTHD_IND_TB
- IN THE CODES APPENDIX

**SOURCE:**
CWF

### 164. Revenue Center Discount Indicator Code

**CHAR 1**

Effective with Version 'I', for all services subject to Outpatient PPS, this code represents a factor that specifies the amount of any APC discount. The discounting factor is applied to a line item with a service indicator (part of the REV_CNTR_PMT_MTHD_IND_CD) of 'T'. The flag is applicable when more than one significant procedure is performed. **"If there is no discounting the factor will be 1.0."**

NOTE1: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain
**CODES:**

*DISCOUNTING FORMULAS*
- **1** = 1.0
- **2** = \{1.0+D(U-1)\}/U
- **3** = T/U
- **4** = (1+D)/U
- **5** = D
- **6** = TD/U
- **7** = D(1+D)/U
- **8** = 2.0/U

**SOURCE:**

CWF

165. Revenue Center Packaging Indicator Code  

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
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<tr>
<td>FI HHA Claim Record -- 08/2002</td>
<td>CHAR</td>
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<td></td>
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</tr>
</tbody>
</table>

**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.
166. Revenue Center Pricing Indicator Code
CHAR 2

Effective with Version 'I', the code used to identify if there was a deviation from the standard method of calculating payment amount.

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

DB2 ALIAS: REV_PRICING_IND_CD
SAS ALIAS: PRICNG
STANDARD ALIAS: REV_CNTR_PRICNG_IND_CD
SYSTEM ALIAS: LTPRICNG
TITLE ALIAS: REV_CNTR_PRICNG_IND

CODES:
REFER TO: REV_CNTR_PRICNG_IND_TB IN THE CODES APPENDIX

SOURCE: CWF

167. Revenue Center Obligation to Accept As Full (OTAF) Payment Code
CHAR 1

Effective with Version 'I' the code used to indicate that the provider was obligated to accept as full payment the amount received from the primary (or secondary) payer.

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.
EDIT-RULES:
Y = provider is obligated to accept the payment as payment in full for the service.  
N or blank = provider is not obligated to accept the payment, or there is no payment by a prior payer.

SOURCE:
CWF

168. Revenue Center Obligation to Accept As Full (OTAF) Payment Code

SOURCE:
CWF

*******FIELD NOT POPULATED**************
This field was intended to collect information for two payers if Medicare was tertiary. It was discovered that MSP system only deals with one payer so there is no need to have 2 OTAF fields.

169. Revenue Center IDE, NDC, UPC Number

SOURCE:
CWF

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.

FI NHA Claim Record -- 08/2002

<table>
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<th>POSITIONS</th>
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</table>

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

SOURCE:
CWF
170. Revenue Center Unit Count  PACK  4

A quantitative measure (unit) of the number of times the service or procedure being reported was performed according to the revenue center/HCPCS code definition as described on an institutional claim.

Depending on type of service, units are measured by number of covered days in a particular accommodation, pints of blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests.

NOTE1: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code.

7 DIGITS SIGNED

DB2 ALIAS: REV_CNTR_UNIT_CNT
SAS ALIAS: REV_UNIT
STANDARD ALIAS: REV_CNTR_UNIT_CNT
TITLE ALIAS: UNITS

SOURCE:
CWF

171. Revenue Center Rate Amount  PACK  6

Charges relating to unit cost associated with the revenue center code. Exception (encounter data only): If plan (e.g. MCO) does not know the actual rate for the accommodations, $1 will be reported in the field.

NOTE1: For SNF PPS claims (when revenue center code equals '0022'), HCFA has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue
NOTE2: For OP PPS claims, HCFA has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index.

NOTE3: Under HH PPS (when revenue center code equals '0023'), HCFA has developed a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode.

On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment.

In cases of SCICs, there will be more than one '0023' revenue center code line, each representing the payment made at each case-mix level.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_CNTR_RATE_AMT
SAS ALIAS: REV_RATE
STANDARD ALIAS: REV_CNTR_RATE_AMT
TITLE ALIAS: CHARGE_PER_UNIT

EFFECTIVE-DATE: 10/01/1993

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

SOURCE:
CWF

172. Revenue Center Blood Deductible Amount PACK 6
Effective with Version 'I', the amount of money for which the intermediary determined the beneficiary is liable for the blood deductible
for the line item service.

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

<table>
<thead>
<tr>
<th>POSITIONS NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>173. Revenue Center Cash Deductible Amount</td>
<td>PACK</td>
<td>6</td>
<td></td>
<td></td>
<td>Effective with Version 'I' the amount of cash deductible the beneficiary paid for the line item service. NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_CASH_DDCTBL SAS ALIAS: REVDDCTBL STANDARD ALIAS: REV_CNTR_CASH_DDCTBL_AMT TITLE ALIAS: CASH_DDCTBL</td>
</tr>
<tr>
<td>174. Revenue Center</td>
<td>PACK</td>
<td>6</td>
<td></td>
<td></td>
<td>Effective with Version 'I', the amount of</td>
</tr>
</tbody>
</table>
Coinsurance/Wage Adjusted

Coinsurance Amount

coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted.

NOTE1: This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification.

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

9.2 DIGITS SIGNED

FI HHA Claim Record -- 08/2002

<table>
<thead>
<tr>
<th>NAME</th>
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<td>DB2 ALIAS: ADJSTD_COINSRNC</td>
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<td>SAS ALIAS: WAGEADJ</td>
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<td>STANDARD ALIAS: REV_CNTR_WAGE_ADJSTD_COINS_AMT</td>
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<td>TITLE ALIAS: WAGE_ADJSTD_COINS</td>
</tr>
</tbody>
</table>

SOURCE:
CWF

175. Revenue Center Reduced

Coinsurance Amount

PACK  6

Effective with Version 'I', for all services subject to Outpatient PPS, the amount of coinsurance applicable to the line for a particular service (HCPCS) for which the provider has elected to reduce the coinsurance amount.
NOTE1: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.

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

9.2 DIGITS SIGNED

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

SOURCE: CWF

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

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

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

9.2 DIGITS SIGNED

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

SOURCE: CWF
<table>
<thead>
<tr>
<th>Revenue Center</th>
<th>Revenue Center Professional</th>
<th>Revenue Center Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd Medicare</td>
<td>PACK 6</td>
<td>Provider</td>
</tr>
<tr>
<td>Secondary Payer Paid Amount</td>
<td></td>
<td>Payment Amount</td>
</tr>
<tr>
<td>Effective with Version 'I', the amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer). NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. 9.2 DIGITS SIGNED</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong><strong><strong>FIELD NOT POPULATED</strong></strong></strong>* Intended to be populated for line item services subject to PPS, as the amount associated with Value Code '05'. However, with line item date of service reporting, there is no way to correctly allocate professional component charges reported in value code '05' to specific line items on the claim. 9.2 DIGITS SIGNED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective with Version 'I', the amount paid to the provider for the services reported on the line item.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Source:

**CWF**

### 180. Revenue Center Beneficiary Payment Amount

<table>
<thead>
<tr>
<th>POSITION</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>180. Revenue Center Beneficiary Payment Amount</td>
<td>PACK</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Effective with Version I, the amount paid to the beneficiary for the services reported on the line item.**

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

**9.2 DIGITS SIGNED**

- **DB2 ALIAS:** REV_BENE_PMT_AMT
- **SAS ALIAS:** RBENEPMT
- **STANDARD ALIAS:** REV_CNTR_BENE_PMT_AMT
- **TITLE ALIAS:** REV_BENE_PMT

### 181. Revenue Center Patient Responsibility Payment

<table>
<thead>
<tr>
<th>POSITION</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>181. Revenue Center Patient Responsibility Payment</td>
<td>PACK</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Effective with Version I, the amount paid by the beneficiary to the provider for the**
line item service.

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

9.2 DIGITS SIGNED

DB2 ALIAS: REV_PTNT_RESP_AMT
SAS ALIAS: PTNRESP
STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT
TITLE ALIAS: REV_PTNT_RESP

SOURCE:
CWF

182. Revenue Center Payment Amount PACK 6

Effective with Version 'I', the line item Medicare payment amount for the specific revenue center.

Under OP PPS, PRICER will compute the standard OPPS payment for a line item based on the payment APC.

Under HH PPS, PRICER will compute/return a line item payment amount for the case-mixed, wage-index adjusted HIPPS code assigned to the '0023' revenue center line. The HIPPS code will be stored in the Revenue Center HCPCS code field.

1

FI HHA Claim Record -- 08/2002

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

9.2 DIGITS SIGNED

COMMON ALIAS: REIMBURSEMENT
DB2 ALIAS: REV_CNTR_PMT_AMT
SAS ALIAS: REV_PMT
STANDARD ALIAS: REV_CNTR_PMT_AMT
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, (i.e., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo).

(2) For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero.

(3) For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line.

(4) For Home Health PPS (final claim), when revenue center code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023').

(5) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be $1 (rate) times units (days).
<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>184. Revenue Center Non-Covered Charge Amount</td>
<td>PACK</td>
<td>6</td>
<td></td>
<td></td>
<td>The charge amount related to a revenue center code for services that are not covered by Medicare.</td>
</tr>
<tr>
<td>185. Revenue Center Deductible Coinsurance Code</td>
<td>CHAR</td>
<td>1</td>
<td></td>
<td></td>
<td>Code indicating whether the revenue center charges are subject to deductible and/or coinsurance.</td>
</tr>
</tbody>
</table>

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

**SOURCE:**
CWF
SAS ALIAS: REVDEDCD  
STANDARD ALIAS: REV_CNTR_DDCTBL_COINSRNC_CD  
TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD  

CODES:  
REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB  
IN THE CODES APPENDIX  

SOURCE:  
CWF  

<table>
<thead>
<tr>
<th>POSITIONS</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
<th>BEG</th>
<th>END</th>
<th>CONTENTS</th>
<th>-------------------------------</th>
<th>------</th>
<th>---------</th>
<th>--------------------------------------------------</th>
<th>---------------------------------</th>
</tr>
</thead>
<tbody>
<tr>
<td>186. FILLER</td>
<td>CHAR</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Effective with Version 'I', the code used to identify the end of a record/segment or the end of the claim.</td>
<td></td>
</tr>
</tbody>
</table>
| 187. End of Record Code | CHAR | 3   |        |     |     |          |                                 |        |           | DB2 ALIAS: END_REC_CD  
SAS ALIAS: EOR  
STANDARD ALIAS: END_REC_CD  
TITLE ALIAS: END_OF_REC |                                 |

Prior to Version I this field was named: END_REC_CNSTNT.  

SOURCE:  
NCH  

<table>
<thead>
<tr>
<th>POSITIONS</th>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
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<th>CONTENTS</th>
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<th>------</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>BENE_IDENT_TB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Beneficiary Identification Code (BIC) Table</td>
<td></td>
<td></td>
<td>Social Security Administration:</td>
<td></td>
</tr>
</tbody>
</table>
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)
B10 = Aged wife (4th claimant)
B11 = Aged wife (5th claimant)
B12 = Aged husband (3rd claimant)
B13 = Aged husband (4th claimant)
B14 = Aged husband (5th claimant)
B15 = Young wife (4th claimant)
B16 = Young wife (5th claimant)
B17 = Divorced wife (3rd claimant)
B18 = Divorced wife (4th claimant)
B19 = Divorced wife (5th claimant)
B20 = Divorced husband (1st claimant)
B21 = Divorced husband (2nd claimant)
B22 = Young husband (2nd claimant)
B23 = Young husband (1st claimant)
C1-C9, CA-CZ = Child (includes minor, student or disabled child)
D = Aged widow, 60 or over (1st claimant)
D1 = Aged widower, age 60 or over (1st claimant)
D2 = Aged widow (2nd claimant)
D3 = Aged widower (2nd claimant)
D4 = Widow (remarried after attainment of age 60) (1st claimant)
D5 = Widower (remarried after attainment of age 60) (1st claimant)
D6 = Surviving divorced wife, age 60 or over (1st claimant)
D7 = Surviving divorced wife (2nd claimant)
D8 = Aged widow (3rd claimant)
D9 = Remarried widow (2nd claimant)
DA = Remarried widow (3rd claimant)
DC = Surviving divorced husband (1st claimant)
DD = Aged widow (4th claimant)
DG = Aged widow (5th claimant)
DN = Remarried widow (2nd claimant)
DK = Aged widower (4th claimant)
DL = Remarried widow (5th claimant)
DM = Surviving divorced husband (2nd claimant)
DR = Remarried widower (4th claimant)
DP = Remarried widower (2nd claimant)
DQ = Remarried widower (3rd claimant)
DR = Remarried widower (4th claimant)
DS = Surviving divorced husband (3rd claimant)
DT = Remarried widower (5th claimant)
DV = Surviving divorced wife (3rd claimant)
DW = Surviving divorced wife (4th claimant)
DX = Surviving divorced husband (4th claimant)
DY = Surviving divorced wife (5th claimant)
DZ = Surviving divorced husband (5th claimant)
E = Mother (widow) (1st claimant)
E1 = Surviving divorced mother (1st claimant)
E2 = Mother (widow) (2nd claimant)
E3 = Surviving divorced mother (2nd claimant)
E4 = Father (widower) (1st claimant)
E5 = Surviving divorced father (widower) (1st claimant)
E6 = Father (widower) (2nd claimant)
E7 = Mother (widow) (3rd claimant)
E8 = Mother (widow) (4th claimant)
E9 = Surviving divorced father (widower)
(2nd claimant)
EA = Mother (widow) (5th claimant)
EB = Surviving divorced mother (3rd claimant)
EC = Surviving divorced mother (4th claimant)
ED = Surviving divorced mother (5th claimant)
EF = Father (widower) (3rd claimant)
EG = Father (widower) (4th claimant)
EH = Father (widower) (5th claimant)
EJ = Surviving divorced father (3rd claimant)
EK = Surviving divorced father (4th claimant)
EM = Surviving divorced father (5th claimant)
F1 = Father
F2 = Mother
F3 = Stepfather
F4 = Stepmother
F5 = Adopting father
F6 = Adopting mother
F7 = Second alleged father
F8 = Second alleged mother
J1 = Primary prouty entitled to HIB (less than 3 Q.C.) (general fund)
J2 = Primary prouty entitled to HIB (over 2 Q.C.) (RSI trust fund)
J3 = Primary prouty not entitled to HIB (less than 3 Q.C.) (general fund)
J4 = Primary prouty not entitled to HIB (over 2 Q.C.) (RSI trust fund)
K1 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)
K2 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)
K3 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)
K4 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)
K5 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)
K6 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)
K7 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)
K8 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)
K9 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)
KA = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)
KB = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)
KC = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)
KD = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (4th claimant)
KE = Prouty wife entitled to HIB (over 2 Q.C) (4th claimant)
KF = Prouty wife not entitled to HIB (less than 3 Q.C.) (4th claimant)
KG = Prouty wife not entitled to HIB (over 2 Q.C.) (4th claimant)
KH = Prouty wife entitled to HIB (less than 3 Q.C.) (5th claimant)
KJ = Prouty wife entitled to HIB (over 2 Q.C.) (5th claimant)
KL = Prouty wife not entitled to HIB (less than 3 Q.C.) (5th claimant)
KM = Prouty wife not entitled to HIB (over 2 Q.C.) (5th claimant)
M = Uninsured-not qualified for deemed HIB
M1 = Uninsured-qualified but refused HIB
T = Uninsured-entitled to HIB under deemed or renal provisions
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TA</td>
<td>MQGE (primary claimant)</td>
</tr>
<tr>
<td>TB</td>
<td>MQGE aged spouse (first claimant)</td>
</tr>
<tr>
<td>TC</td>
<td>MQGE disabled adult child (first claimant)</td>
</tr>
<tr>
<td>TD</td>
<td>MQGE aged widow(er) (first claimant)</td>
</tr>
<tr>
<td>TE</td>
<td>MQGE young widow(er) (first claimant)</td>
</tr>
<tr>
<td>TF</td>
<td>MQGE parent (male)</td>
</tr>
<tr>
<td>TG</td>
<td>MQGE aged spouse (second claimant)</td>
</tr>
<tr>
<td>TH</td>
<td>MQGE aged spouse (third claimant)</td>
</tr>
<tr>
<td>TJ</td>
<td>MQGE aged spouse (fourth claimant)</td>
</tr>
<tr>
<td>TK</td>
<td>MQGE aged spouse (fifth claimant)</td>
</tr>
<tr>
<td>TL</td>
<td>MQGE aged widow(er) (second claimant)</td>
</tr>
<tr>
<td>TM</td>
<td>MQGE aged widow(er) (third claimant)</td>
</tr>
<tr>
<td>TN</td>
<td>MQGE aged widow(er) (fourth claimant)</td>
</tr>
<tr>
<td>TP</td>
<td>MQGE aged widow(er) (fifth claimant)</td>
</tr>
<tr>
<td>TQ</td>
<td>MQGE parent (female)</td>
</tr>
<tr>
<td>TR</td>
<td>MQGE young widow(er) (second claimant)</td>
</tr>
<tr>
<td>TS</td>
<td>MQGE young widow(er) (third claimant)</td>
</tr>
<tr>
<td>TT</td>
<td>MQGE young widow(er) (fourth claimant)</td>
</tr>
<tr>
<td>TU</td>
<td>MQGE young widow(er) (fifth claimant)</td>
</tr>
<tr>
<td>TV</td>
<td>MQGE disabled widow(er) fifth claimant</td>
</tr>
<tr>
<td>TW</td>
<td>MQGE disabled widow(er) first claimant</td>
</tr>
<tr>
<td>TX</td>
<td>MQGE disabled widow(er) second claimant</td>
</tr>
<tr>
<td>TY</td>
<td>MQGE disabled widow(er) third claimant</td>
</tr>
<tr>
<td>TZ</td>
<td>MQGE disabled widow(er) fourth claimant</td>
</tr>
<tr>
<td>T2-T9</td>
<td>Disabled child (second to ninth claimant)</td>
</tr>
<tr>
<td>W</td>
<td>Disabled widow, age 50 or over (1st claimant)</td>
</tr>
<tr>
<td>W1</td>
<td>Disabled widower, age 50 or over (1st claimant)</td>
</tr>
<tr>
<td>W2</td>
<td>Disabled widow (2nd claimant)</td>
</tr>
<tr>
<td>W3</td>
<td>Disabled widower (2nd claimant)</td>
</tr>
<tr>
<td>W4</td>
<td>Disabled widow (3rd claimant)</td>
</tr>
<tr>
<td>W5</td>
<td>Disabled widower (3rd claimant)</td>
</tr>
<tr>
<td>W6</td>
<td>Disabled surviving divorced wife (1st claimant)</td>
</tr>
<tr>
<td>W7</td>
<td>Disabled surviving divorced wife (2nd claimant)</td>
</tr>
<tr>
<td>W8</td>
<td>Disabled surviving divorced wife (3rd claimant)</td>
</tr>
</tbody>
</table>
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

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

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

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

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

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

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

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

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

***Prior to 12/90***

Y = Other secondary payer investigation shows Medicare as primary payer

<table>
<thead>
<tr>
<th>1</th>
<th>BENE_PRMRY_PYR_TB</th>
<th>Beneficiary Primary Payer Table</th>
</tr>
</thead>
</table>
| Z = Medicare is primary payer

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

<table>
<thead>
<tr>
<th>1</th>
<th>BETOS_TB</th>
<th>BETOS Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIA = Office visits - new</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MIB = Office visits - established</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
M2A = Hospital visit - initial
M2B = Hospital visit - subsequent
M2C = Hospital visit - critical care
M3 = Emergency room visit
M4A = Home visit
M4B = Nursing home visit
M5A = Specialist - pathology
M5B = Specialist - psychiatry
M5C = Specialist - ophthalmology
M5D = Specialist - other
M6 = Consultations
P0 = Anesthesia
P1A = Major procedure - breast
P1B = Major procedure - colectomy
P1C = Major procedure - cholecystectomy
P1D = Major procedure - turp
P1E = Major procedure - hysterectomy
P1F = Major procedure - explor/decompr/excis/disc
P1G = Major procedure - Other
P2A = Major procedure, cardiovascular-CABG
P2B = Major procedure, cardiovascular-Aneurysm repair
P2C = Major Procedure, cardiovascular-Thromboendarterectomy
P2D = Major procedure, cardiovascularl-Coronary angioplasty (PTCA)
P2E = Major procedure, cardiovascular-Pacemaker insertion
P2F = Major procedure, cardiovascular-Other
P3A = Major procedure, orthopedic - Hip fracture repair
P3B = Major procedure, orthopedic - Hip replacement
P3C = Major procedure, orthopedic - Knee replacement
P3D = Major procedure, orthopedic - Other
P4A = Eye procedure - corneal transplant
P4B = Eye procedure - cataract removal/lens insertion
P4C = Eye procedure - retinal detachment
P4D = Eye procedure - treatment
P4E = Eye procedure - other
P5A = Ambulatory procedures - skin
P5B = Ambulatory procedures - musculoskeletal
P5C = Ambulatory procedures - inguinal hernia repair
P5D = Ambulatory procedures - lithotripsy
P5E = Ambulatory procedures - Other
P6A = Minor procedures - skin
P6B = Minor procedures - musculoskeletal
P6C = Minor procedures - other (Medicare fee schedule)
P6D = Minor procedures - other (non-Medicare fee schedule)
P7A = Oncology - radiation therapy
P7B = Oncology - other
P8A = Endoscopy - arthroscopy
P8B = Endoscopy - upper gastrointestinal
P8C = Endoscopy - sigmoidoscopy
P8D = Endoscopy - colonoscopy
P8E = Endoscopy - cystoscopy
P8F = Endoscopy - bronchoscopy
P8G = Endoscopy - laparoscopic cholecystectomy
P8H = Endoscopy - laryngoscopy
P8I = Endoscopy - other
P9A = Dialysis services

1  BETOS_TB
    -------  BETOS Table

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

1 CARR_CLM_PMT_DNL_TB  
----------------------------------  
Carrier Claim Payment Denial Table  
----------------------------------  

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

For Physician/Supplier (RIC O) Claims:

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

For DMERC (RIC M) Claims - PRIOR TO VERSION H:
0 = Clinics, groups, associations, partnerships, or other entities for whom the carrier's own ID number has been assigned.

1 = Physicians or suppliers billing as solo practitioners for whom SSN's are shown in the physician ID code field.

2 = Physicians or suppliers billing as solo practitioners for whom the carrier's own physician ID code is shown.

3 = Suppliers (other than sole proprietorship) for whom EI numbers are used in coding the ID field.

4 = Suppliers (other than sole proprietorship) for whom the carrier's own code has been shown.

5 = Institutional providers and independent laboratories for whom EI numbers are used in coding the ID field.

6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.

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

8 = Other entities for whom EI numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.

---

**1CARR_LINE_RDCD_PHYSN_ASTNT_TB**

---

**Carrier Line Part B Reduced Physician Assistant Table**

---

**BLANK** - Adjustment situation (where CLM_DISP_CD equal 3)

0 = N/A

1 = 65%
   A) Physician assistants assisting in surgery
   B) Nurse midwives

2 = 75%
   A) Physician assistants performing
services in a hospital (other than assisting surgery)
B) Nurse practitioners and clinical nurse specialists performing services in rural areas
C) Clinical social worker services

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

<table>
<thead>
<tr>
<th>CARR_NUM_TB</th>
<th>Carrier Number Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>00510</td>
<td>= Alabama BS (eff. 1983)</td>
</tr>
<tr>
<td>00511</td>
<td>= Georgia - Alabama BS (eff. 1998)</td>
</tr>
<tr>
<td>00512</td>
<td>= Mississippi - Alabama BS (eff. 2000)</td>
</tr>
<tr>
<td>00520</td>
<td>= Arkansas BS (eff. 1983)</td>
</tr>
<tr>
<td>00521</td>
<td>= New Mexico - Arkansas BS (eff. 1998)</td>
</tr>
<tr>
<td>00522</td>
<td>= Oklahoma - Arkansas BS (eff. 1998)</td>
</tr>
<tr>
<td>00523</td>
<td>= Missouri - Arkansas BS (eff. 1999)</td>
</tr>
<tr>
<td>00528</td>
<td>= Louisianna - Arkansas BS (eff. 1984)</td>
</tr>
<tr>
<td>00542</td>
<td>= California BS (eff. 1983; term. 1996)</td>
</tr>
<tr>
<td>00550</td>
<td>= Colorado BS (eff. 1983; term. 1994)</td>
</tr>
<tr>
<td>00570</td>
<td>= Delaware - Pennsylvania BS (eff. 1983; term. 1997)</td>
</tr>
<tr>
<td>00580</td>
<td>= District of Columbia - Pennsylvania BS (eff. 1983; term. 1997)</td>
</tr>
<tr>
<td>00590</td>
<td>= Florida BS (eff. 1983)</td>
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<tr>
<td>00591</td>
<td>= Connecticut - Florida BS (eff. 2000)</td>
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<tr>
<td>00621</td>
<td>= Illinois BS - HCSC (eff. 1983; term. 1998)</td>
</tr>
<tr>
<td>00630</td>
<td>= Indiana - Administar (eff. 1983)</td>
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<tr>
<td>00635</td>
<td>= DMERC-B (Administar Federal, Inc.) (eff. 1993)</td>
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<tr>
<td>00640</td>
<td>= Iowa - Wellmark, Inc. (eff. 1983; term. 1998)</td>
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<tr>
<td>00645</td>
<td>= Nebraska - Iowa BS (eff. 1985; term. 1987)</td>
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<td>00650</td>
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<tr>
<td>00655</td>
<td>= Nebraska - Kansas BS (eff. 1988)</td>
</tr>
<tr>
<td>00660</td>
<td>= Kentucky - Administar (eff. 1983)</td>
</tr>
<tr>
<td>00690</td>
<td>= Maryland BS (eff. 1983; term. 1994)</td>
</tr>
</tbody>
</table>
00700 = Massachusetts BS (eff. 1983; term. 1997)
00710 = Michigan BS (eff. 1983; term. 1994)
00720 = Minnesota BS (eff. 1983; term. 1995)
00740 = Missouri - BS Kansas City (eff. 1983)
00751 = Montana BS (eff. 1983)
00770 = New Hampshire/Vermont Physician Services (eff. 1983; term. 1984)
00780 = New Hampshire/Vermont - Massachusetts BS (eff. 1985; term. 1997)
00801 = New York - Western BS (eff. 1983)
00803 = New York - Empire BS (eff. 1983)
00805 = New Jersey - Empire BS (eff. 3/99)
00813 = DMERC (A) - Western New York BS (eff. 2000)
00820 = North Dakota - North Dakota BS (eff. 1983)
00824 = Colorado - North Dakota BS (eff. 1995)
00825 = Wyoming - North Dakota BS (eff. 1990)
00826 = Iowa - North Dakota BS (eff. 1999)
00831 = Alaska - North Dakota BS (eff. 1998)
00832 = Arizona - North Dakota BS (eff. 1998)
00833 = Hawaii - North Dakota BS (eff. 1998)
00834 = Nevada - North Dakota BS (eff. 1998)
00835 = Oregon - North Dakota BS (eff. 1998)
00836 = Washington - North Dakota BS (eff. 1998)
00860 = New Jersey - Pennsylvania BS (eff. 1988; term. 1999)
00865 = Pennsylvania BS (eff. 1983)
00870 = Rhode Island BS (eff. 1983)
00880 = South Carolina BS (eff. 1983)
00882 = RRB - South Carolina PGBA (eff. 2000)
00885 = DMERC C - Palmetto (eff. 1993)
00900 = Texas BS (eff. 1983)
00901 = Maryland - Texas BS (eff. 1995)
00902 = Delaware - Texas BS (eff. 1998)
00903 = District of Columbia - Texas BS (eff. 1998)
00904 = Virginia - Texas BS (eff. 2000)
00910 = Utah BS (eff. 1983)
00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)
00952 = Illinois - Wisconsin Phy Svc (eff. 1999)
00953 = Michigan - Wisconsin Phy Svc (eff. 1999)
00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
00973 = Triple-S, Inc. - Puerto Rico (eff. 1983)
00974 = Triple-S, Inc. - Virgin Islands
01020 = Alaska - AETNA (eff. 1983; term. 1997)
01030 = Arizona - AETNA (eff. 1983; term. 1997)
01040 = Georgia - AETNA (eff. 1988; term. 1997)
01120 = Hawaii - AETNA (eff. 1983; term. 1997)
01290 = Nevada - AETNA (eff. 1983; term. 1997)
01360 = New Mexico - AETNA (eff. 1986; term. 1997)
01370 = Oklahoma - AETNA (eff. 1983; term. 1997)
01380 = Oregon - AETNA (eff. 1983; term. 1997)
01390 = Washington - AETNA (eff. 1994; term. 1997)
02050 = California - TOLIC (eff. 1983)
             (term. 2000)
03070 = Connecticut General Life Insurance Co.
             (eff. 1983; term. 1985)
05130 = Idaho - Connecticut General (eff. 1983)
05320 = New Mexico - Equitable Insurance
             (eff. 1983; term. 1985)
05440 = Tennessee - Connecticut General (eff. 1983)
05530 = Wyoming - Equitable Insurance (eff. 1983)
             (term. 1989)
05535 = North Carolina - Connecticut General
             (eff. 1988)
05655 = DMERC-D - Connecticut General (eff. 1993)
10070 = Railroad Board Travelers (eff. 1983)
             (term. 2000)
10230 = Connecticut - Metra Health (eff. 1986)
             (term. 2000)
10240 = Minnesota - Metra Health (eff. 1983)
             (term. 2000)
10250 = Mississippi - Metra Health (eff. 1983)
             (term. 2000)
10490 = Virginia - Metra Health (eff. 1983)
             (term. 2000)
10555 = Travelers Insurance Co. (eff. 1993)
             (term. 2000)
11260 = Missouri - General American Life
             (eff. 1983; term. 1998)
14330 = New York - GHI (eff. 1983)
16360 = Ohio - Nationwide Insurance Co.
16510 = West Virginia - Nationwide Insurance Co.
21200 = Maine - BS of Massachusetts
31140 = California - National Heritage Ins.
| 31142 | Maine - National Heritage Ins. |
| 31143 | Massachusetts - National Heritage Ins. |
| 31144 | New Hampshire - National Heritage Ins. |
| 31145 | Vermont - National Heritage Ins. |

### Carrier Number Table

<table>
<thead>
<tr>
<th>Carrier Number Table</th>
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<td>31146</td>
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### Claim Bill Type Table

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<td>Claim Bill Type Table</td>
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<td>-----------------------</td>
</tr>
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<td>1  CLM_BILL_TYPE_TB</td>
</tr>
</tbody>
</table>

hospital-inpatient (including Part A) (all references to Christian Science (CS) is obsolete eff. 8/00 and replaced with RNHCI)
42 = RNHCI hospital-inpatient or home health visits (Part B only)
43 = RNHCI hospital-outpatient (HHA-A also)
44 = RNHCI hospital-other (Part B)
45 = RNHCI hospital-intermediate care - level I
46 = RNHCI hospital-intermediate care - level II
47 = RNHCI hospital-intermediate care - level III
48 = RNHCI hospital-swing beds
49 = RNHCI hospital-reserved for national assignment
50 = CS extended care-inpatient (including Part A) OBsolete eff. 7/00 - implementation of Religious Nonmedical Health Care Institutions (RNHCI)
51 = RNHCI extended care-inpatient or home health visits (Part B only) (eff. 7/00); prior to 7/00 Christian Science (CS)
52 = RNHCI extended care-outpatient (HHA-A also) (eff. 7/00); prior to 7/00 referenced CS
53 = RNHCI extended care-other (Part B) (eff. 7/00); prior to 7/00 referenced CS
54 = RNHCI extended care-intermediate care - level I (eff. 7/00)
55 = RNHCI extended care-intermediate care - level II (eff. 7/00)
56 = RNHCI extended care-intermediate care - level III (eff. 7/00)
57 = RNHCI extended care-swing beds (eff. 7/00)
58 = RNHCI extended care-reserved for national assignment (eff. 7/00)
59 = Intermediate care-inpatient (including Part A)
60 = Intermediate care-inpatient or home health visits (Part B only)
61 = Intermediate care-outpatient (HHA-A also)
62 = Intermediate care-other (Part B)
63 = Intermediate care-intermediate care - level I
64 = Intermediate care-intermediate care - level II
65 = Intermediate care-intermediate care - level III
66 = Intermediate care-swing beds
67 = Intermediate care-reserved for national assignment
68 = Clinic-rural health
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>72</td>
<td>Clinic-hospital based or independent renal dialysis facility</td>
</tr>
<tr>
<td>73</td>
<td>Clinic-independent provider based FQHC (eff 10/91)</td>
</tr>
<tr>
<td>74</td>
<td>Clinic-GMF only (eff 4/97); ORF and CMHC (10/91 - 3/97)</td>
</tr>
<tr>
<td>75</td>
<td>Clinic-CORF</td>
</tr>
<tr>
<td>76</td>
<td>Clinic-CNHK (eff 4/97)</td>
</tr>
<tr>
<td>77</td>
<td>Clinic-reserved for national assignment</td>
</tr>
<tr>
<td>78</td>
<td>Clinic-reserved for national assignment</td>
</tr>
<tr>
<td>79</td>
<td>Clinic-other</td>
</tr>
<tr>
<td>81</td>
<td>Special facility or ASC surgery-hospice (non-hospital based)</td>
</tr>
<tr>
<td>82</td>
<td>Special facility or ASC surgery-hospice (hospital based)</td>
</tr>
<tr>
<td>83</td>
<td>Special facility or ASC surgery-ambulatory surgical center (Discontinued for Hospitals Subject to Outpatient PPS; hospitals must use 13X for ASC claims submitted for OPPS payment -- eff. 7/00)</td>
</tr>
<tr>
<td>84</td>
<td>Special facility or ASC surgery-freestanding birthing center</td>
</tr>
<tr>
<td>85</td>
<td>Special facility or ASC surgery-rural primary care hospital (eff 4/97)</td>
</tr>
<tr>
<td>86</td>
<td>Special facility or ASC surgery-reserved for national use</td>
</tr>
<tr>
<td>87</td>
<td>Special facility or ASC surgery-reserved for national use</td>
</tr>
<tr>
<td>88</td>
<td>Special facility or ASC surgery-reserved for national use</td>
</tr>
<tr>
<td>89</td>
<td>Special facility or ASC surgery-other</td>
</tr>
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<td>91</td>
<td>Reserved-inpatient (including Part A)</td>
</tr>
<tr>
<td>92</td>
<td>Reserved-inpatient or home health visits (Part B only)</td>
</tr>
<tr>
<td>93</td>
<td>Reserved-outpatient (HHA-A also)</td>
</tr>
<tr>
<td>94</td>
<td>Reserved-other (Part B)</td>
</tr>
<tr>
<td>95</td>
<td>Reserved-intermediate care - level I</td>
</tr>
<tr>
<td>96</td>
<td>Reserved-intermediate care - level II</td>
</tr>
<tr>
<td>97</td>
<td>Reserved-intermediate care - level III</td>
</tr>
<tr>
<td>98</td>
<td>Reserved-swing beds</td>
</tr>
<tr>
<td>99</td>
<td>Reserved-reserved for national assignment</td>
</tr>
</tbody>
</table>

---

1 CLM_DISP_TB

Claim Disposition Table

01 = Debit accepted
02 = Debit accepted (automatic adjustment) applicable through 4/4/93
03 = Cancel accepted
61 = *Conversion code: debit accepted
62 = *Conversion code: debit accepted (automatic adjustment)
63 = *Conversion code: cancel accepted
*Used only during conversion period:
1/1/91 - 2/21/91

<table>
<thead>
<tr>
<th>CLM_FAC_TYPE_TB</th>
<th>Claim Facility Type Table</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Hospital</td>
</tr>
<tr>
<td>2</td>
<td>Skilled nursing facility (SNF)</td>
</tr>
<tr>
<td>3</td>
<td>Home health agency (HHA)</td>
</tr>
<tr>
<td>4</td>
<td>Religious Nonmedical (Hospital) (eff. 8/1/00); prior to 8/00 referenced Christian Science (CS)</td>
</tr>
<tr>
<td>5</td>
<td>Religious Nonmedical (Extended Care) (eff. 8/1/00); prior to 8/00 referenced CS</td>
</tr>
<tr>
<td>6</td>
<td>Intermediate care</td>
</tr>
<tr>
<td>7</td>
<td>Clinic or hospital-based renal dialysis facility</td>
</tr>
<tr>
<td>8</td>
<td>Special facility or ASC surgery</td>
</tr>
<tr>
<td>9</td>
<td>Reserved</td>
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<table>
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<tbody>
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<td>Non-payment/zero claims</td>
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<tr>
<td>1</td>
<td>Admit thru discharge claim</td>
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<tr>
<td>2</td>
<td>Interim - first claim</td>
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<tr>
<td>3</td>
<td>Interim - continuing claim</td>
</tr>
<tr>
<td>4</td>
<td>Interim - last claim</td>
</tr>
<tr>
<td>5</td>
<td>Late charge(s) only claim</td>
</tr>
<tr>
<td>6</td>
<td>Adjustment of prior claim</td>
</tr>
<tr>
<td>7</td>
<td>Replacement of prior claim; eff 10/93, provider debit</td>
</tr>
<tr>
<td>8</td>
<td>Void/cancel prior claim; eff 10/93, provider cancel</td>
</tr>
<tr>
<td>9</td>
<td>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)</td>
</tr>
</tbody>
</table>
| A           | Admission notice - used when hospice is submitting the HCFA-1450 as an
<table>
<thead>
<tr>
<th>1</th>
<th>CLM_HHA_RFRL TB</th>
<th>Claim Home Health Referral Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Physician referral - The patient was admitted upon the recommendation of a personal physician.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Clinic referral - The patient was admitted upon the recommendation of</td>
<td></td>
</tr>
</tbody>
</table>
this facility's clinic physician.

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

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

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

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

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

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

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

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

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

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

NOTE: the use of this code will permit
the agency to send a new RAP allowing all claims to be accepted by Medicare. (eff. 10/00)

<table>
<thead>
<tr>
<th>CLM_HIPPS_TB</th>
<th>Claim SNF &amp; HHA Health Insurance</th>
<th>PPS Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>--------------</td>
<td>----------------------------------</td>
<td>------------</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

RHA, RHB, RUC, RVA = Very high/ultra high rehabilitation: highest level
RVB, RVC

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

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

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

00 = No assessment completed
01 = Medicare 5-day full assessment/not an initial admission assessment
02 = Medicare 30-day full assessment
03 = Medicare 60-day full assessment
04 = Medicare 90-day full assessment
05 = Medicare Readmission/Return required assessment (eff. 10/2000)
07 = Medicare 14-day full or comprehensive assessment/
     not an initial admission assessment
08 = Off-cycle Other Medicare Required Assessment (OMRA)
11 = Admission assessment AND Medicare 5-day (or readmission/
     return) assessment
17 = Medicare 14-day required assessment AND initial
     admission assessment (eff. 10/2000)
18 = OMRA replacing Medicare 5-day required assessment
     (eff. 10/2000)
28 = OMRA replacing Medicare 30-day required assessment
     (eff. 10/2000)
30 = Off-cycle significant change assessment (outside
     assessment window) (eff. 10/2000)
31 = Significant change assessment replaces Medicare
     5-day assessment (eff. 10/2000)
32 = Significant change assessment replaces Medicare
     30-day assessment
33 = Significant change assessment replaces Medicare
     6-day assessment
34 = Significant change assessment replaces Medicare
     90-day assessment
35 = Significant change assessment replaces a Medicare
     readmission/return assessment
37 = Significant change assessment replaces Medicare
     14-day assessment
38 = OMRA replacing Medicare 60-day required
     assessment
40 = Off-cycle significant correction assessment of a
     prior assessment (outside assessment window)
     (eff. 10/2000)
41 = Significant correction of prior full assessment
     replaces a Medicare 5-day assessment
42 = Significant correction of prior full assessment
     replaces a Medicare 30-day assessment
43 = Significant correction of prior full assessment
44 = Significant correction of prior full assessment
replaces a Medicare 90-day assessment
45 = Significant correction of a prior assessment
replaces a readmission/return assessment
  (eff. 10/2000)
47 = Significant correction of prior full assessment
replaces a Medicare 14-day required assessment
48 = OMRA replacing Medicare 90-day required assessment
54 = Quarterly review assessment - Medicare 90-day
  full assessment
78 = OMRA replacing a Medicare 14-day assessment
  (eff. 10/2000)

******************************************************
*************Claim Home Health PPS HIPPS Table**********
**************************************************************
*************** Claim Home Health PPS HIPPS Table***********
**************************************************************
Position 1 = 'H'
Position 2 = Clinical (A, B, C, D)
Position 3 = Functional (E, F, G, H, I)
Position 4 = Service (J, K, L, M)
Position 5 = identifies which elements of the code were
  computed or derived:
  1 = 2nd, 3rd, 4th positions computed
  2 = 2nd position derived
  3 = 3rd position derived
  4 = 4th position derived
  5 = 2nd & 3rd positions derived
  6 = 3rd & 4th positions derived
  7 = 2nd & 4th positions derived
  8 = 2nd, 3rd, 4th positions derived
**************************************************************
**HHRG = C0F0S0/Clinical = Min, Functional = Min, Service = Min**
HAEJ1
HAEJ2
HAEJ3

1  CLM_HIPPS_TB  Claim SNF & HHA Health Insurance  PPS Table
  ------------------  ----------------------------------
**HHRG = COF0S1/Clinical = Min, Functional = Min, Service = Low**

**HHRG = COF0S2/Clinical = Min, Functional = Min, Service = Mod**

**HHRG = COF0S3/Clinical = Min, Functional = Min, Service = High**

**HHRG = COF1S0/Clinical = Min, Functional = Low, Service = Min**

**HHRG = COF1S1/Clinical = Min, Functional = Low, Service = Low**
Claim SNF & HHA Health Insurance  PPS Table

---

HAFK2
HAFK3
HAFK4
HAFK5
HAFK6
HAFK7
HAFK8

**HHRG = COFS2/Clinical = Min, Functional = Low, Service = Mod**

HAFL1
HAFL2
HAFL3
HAFL4
HAFL5
HAFL6
HAFL7

**HHRG = COFS3/Clinical = Min, Functional = Low, Service = High**

HAFM1
HAFM2
HAFM3
HAFM4
HAFM5
HAFM6
HAFM7
HAFM8

**HHRG = COFS0/Clinical = Min, Functional = Mod, Service = Min**

HAGJ1
HAGJ2
HAGJ3
HAGJ4
HAGJ5
HAGJ6
HAGJ7
HAGJ8

**HHRG = COFS1/Clinical = Min, Functional = Mod, Service = Low**

HAGK1
HAGK2
HAGK3
HAGK4
HAGK5
**HHRG = C0F2S2/Clinical = Min, Service = Mod**

**HHRG = C0F2S3/Clinical = Min, Service = High**

**HHRG = C0F3S0/Clinical = Min, Service = Min**

**HHRG = C0F3S1/Clinical = Min, Service = Low**

**HHRG = C0F3S2/Clinical = Min, Service = Mod**
**HHRG = COF3S3/Clinical = Min, Functional = High, Service = High**

**HHRG = COF4S0/Clinical = Min, Functional = Max, Service = Min**

**HHRG = COF4S1/Clinical = Min, Functional = Max, Service = Low**

**HHRG = COF4S2/Clinical = Min, Functional = Max, Service = Mod**
<table>
<thead>
<tr>
<th>HAIL8</th>
<th>HAIM1</th>
<th>HAIM2</th>
<th>HAIM3</th>
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<th>HAIM6</th>
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<tbody>
<tr>
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<td><strong>HHRG = C0F4S3/Clinical = Min, Functional = Max, Service = High</strong></td>
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<tbody>
<tr>
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<td><strong>HHRG = C1F0S0/Clinical = Low, Functional = Min, Service = Min</strong></td>
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</table>

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<th>HBEJ1</th>
<th>HBEJ2</th>
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<tbody>
<tr>
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<td><strong>HHRG = C1F0S1/Clinical = Low, Functional = Min, Service = Low</strong></td>
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<table>
<thead>
<tr>
<th>HBEK1</th>
<th>HBEK2</th>
<th>HBEK3</th>
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<th>HBEL3</th>
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HBEM3  
HBEM4  
HBEM5  
HBEM6  
HBEM7  
HBEM8

**HHRG = C1F1S0/Clinical = Low, Functional = Low, Service = Min**
HBFJ1  
HBFJ2  
HBFJ3  
HBFJ4  
HBFJ5  
HBFJ6  
HBFJ7  
HBFJ8

**HHRG = C1F1S1/Clinical = Low, Functional = Low, Service = Low**
HBFK1  
HBFK2  
HBFK3  
HBFK4  
HBFK5  
HBFK6  
HBFK7  
HBFK8

**HHRG = C1F1S2/Clinical = Low, Functional = Low, Service = Mod**
HBFJ1

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

HBFL1  
HBFL2  
HBFL3  
HBFL4  
HBFL5  
HBFL6  
HBFL7  
HBFL8

**HHRG = C1F1S3/Clinical = Low, Functional = Low, Service = High**
HBFM1  
HBFM2  
HBFM3  
HBFM4  
HBFM5  
HBFM6
**HHRG = C1F2S0/Clinical = Low, Functional = Mod, Service = Min**

**HHRG = C1F2S1/Clinical = Low, Functional = Mod, Service = Low**

**HHRG = C1F2S2/Clinical = Low, Functional = Mod, Service = Mod**

**HHRG = C1F2S3/Clinical = Low, Functional = Mod, Service = High**

**HHRG = C1F3S0/Clinical = Low, Functional = High, Service = Min**
HBHJ5

1            CLM_HIPPS_TB  Claim SNF & HHA Health Insurance  PPS Table

HBHJ6

HBHJ7

HBHJ8

**HHRG  =  C1F3S1/Clinical  =  Low, Functional  =  High, Service  =  Low**

HBHK1

HBHK2

HBHK3

HBHK4

HBHK5

HBHK6

HBHK7

HBHK8

**HHRG  =  C1F3S2/Clinical  =  Low, Functional  =  High, Service  =  Mod**

HBHL1

HBHL2

HBHL3

HBHL4

HBHL5

HBHL6

HBHL7

HBHL8

**HHRG  =  C1F3S3/Clinical  =  Low, Functional  =  High, Service  =  High**

HBHM1

HBHM2

HBHM3

HBHM4

HBHM5

HBHM6

HBHM7

HBHM8

**HHRG  =  C1F4S0/Clinical  =  Low, Functional  =  Max, Service  =  Min**

HBHJ1

HBHJ2

HBHJ3

HBHJ4

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HBHJ6

HBHJ7

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**HHRG = C1F4S1/Clinical = Low, Functional = Max, Service = Low**

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**HHRG = C1F4S2/Clinical = Low, Functional = Max, Service = Mod**

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**HHRG = C1F4S3/Clinical = Low, Functional = Max, Service = High**

<table>
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<th>1</th>
<th>CLM_HIPPS_TB</th>
<th>Claim SNF &amp; HMA Health Insurance</th>
<th>PPS Table</th>
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<tbody>
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<table>
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<th>HBIM5</th>
<th>HBIM6</th>
<th>HBIM7</th>
<th>HBIM8</th>
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</table>

**HHRG = C2F0S0/Clinical = Mod, Functional = Min, Service = Min**

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<th>HCEJ1</th>
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<th>HCEJ5</th>
<th>HCEJ6</th>
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</table>

**HHRG = C2F0S1/Clinical = Mod, Functional = Min, Service = Low**

<table>
<thead>
<tr>
<th>HCEK1</th>
<th>HCEK2</th>
<th>HCEK3</th>
</tr>
</thead>
</table>
**HRG = C2F0S2/Clinical = Mod, Functional = Min, Service = Mod**

**HRG = C2F0S3/Clinical = Mod, Functional = Min, Service = High**

**HRG = C2F1S0/Clinical = Mod, Functional = Low, Service = Min**

**HRG = C2F1S2/Clinical = Mod, Functional = Low, Service = Mod**

1   CLM_HIPPS_TB

Claim SNF & HHA Health Insurance

PPS Table
**HHRG = C2F1S3/Clinical = Mod, Functional = Low, Service = High**

**HHRG = C2F2S0/Clinical = Mod, Functional = Mod, Service = Min**

**HHRG = C2F2S1/Clinical = Mod, Functional = Mod, Service = Low**

**HHRG = C2F2S2/Clinical = Mod, Functional = Mod, Service = Mod**

**HHRG = C2F2S3/Clinical = Mod, Functional = Mod, Service = High**
**HHRG = C2F3S0/Clinical = Mod, Functional = High, Service = Min**

HCHJ1
HCHJ2
HCHJ3
HCHJ4
HCHJ5
HCHJ6
HCHJ7
HCHJ8

**HHRG = C2F3S1/Clinical = Mod, Functional = High, Service = Low**

HCHK1
HCHK2
HCHK3
HCHK4
HCHK5
HCHK6
HCHK7
HCHK8

**HHRG = C2F3S2/Clinical = Mod, Functional = High, Service = Mod**

HCHL1
HCHL2
HCHL3
HCHL4
HCHL5
HCHL6
HCHL7
HCHL8

**HHRG = C2F3S3/Clinical = Mod, Functional = High, Service = High**

HCHM1
HCHM2
HCHM3
HCHM4
HCHM5
HCHM6
HCHM7
HCHM8

**HHRG = C2F4S0/Clinical = Mod, Functional = Max, Service = Min**
**HRG - C2F4S1/Clinical - Mod, Functional - Max, Service - Low**

**HRG - C2F4S2/Clinical - Mod, Functional - Max, Service - Mod**

**HRG - C2F4S3/Clinical - Mod, Functional - Max, Service - High**

**HRG - C3F0S0/Clinical - High, Functional - Min, Service - Min**
**HHRG = C3F0S1/Clinical = High, Functional = Min, Service = Low**
HDEJ5  
HDEJ6  
HDEJ7  
HDEJ8  

**HHRG = C3F0S2/Clinical = High, Functional = Min, Service = Mod**
HDEK1  
HDEK2  
HDEK3  
HDEK4  
HDEK5  
HDEK6  
HDEK7  
HDEK8  

**HHRG = C3F0S3/Clinical = High, Functional = Min, Service = High**
HDEL1  
HDEL2  
HDEL3  
HDEL4  
HDEL5  
HDEL6  
HDEL7  
HDEL8  

**HHRG = C3F1S0/Clinical = High, Functional = Low, Service = Min**
HDEM1  
HDEM2  
HDEM3  
HDEM4  
HDEM5  
HDEM6  
HDEM7  
HDEM8  

**HHRG = C3F1S1/Clinical = High, Functional = Low, Service = Low**
HDFJ1  
HDFJ2  
HDFJ3  
HDFJ4  
HDFJ5  
HDFJ6  
HDFJ7  
HDFJ8  

**HHRG = C3F1S2/Clinical = High, Functional = Low, Service = Mod**
HDFK1  
HDFK2
**HHRG = C3F1S2/Clinical = High, Functional = Low, Service = Mod**

**HHRG = C3F1S3/Clinical = High, Functional = Low, Service = High**

**HHRG = C3F2S0/Clinical = High, Functional = Mod, Service = Min**

**HHRG = C3F2S1/Clinical = High, Functional = Mod, Service = Low**
<table>
<thead>
<tr>
<th>CLM_HIPPS_TB</th>
<th>Claim SNF &amp; HHA Health Insurance</th>
<th>PPS Table</th>
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</table>

**HHRG = C3F2S2/Clinical = High, Functional = Mod, Service = Mod**

**HHRG = C3F3S3/Clinical = High, Functional = High, Service = Mod**

**HHRG = C3F3S0/Clinical = High, Functional = High, Service = Min**

**HHRG = C3F3S1/Clinical = High, Functional = High, Service = Low**

**HHRG = C3F3S2/Clinical = High, Functional = High, Service = Mod**
### Claim Medicare Non-Payment Reason Table

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

<table>
<thead>
<tr>
<th>CLM_OCRNC_SPAN_TB</th>
<th>Claim Occurrence Span Table</th>
</tr>
</thead>
</table>

1. **70** - Eff 10/93, payer use only, the nonutilization from/thru dates for PPS-inlier stay where bene had exhausted all full/coinsurance days, but covered on cost report. SNF qualifying hospital stay from/thru dates.

2. **71** - Hospital prior stay dates - the from/thru dates of any hospital stay that ended within 60 days of this hospital or SNF admission.

3. **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.

4. **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.

5. **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.

6. **75** - The from/thru dates of SNF level of care.
during IP hospital stay. Shows PRO approval of patient remaining in hospital because SNF bed not available. not applicable to swing bed cases. PPS hospitals use in day outlier cases only.

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

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>CLM_OCRRC_SPAN_TB</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Claim Occurrence Span Table</td>
</tr>
</tbody>
</table>
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***Effective NCH weekly process date 10/3/97 - 5/29/98***

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

***Effective NCH weekly process date 6/5/98***

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

---

1  CLM_RLT_COND_TB
Claim Related Condition Table
---

01 = Military service related - Medical condition incurred during military service.

02 = Employment related - Patient alleged that the medical condition causing this episode of care was due to environment/events resulting from employment.

03 = Patient covered by insurance not reflected here - Indicates that patient or patient representative has stated that coverage may exist beyond that reflected on this bill.

04 = Health Maintenance Organization (HMO) enrollee - Medicare beneficiary is enrolled in an HMO. Eff 9/93, hospital must also expect to receive payment from HMO.

05 = Lien has been filed - Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.
06 = ESRD patient in 1st 18 months of entitlement 
covered by employer group health insurance - 
indicates Medicare may be secondary 
insurer. Eff 3/1/96, ESRD patient in 1st 
30 months of entitlement covered by employer 
group health insurance.

07 = Treatment of nonterminal condition for 
hospice patient - The patient is a 
hospice enrollee, but the provider is 
not treating a terminal condition and 
is requesting Medicare reimbursement.

08 = Beneficiary would not provide information 
concerning other insurance coverage.

09 = Neither patient nor spouse is employed 
- Code indicates that in response to 
development questions, the patient and 
spouse have denied employment.

10 = Patient and/or spouse is employed but 
no EGHP coverage exists or (eff 9/93) 
other employer sponsored/provided 
health insurance covering patient.

11 = The disabled beneficiary and/or family 
member has no group coverage from a LGHP 
or (eff 9/93) other employer 
sponsored/provided health insurance 
covering patient.

12 = Payer code - Reserved for internal 
use only by third party payers. HCFA 
will assign as needed. Providers will 
not report them.

13 = Payer code - Reserved for internal 
use only by third party payers. HCFA 
will assign as needed. Providers will 
not report them.

14 = Payer code - Reserved for internal 
Claim Related Condition Table 
------------------------------

use only by third party payers. HCFA 
will assign as needed. Providers will 
not report them.

15 = Clean claim (eff 10/92)

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

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

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

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

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

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

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

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

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

25 - Reserved for national assignment

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

27 - Patient referred to a sole community hospital for a diagnostic laboratory test - (sole community hospital only).
(eff 9/93)

28 = Patient and/or spouse's EGHP is secondary to Medicare - Qualifying EGHP for employers who have fewer than 20 employees. (eff 9/93)

29 = Disabled beneficiary and/or family member's LGHP is secondary to Medicare - Qualifying LGHP for employer having fewer than 100 full and part-time employees

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 accommodations were not available.

39 = Private room medically necessary - Patient needed a private room for medical reasons.

40 = Same day transfer - Patient transferred to another facility before midnight of the day of admission.

41 = Partial hospitalization - Eff 3/92,
indicates claim is for partial hospitalization services. For OP services, this includes a variety of psych programs.

42 = Reserved for national assignment.
43 = Reserved for national assignment.
44 = Reserved for national assignment.
45 = Reserved for national assignment.
46 = Nonavailability statement on file for CHAMPUS claim for nonemergency IP care for CHAMPUS bene residing within the catchment area (usually a 40 mile radius) of a uniform services hospital.
47 = Reserved for CHAMPUS.
48 = Reserved for national assignment.
49 = Reserved for national assignment.
50 = Reserved for national assignment.
51 = Reserved for national assignment.
52 = Reserved for national assignment.
53 = Reserved for national assignment.
54 = Reserved for national assignment.
55 = SNF bed not available - The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56 = Medical appropriateness - Patient's SNF admission was delayed more than 30 days after hospital discharge because physical condition made it inappropriate to begin active care within that period.
57 = SNF readmission - Patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
58 = Payment of SNF claims for beneficiaries disenrolling from terminating M+C plans plans who have not met the 3-day hospital stay requirement (eff. 10/1/00)
59 = Reserved for national assignment.
60 = Operating cost day outlier - PRICER
indicates this bill is length of stay outlier (PPS)

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

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

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

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

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

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

67 = Beneficiary elects not to use LTR days

68 = Beneficiary elects to use LTR days

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

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

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

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

73 = Self care training - Billing is for special dialysis services where the
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 dialysis patient using a dialysis machine that was purchased under the 100% program.

76 = Back-up facility - Billing is for a patient who received dialysis services in a back-up facility.

77 = Provider accepts or is obligated/required due to contractual agreement or law to accept payment by a primary payer as payment in full - Medicare pays nothing.

78 = New coverage not implemented by HMO - eff 3/92, indicates newly covered service under Medicare for which HMO does not pay.

79 = CORF services provided off site - Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.

80 = 99 = Reserved for state assignment.

A0 = CRAMPUS external partnership program special program indicator code. (eff 10/93)

A1 = EPSDT/CHAP - Early and periodic screening diagnosis and treatment special program indicator code. (eff 10/93)

A2 = Physically handicapped children's program - Services provided receive special funding through Title 8 of the Social Security Act or the CHAMPUS program for the handicapped. (eff 10/93)

A3 = Special federal funding - Designed for
uniform use by state uniform billing committees.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4</td>
<td>Family planning - Designed for uniform use by state uniform billing committees.</td>
</tr>
<tr>
<td>A5</td>
<td>Disability - Designed for uniform use by state uniform billing committees.</td>
</tr>
<tr>
<td>A6</td>
<td>PPV/Medicare - Identifies that pneumococcal pneumonia 100% payment vaccine (PPV) services should be reimbursed under a special Medicare program provision.</td>
</tr>
<tr>
<td>A7</td>
<td>Induced abortion to avoid danger to woman's life.</td>
</tr>
<tr>
<td>A8</td>
<td>Induced abortion - Victim of rape/incest.</td>
</tr>
<tr>
<td>A9</td>
<td>Second opinion surgery - Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.</td>
</tr>
<tr>
<td>B0</td>
<td>Special program indicator Reserved for national assignment.</td>
</tr>
<tr>
<td>B1</td>
<td>Special program indicator Reserved for national assignment.</td>
</tr>
<tr>
<td>B2</td>
<td>Special program indicator Reserved for national assignment.</td>
</tr>
<tr>
<td>B3</td>
<td>Special program indicator Reserved for national assignment.</td>
</tr>
<tr>
<td>B4</td>
<td>Special program indicator Reserved for national assignment.</td>
</tr>
<tr>
<td>B5</td>
<td>Special program indicator Reserved for national assignment.</td>
</tr>
</tbody>
</table>

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**Claim Related Condition Table**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLM_RLT_COND_TB</td>
<td>Claim Related Condition Table</td>
</tr>
</tbody>
</table>
B6 = Special program indicator
Reserved for national assignment.

B7 = Special program indicator
Reserved for national assignment.

B8 = Special program indicator
Reserved for national assignment.

B9 = Special program indicator
Reserved for national assignment.

C0 = Reserved for national assignment.

C1 = Approved as billed - The services
provided for this billing period have
been reviewed by the PRO/UR or
intermediary and are fully approved
including any day or cost outlier. (eff 10/93)

C2 = Automatic approval as billed based on
focused review. (No longer used for
Medicare)

PRO approval indicator services (eff 10/93)

C3 = Partial approval - The services
provided for this billing period have
been reviewed by the PRO/UR or
intermediary and some portion has been
denied (days or services). (eff 10/93)

C4 = Admission/services denied - Indicates
that all of the services were denied
by the PRO/UR.

PRO approval indicator services (eff 10/93)

C5 = Postpayment review applicable - PRO/UR
review to take place after payment.

PRO approval indicator services (eff 10/93)

C6 = Admission preauthorization - The
PRO/UR authorized this admission/
service but has not reviewed the
services provided.

PRO approval indicator services (eff 10/93)

C7 = Extended authorization - the PRO has
authorized these services for an
extended length of time but has not
reviewed the services provided.

PRO approval indicator services (eff 10/93)

1  CLM_RLT_COND_TB
   -------------------
   Claim Related Condition Table
   -----------------------------------

PRO approval indicator services (eff 10/93)
C8 = Reserved for national assignment.
   PRO approval indicator services (eff 10/93)

C9 = Reserved for national assignment.
   PRO approval indicator services (eff 10/93)

D0 = Changes to service dates.
   Change condition (eff 10/93)

D1 = Changes in charges.
   Change condition (eff 10/93)

D2 = Changes in revenue codes/HCPCS.
   Change condition (eff 10/93)

D3 = Second or subsequent interim PPS bill.
   Change condition (eff 10/93)

D4 = Change in grouper input (diagnosis and/or procedures are changed resulting in a different DRG).
   Change condition (eff 10/93)

D5 = Cancel only to correct a beneficiary claim account number or provider identification number.
   Change condition (eff 10/93)

D6 = Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an OP bill containing services required to be included on the IP bill). Change condition eff 10/93.

D7 = Change to make Medicare the secondary payer.
   Change condition (eff 10/93)

D8 = Change to make Medicare the primary payer.
   Change condition (eff 10/93)

D9 = Any other change.
   Change condition (eff 10/93)

E0 = Change in patient status.
   Change condition (eff 10/93)

EY = National Emphysema Treatment Trial (NETT) or Lung Volume Reduction Surgery (LVRS) clinical study (eff. 11/97)

G0 = Multiple medical visits occur on the same day in the same revenue center but visits are distinct and constitute independent visits (allows for payment under outpatient...
PPS -- eff. 7/3/00).
M0 = All inclusive rate for outpatient services. (payer only code)
M1 = Roster billed influenza virus vaccine. (payer only code)
    Eff 10/96, also includes pneumococcal pneumonia vaccine (PPV)
M2 = HH override code - home health total reimbursement exceeds the $150,000 cap
    or the number of total visits exceeds the 150 limitation. (eff 4/3/95)
    (payer only code)
W0 = United Mine Workers of America (UMWA)
    SNF demonstration indicator (eff 1/97);

but no claims transmitted until 2/98)

1  CLM_RLTCOND_TB  Claim Related Condition Table
   -----------------
   ------------------

1  CLM_RLTOCRNC_TB  Claim Related Occurrence Table
   -----------------
   ------------------

01 = Auto accident - The date of an auto accident.
02 = No-fault insurance involved, including auto accident/other - The date of an accident where the state has applicable no-fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt).
03 = Accident/tort liability - The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04 = Accident/employment related - The date of an accident relating to the patient's employment.
05 = Other accident - The date of an accident not described by the codes 01 thru 04.
06 = Crime victim - Code indicating the
date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07 = Reserved for national assignment.
08 = Reserved for national assignment.
11 = Onset of symptoms/illness - The date the patient first became aware of symptoms/illness.
12 = Date of onset for a chronically dependent individual - Code indicates the date the patient/bene became a chronically dependent individual.
13 = Reserved for national assignment.
14 = Reserved for national assignment.
15 = Reserved for national assignment.
16 = Reserved for national assignment.
17 = Date outpatient occupational therapy plan established or last reviewed - Code indicating the date an occupational therapy plan was established or last reviewed (eff 3/93)
18 = Date of retirement (patient/bene) - Code indicates the date of retirement for the patient/bene.
19 = Date of retirement spouse - Code indicates the date of retirement for the patient's spouse.
20 = Guarantee of payment began - The date on which the provider began claiming Medicare payment under the guarantee of payment provision.
21 = UR notice received - Code indicating the date of receipt by the hospital of the UR committee's finding that the admission or future stay was not medically necessary.
22 = Active care ended - The date on which a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis
hospital. (For use by intermediary only)

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

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

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

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

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

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

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

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

31 = Date bene notified of intent to bill (accommodations) - The date of the notice provided to the patient by
the hospital stating that he no longer required a covered level of IP care.

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

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

1 Claim Related Occurrence Table

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Required only for ESRD beneficiaries.

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

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

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

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

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

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

40 = Scheduled date of admission - The date on which a patient will be admitted
as an inpatient to the hospital. (This code may only be used on an outpatient claim.)

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

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

43 = Reserved for national assignment.

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

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

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

47 = Noncovered Outlier Stay Began - code indicates the date that cost outlier status began and no Medicare payment will be made because all benefits have been exhausted during the inlier stay or the beneficiary does not elect to use lifetime reserve days (to be implemented in 1999).

48 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for
your use. Providers will not report it.

49 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.

50 = 69 = Reserved for state assignment

A1 = Birthdate, Insured A - The birthdate of the individual in whose name the insurance is carried. (Eff 10/93)

A2 = Effective date, Insured A policy - A code indicating the first date insurance is in force. (eff 10/93)

A3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer A. (eff 10/93)

B1 = Birthdate, Insured B - The birthdate of the individual in whose name the insurance is carried. (eff 10/93)

B2 = Effective date, Insured B policy - A code indicating the first date insurance is in force. (eff 10/93)

B3 = Benefits exhausted - code indicating the last date for which benefits are available and after which no payment can be made to payer B. (eff 10/93)

C1 = Birthdate, Insured C - The birthdate of the individual in whose name the insurance is carried. (eff 10/93)

C2 = Effective date, Insured C policy - A code indicating the first date insurance is in force. (eff 10/93)

C3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer C. (eff 10/93)

<table>
<thead>
<tr>
<th>CLM_SRVC_CLSFCTN_TYPE_TB</th>
<th>Claim Service Classification Type Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>---------------------------------------</td>
</tr>
</tbody>
</table>

For facility type code 1 thru 6, and 9
<table>
<thead>
<tr>
<th>Code</th>
<th>Facility Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inpatient (including Part A)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Hospital based or Inpatient (Part B only)</td>
<td>or home health visits under Part B</td>
</tr>
<tr>
<td>3</td>
<td>Outpatient (HHA-A also)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Other (Part B)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Intermediate care - level I</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Intermediate care - level II</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Subacute Inpatient (formerly Intermediate care - level III)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Swing beds (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Reserved for national assignment</td>
<td></td>
</tr>
</tbody>
</table>

For facility type code 7

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

For facility type code 8

<table>
<thead>
<tr>
<th>Code</th>
<th>Facility Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hospice (non-hospital based)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Hospice (hospital based)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Ambulatory surgical center in hospital outpatient department</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Freestanding birthing center</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Critical Access Hospital (eff. 10/99) formerly Rural primary care hospital (eff. 10/94)</td>
<td></td>
</tr>
<tr>
<td>6-8</td>
<td>Reserved for national use</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
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

Claim Value Table

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

11 = Medicare Part A coinsurance amount in the second calendar year - Coinsurance amount charged in the year of discharge where the bill spans two calendar years.
(not stored in NCH until 2/93)

12 = Amount is that portion of higher priority EGHF 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.
(not stored in NCH until 2/93)

13 = Amount is that portion of higher priority EGHF insurance payment made on behalf of ESRD bene provider applied to Medicare covered services on this bill. Six zeroes indicate 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
<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>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).</td>
</tr>
<tr>
<td>18</td>
<td>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 adjustment in this entry).</td>
</tr>
<tr>
<td>19</td>
<td>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).</td>
</tr>
<tr>
<td>20</td>
<td>Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount. (used 10/1/91 - 3/1/92 for provider reporting. Payer only code eff 9/93.)</td>
</tr>
<tr>
<td>21</td>
<td>Catastrophic - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)</td>
</tr>
<tr>
<td>22</td>
<td>Surplus - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)</td>
</tr>
<tr>
<td>23</td>
<td>Recurring monthly income - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)</td>
</tr>
<tr>
<td>24</td>
<td>Medicaid rate code - Medicaid -</td>
</tr>
</tbody>
</table>
Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)

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

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

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

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

40 - New coverage not implemented by HMO - amount shown is for inpatient charges covered by HMO (eff 3/92).

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

42 - Amount is that portion of a payment from higher priority VA made on behalf of bene the provider applied to Medicare covered services on this
Bill. Six zeroes indicate the
provider claimed conditional Medicare
payment.

43 = Disabled bene under age 65 with
LGHP – Amount is that portion of
a payment from a higher priority LGHP
made on behalf of a disabled Medicare
bene the provider applied to
Medicare covered services on this bill.

44 = Amount provider agreed to accept from
primary payer when amount less than charges
but more than payment received –
When a lesser amount is received and the
received amount is less than charges, a
Medicare secondary payment is due.

46 = Number of grace days - Following the
date of the PRO/UR determination, this
is the number of days determined by the
PRO/UR to be necessary to arrange for
the patient’s post-discharge care.
(Eff 10/93)

47 = Any liability insurance - Amount
is that portion from a higher priority
liability insurance made on behalf of
Medicare bene the provider
is applying to Medicare covered
services on this bill. (Eff 9/93)

48 = Hemoglobin reading - The latest
hemoglobin reading taken during this
billing cycle.

49 = Latest hematocrit reading taken
during billing cycle - Usually
reported in two pos. (a percentage) to
left of the dollar/cent delimiter.
If provided with a
decimal, use the 3rd pos. to right
of the delimiter for the third digit.

50 = Physical therapy visits - Indicates
the number of physical therapy
visits from onset (at billing provider)
through this billing period.

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

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

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

54 = Reserved for national assignment.

55 = Reserved for national assignment.

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

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

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

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

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

61 = Location of HHA service or hospice service - the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of the provider.
62 = Number of Part A home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

63 = Number of Part B home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

64 = Amount of home health payments attributed to the Part A trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

65 = Amount of home health payments attributed to the Part B trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

66 = Reserved for national assignment.

67 = Peritoneal dialysis - The number of hours of peritoneal dialysis provided during the billing period (only the hours spent in the home).

(eff. 10/97)

68 = EPO drug - Number of units of EPO administered relating to the billing period.

69 = Reserved for national assignment

70 = Interest amount - (Providers do not report this.) Report the amount applied to this bill.

71 = Funding of ESRD networks - (Providers do not report this.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.

72 = Flat rate surgery charge - Code indicates the amount of the charge for outpatient surgery where the hospital has such a charging structure.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>73</td>
<td>Drug deductible - (For internal use by third party payers only). Report the amount of the drug deductible to be applied to the claim.</td>
</tr>
<tr>
<td>74</td>
<td>Drug coinsurance - (For internal use by third party payers only). Report the amount of drug coinsurance to be applied to the claim.</td>
</tr>
<tr>
<td>75</td>
<td>Gramm/Rudman/Hollings - (Providers do not report this.) Report the amount of the sequestration applied to this bill.</td>
</tr>
<tr>
<td>76</td>
<td>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/cent delimiter. (TP payers internal use only)</td>
</tr>
<tr>
<td>77</td>
<td>Payer code - This code is set aside for payer use only. Providers do not report these codes.</td>
</tr>
<tr>
<td>78</td>
<td>Payer code - This code is set aside for payer use only. Providers do not report these codes.</td>
</tr>
<tr>
<td>79</td>
<td>Payer code - This code is set aside for payer use only. Providers do not report these codes.</td>
</tr>
<tr>
<td>80</td>
<td>99 = Reserved for state assignment.</td>
</tr>
<tr>
<td>A1</td>
<td>Deductible Payer A - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93) - Prior value 07</td>
</tr>
<tr>
<td>A2</td>
<td>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)</td>
</tr>
<tr>
<td>A4</td>
<td>Self-administered drugs administered in an emergency situation - Ordinarily the only noncovered self-administered drug</td>
</tr>
</tbody>
</table>
paid for under Medicare in an emergency situation is insulin administered to a patient in a diabetic coma. (eff 7/97)

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

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

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

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

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

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

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

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

1 CTGRY_EQTBL_BENE_IDENT_TB Category Equatable Beneficiary Identification Code (BIC) Table
### NCH BIC

<table>
<thead>
<tr>
<th>Category</th>
<th>SSA Categories</th>
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<td>B</td>
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<td>B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M)</td>
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<td>TE(M)</td>
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<tr>
<td>TW(M)</td>
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<tr>
<td>B3</td>
<td>B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2 W7;WG(F);TL(F);TR(F);TW(F)</td>
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<tr>
<td>B4</td>
<td>B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG(M)</td>
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<tr>
<td>TL(H)</td>
<td>TR(M)</td>
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<tr>
<td>TX(M)</td>
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<tr>
<td>B8</td>
<td>B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4 W8;WH(F);TM(F);TS(F);TY(F)</td>
</tr>
<tr>
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<td>F2;TQ</td>
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<td>F3-F8</td>
<td>Equatable only to itself (e.g., F3 IS equatable to F3)</td>
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<tr>
<td>CA-CZ</td>
<td>Equatable only to itself. (e.g., CA is only equatable to CA)</td>
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</tbody>
</table>

**RRB Categories**

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**Notes:**
- CA = Equatable only to itself. (e.g., CA is only equatable to CA)
- F3-F8 = Equatable only to itself (e.g., F3 IS equatable to F3)
A = Denied for lack of medical necessity; highest level of review was automated level I review
B = Reduced (partially denied) for lack of medical necessity; highest level of review was automated level I review
C = Denied as statutorily noncovered; highest level of review was automated level I review
D = Reserved for future use
E = Paid after automated level I review
F = Denied for lack of medical necessity; highest level of review was manual level I review
G = Reduced (partially denied) for lack of medical necessity; highest level of review was manual level I review
H = Denied as statutorily noncovered; highest level of review was manual level I review
I = Denied for coding/unbundling reasons; highest level of review was manual level I review
J = Paid after manual level I review
K = Denied for lack of medical necessity; highest level of review was manual
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<th>DMERC Line Supplier Type Table</th>
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<td>Clinics, groups, associations,</td>
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</tr>
<tr>
<td></td>
<td>partnerships, or other entities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for whom the carrier’s own ID number has been</td>
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</tr>
<tr>
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<td>assigned.</td>
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<td>solo practitioners for whom SSN’s are</td>
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<td>shown in the physician ID code field.</td>
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</tr>
<tr>
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<td>Physicians or suppliers billing as</td>
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<td>solo practitioners for whom the carrier's</td>
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<td>own physician ID code is shown.</td>
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<tr>
<td>3</td>
<td>Suppliers (other than sole proprietorship)</td>
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<td>for whom EI numbers are used in coding the</td>
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<td>ID field.</td>
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</tr>
<tr>
<td>4</td>
<td>Suppliers (other than sole proprietorship)</td>
<td></td>
</tr>
</tbody>
</table>
for whom the carrier's own code has been shown.

5 = Institutional providers and independent laboratories for whom EI numbers are used in coding the ID field.

6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.

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

8 = Other entities for whom EI numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.

1 = 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 HHFPPS, updates the RAP).

3 = Secondary debit adjustment - used only in credit/debit pairs (under HHFPPS, would be the final claim or an adjustment on a LUPA).

4 = Cancel only adjustment (under HHFPPS, RAP/final claim/LUPA).

5 = Force action code 3

6 = Force action code 2

8 = Benefits refused (for inpatient bills, an 'R' nonpayment code must also be present

9 = Payment requested (used on bills that replace previously-submitted benefits-refused bills, action code 8. In such cases a debit/credit pair is not required. For inpatient bills, a 'P' should be entered in the nonpayment
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<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>00030</td>
<td>Arizona BC</td>
</tr>
<tr>
<td>00040</td>
<td>California BC (term. 12/00)</td>
</tr>
<tr>
<td>00050</td>
<td>New Mexico BC/CO</td>
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<tr>
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<td>Connecticut BC</td>
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<td>00070</td>
<td>Delaware BC - terminated 2/98</td>
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<td>Michigan - HCSC</td>
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<td>00130</td>
<td>Indiana BC/Administrar Federal</td>
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<td>00131</td>
<td>Illinois - Administar</td>
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<tr>
<td>00140</td>
<td>Iowa - Wellmark (term. 6/2000)</td>
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<tr>
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<td>Maine BC</td>
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<td>00181</td>
<td>Maine BC - Massachusetts</td>
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<td>Massachusetts BC - terminated 7/97</td>
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<td>00210</td>
<td>Michigan BC - terminated 9/94</td>
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<td>Mississippi BC/LA</td>
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<td>Mississippi BC</td>
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<td>New Jersey BC (term. 8/2000)</td>
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<td>00290</td>
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<td>00308</td>
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<td>00310</td>
<td>North Carolina BC</td>
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<td>00320</td>
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<td>00332</td>
<td>Community Mutual Ins Co; Ohio-Administar</td>
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<tr>
<td>00340</td>
<td>Oklahoma BC</td>
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<tr>
<td>FI_NUM_TB</td>
<td>Fiscal Intermediary Number Table</td>
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<tr>
<td>-----------</td>
<td>----------------------------------</td>
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<td>50333</td>
<td>Travelers; Connecticut United Healthcare (terminated - date unknown)</td>
</tr>
<tr>
<td>51051</td>
<td>Aetna California - terminated 6/97</td>
</tr>
<tr>
<td>51070</td>
<td>Aetna Connecticut - terminated 6/97</td>
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<td>51140</td>
<td>Aetna Illinois - terminated 6/97</td>
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<td>51390</td>
<td>Aetna Pennsylvania - terminated 6/97</td>
</tr>
<tr>
<td>52280</td>
<td>Mutual of Omaha</td>
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<td>57400</td>
<td>Cooperative, San Juan, PR</td>
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<td>61000</td>
<td>Aetna</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>FI_RQST_CLM_CNCL_RSN_TB</th>
<th>Claim Cancel Reason Code Table</th>
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</thead>
<tbody>
<tr>
<td>C</td>
<td>Coverage Transfer</td>
</tr>
<tr>
<td>D</td>
<td>Duplicate Billing</td>
</tr>
<tr>
<td>H</td>
<td>Other or blank</td>
</tr>
<tr>
<td>L</td>
<td>Combining two beneficiary master records</td>
</tr>
<tr>
<td>P</td>
<td>Plan Transfer</td>
</tr>
</tbody>
</table>
S = Scramble

**********For Action Code 4 *******************
**********Effective with HHFPS - 10/01**********
A = RAP/Final claim/LUPA is cancelled by Intermediary. Does not delete episode. Do not set
cancellation indicator.
B = RAP/Final claim/LUPA is cancelled by Intermediary. Does not delete episode. Set
cancellation indicator to 1.
E = RAP/Final claim/LUPA is cancelled by Intermediary. Remove episode.
F = RAP/Final claim/LUPA is cancelled by Provider. Remove episode.

<table>
<thead>
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<th>GEO_SSA_STATE_TB</th>
<th>State Table</th>
</tr>
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<td></td>
</tr>
<tr>
<td>62</td>
<td>South America</td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>U.S. Possessions</td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>American Samoa</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>Guam</td>
<td></td>
</tr>
<tr>
<td>HCFA_PRVDR_SPCLTY_TB</td>
<td>HCFA Provider Specialty Table</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------</td>
<td></td>
</tr>
</tbody>
</table>

**Prior to 5/92**

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

18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Pathologic anatomy, clinical pathology- osteopaths only (deleted 10/91; changed to '92')
22 = Pathology
23 = Peripheral vascular disease or surgery (deleted 10/91; changed to '76')
24 = Plastic surgery (revised to mean plastic and reconstructive surgery).
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Psychiatry, neurology (osteopaths only) (deleted 10/91; changed to '86')
28 = Proctology (revised 10/91 to mean colorectal surgery).
29 = Pulmonary disease
30 = Radiology (revised 10/91 to mean diagnostic radiology)
31 = Roentgenology, radiology (osteopaths) (deleted 10/91; changed to '30')
32 = Radiation therapy--osteopaths (deleted 10/91; changed to '92')
33 = Thoracic surgery
34 = Urology
35 = Chiropractor, licensed (revised 10/91 to mean chiropractic)
36 = Nuclear medicine
37 = Pediatrics (revised 10/91 to mean pediatric medicine)
38 = Geriatrics (revised 10/91 to mean geriatric medicine)
39 = Nephrology
40 = Hand surgery
41 = Optometrist - services related to condition of aphakia (revised 10/91 to mean optometrist)
42 = Certified nurse midwife (added 7/88)
43 - Certified registered nurse anesthetist
   (revised 10/91 to mean CRNA,
anesthesia assistant)
44 - Infectious disease
46 - Endocrinology (added 10/91)
48 - Podiatry - surgery chiropody (revised
   10/91 to mean podiatry)
49 - Miscellaneous (include ASCS)
51 - Medical supply company with C.O.
certification (certified orthotist -
certified by American Board for
Certification in Prosthetics and
Orthotics.
52 - Medical supply company with C.P.
certification (certified prosthetist -
certified by American Board for
Certification in Prosthetics and Orthotics).
53 - Medical supply company with C.P.O.
certification (certified prosthetist -
orthotist - certified by American
Board for Certification in Prosthetics
and Orthotics).
54 - Medical supply company not included in
51, 52, or 53.
55 - Individual certified orthotist
56 - Individual certified prosthetist
57 - Individual certified prosthetist -
orthotist
58 - Individuals not included in 55,56 or 57
59 - Ambulance service supplier (e.g.
private ambulance companies, funeral
homes, etc.)
60 - Public health or welfare agencies
   (federal, state, and local)
61 - Voluntary health or charitable agencies
   (e.g. National Cancer Society, National
Heart Association, Catholic Charities)
62 - Psychologist--billing independently
63 - Portable X-ray supplier--billing
   independently (revised 10/91 to mean
portable X-ray supplier)
64 - Audiologist (billing independently)
65 = Physical therapist (independent practice)
66 = Rheumatology (added 10/91)
67 = Occupational therapist--independent practice
68 = Clinical psychologist
69 = Independent laboratory--billing independently (revised 10/91 to mean independent clinical laboratory -- billing independently)
70 = Clinic or other group practice, except Group Practice Prepayment Plan (GPPP)
71 = Group Practice Prepayment Plan - diagnostic X-ray (do not use after 1/92)
72 = Group Practice Prepayment Plan - diagnostic laboratory (do not use after 1/92)
73 = Group Practice Prepayment Plan - physiotherapy (do not use after 1/92)
74 = Group Practice Prepayment Plan - occupational therapy (do not use after 1/92)
75 = Group Practice Prepayment Plan - other medical care (do not use after 1/92)
76 = Peripheral vascular disease (added 10/91)
77 = Vascular surgery (added 10/91)
78 = Cardiac surgery (added 10/91)
79 = Addiction medicine (added 10/91)
80 = Clinical social worker (1991)
81 = Critical care-intensivists (added 10/91)
82 = Ophthalmology, cataracts specialty (added 10/91; used only until 5/92)
83 = Hematology/oncology (added 10/91)
84 = Preventive medicine (added 10/91)
85 = Maxillofacial surgery (added 10/91)
86 = Neuropsychiatry (added 10/91)
87 = All other (e.g. drug and department stores) (revised 10/91 to mean all other suppliers)
88 = Unknown (revised 10/91 to mean physician assistant)
90 = Medical oncology (added 10/91)
91 = Surgical oncology (added 10/91)
92 = Radiation oncology (added 10/91)
93 = Emergency medicine (added 10/91)
94 = Interventional radiology (added 10/91)
95 = Independent physiological laboratory (added 10/91)
96 = Unknown physician specialty (added 10/91)
99 = Unknown--incl. social worker's psychiatric services (revised 10/91 to mean unknown supplier/provider)

**Effective 5/92**

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

04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Gynecology (osteopaths only) (discontinued 5/92 use code 16)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative therapy
13 = Neurology
14 = Neurosurgery
15 = Obstetrics (osteopaths only) (discontinued 5/92 use code 16)
16 = Obstetrics/gynecology
17 = Ophthalmology, otology, laryngology, rhinology (osteopaths only) (discontinued 5/92 use codes 18 or 04 depending on percentage of practice)
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Pathologic anatomy, clinical
<table>
<thead>
<tr>
<th>Code</th>
<th>Specialty Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Pathology (osteopaths only) (discontinued 5/92 use code 22)</td>
</tr>
<tr>
<td>23</td>
<td>Peripheral vascular disease, medical or surgical (osteopaths only) (discontinued 5/92 use code 76)</td>
</tr>
<tr>
<td>24</td>
<td>Plastic and reconstructive surgery</td>
</tr>
<tr>
<td>25</td>
<td>Physical medicine and rehabilitation</td>
</tr>
<tr>
<td>26</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>27</td>
<td>Psychiatry, neurology (osteopaths only) (discontinued 5/92 use code 86)</td>
</tr>
<tr>
<td>28</td>
<td>Colorectal surgery (formerly proctology)</td>
</tr>
<tr>
<td>29</td>
<td>Pulmonary disease</td>
</tr>
<tr>
<td>30</td>
<td>Diagnostic radiology</td>
</tr>
<tr>
<td>31</td>
<td>Roentgenology, radiology (osteopaths only) (discontinued 5/92 use code 30)</td>
</tr>
<tr>
<td>32</td>
<td>Radiation therapy (osteopaths only) (discontinued 5/92 use code 92)</td>
</tr>
<tr>
<td>33</td>
<td>Thoracic surgery</td>
</tr>
<tr>
<td>34</td>
<td>Urology</td>
</tr>
<tr>
<td>35</td>
<td>Chiropractic</td>
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<td>36</td>
<td>Nuclear medicine</td>
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<td>37</td>
<td>Pediatric medicine</td>
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<tr>
<td>38</td>
<td>Geriatric medicine</td>
</tr>
<tr>
<td>39</td>
<td>Nephrology</td>
</tr>
<tr>
<td>40</td>
<td>Hand surgery</td>
</tr>
<tr>
<td>41</td>
<td>Optometry (revised 10/93 to mean optometrist)</td>
</tr>
<tr>
<td>42</td>
<td>Certified nurse midwife (eff 1/87)</td>
</tr>
<tr>
<td>43</td>
<td>Crna, anesthesia assistant (eff 1/87)</td>
</tr>
<tr>
<td>44</td>
<td>Infectious disease</td>
</tr>
<tr>
<td>45</td>
<td>Mammography screening center</td>
</tr>
<tr>
<td>46</td>
<td>Endocrinology (eff 5/92)</td>
</tr>
<tr>
<td>47</td>
<td>Independent Diagnostic Testing Facility (IDTF) (eff. 6/98)</td>
</tr>
<tr>
<td>48</td>
<td>Podiatry</td>
</tr>
<tr>
<td>49</td>
<td>Ambulatory surgical center (formerly miscellaneous)</td>
</tr>
</tbody>
</table>
50 = Nurse practitioner
51 = Medical supply company with
    certified orthotist (certified by American Board for Certification in
    Prosthetics And Orthotics)
52 = Medical supply company with
    certified prosthetist
    (certified by American Board for Certification In Prosthetics And
    Orthotics)
53 = Medical supply company with
    certified prosthetist-orthotist
    (certified by American Board for Certification in Prosthetics
    and Orthotics)
54 = Medical supply company not included
    in 51, 52, or 53. (Revised 10/93
    to mean medical supply company for DMERC)
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-
    orthotist
58 = Individuals not included in 55, 56,
    or 57 (revised 10/93 to mean medical
    supply company with registered
    pharmacist)
59 = Ambulance service supplier, e.g.,
    private ambulance companies, funeral
    homes, etc.
60 = Public health or welfare agencies
    (federal, state, and local)
61 = Voluntary health or charitable
    agencies (e.g., National Cancer
    Society, National Heart Association,
    Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier
64 = Audiologist (billing independently)
65 = Physical therapist (independently
    practicing)
66 = Rheumatology (eff 5/92)
    Note: during 93/94 DMERC also used this
    to mean medical supply company with
respiratory therapist
67 = Occupational therapist (independently practicing)
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Multispecialty clinic or group practice
71 = Diagnostic X-ray (GPPP) (not to be assigned after 5/92)

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

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

<table>
<thead>
<tr>
<th>HCFA_PRVDR_SPCLTY_TB</th>
<th>HCFA Provider Specialty Table</th>
</tr>
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<tbody>
<tr>
<td>code 88 eff 10/93</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>HCFA_TYPE_SRVC_TB</th>
<th>HCFA Type of Service Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Medical care</td>
<td></td>
</tr>
<tr>
<td>2 Surgery</td>
<td></td>
</tr>
<tr>
<td>3 Consultation</td>
<td></td>
</tr>
<tr>
<td>4 Diagnostic radiology</td>
<td></td>
</tr>
<tr>
<td>5 Diagnostic laboratory</td>
<td></td>
</tr>
<tr>
<td>6 Therapeutic radiology</td>
<td></td>
</tr>
</tbody>
</table>
7 = Anesthesia
8 = Assistant at surgery
9 = Other medical items or services
0 = Whole blood only (eff 01/96)
   whole blood or packed red cells before 01/96
A = Used durable medical equipment (DME)
B = High risk screening mammography
   (obsolete 1/1/98)
C = Low risk screening mammography
   (obsolete 1/1/98)
D = Ambulance (eff 04/95)
E = Enteral/parenteral nutrients/supplies
   (eff 04/95)
F = Ambulatory surgical center (facility
   usage for surgical services)
G = Immunosuppressive drugs
H = Hospice services (discontinued 01/95)
I = Purchase of DME (installment basis)
   (discontinued 04/95)
J = Diabetic shoes (eff 04/95)
K = Hearing items and services (eff 04/95)
L = ESRD supplies (eff 04/95)
   (renal supplier in the home before 04/95)
M = Monthly capitation payment for dialysis
N = Kidney donor
P = Lump sum purchase of DME, prosthetics,
   orthotics
Q = Vision items or services
R = Rental of DME
S = Surgical dressings or other medical supplies
   (eff 04/95)
T = Psychological therapy (term. 12/31/97)
   outpatient mental health limitation (eff. 1/1/98)
U = Occupational therapy
V = Pneumococcal/flu vaccine (eff 01/96),
   Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),
   Pneumococcal only before 04/95
W = Physical therapy
Y = Second opinion on elective surgery
   (obsolete 1/97)
Z = Third opinion on elective surgery
   (obsolete 1/97)
**Line Additional Claim Documentation Indicator Table**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>No additional documentation</td>
</tr>
<tr>
<td>1</td>
<td>Additional documentation submitted for non-DME EMC claim</td>
</tr>
<tr>
<td>2</td>
<td>CMN/prescription/other documentation submitted which justifies medical necessity</td>
</tr>
<tr>
<td>3</td>
<td>Prior authorization obtained and approved</td>
</tr>
<tr>
<td>4</td>
<td>Prior authorization requested but not approved</td>
</tr>
<tr>
<td>5</td>
<td>CMN/prescription/other documentation submitted but did not justify medical necessity</td>
</tr>
<tr>
<td>6</td>
<td>CMN/prescription/other documentation submitted and approved after prior authorization rejected</td>
</tr>
<tr>
<td>7</td>
<td>Recertification CMN/prescription/other documentation</td>
</tr>
</tbody>
</table>

**Line Place Of Service Table**

**Prior To 1/92**

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

**Effective 1/92**
11 = Office
12 = Home
21 = Inpatient hospital
22 = Outpatient hospital
23 = Emergency room - hospital
24 = Ambulatory surgical center
25 = Birthing center
26 = Military treatment facility
31 = Skilled nursing facility
32 = Nursing facility
33 = Custodial care facility
34 = Hospice
35 = Adult living care facilities (ALCF)
      (eff. NYD - added 12/3/97)
41 = Ambulance - land
42 = Ambulance - air or water
50 = Federally qualified health centers
      (eff. 10/1/93)
51 = Inpatient psychiatric facility
52 = Psychiatric facility partial hospitalization
53 = Community mental health center
54 = Intermediate care facility/mentally
tardced
55 = Residential substance abuse treatment
facility
56 = Psychiatric residential treatment
center
60 = Mass immunizations center (eff. 9/1/97)
61 = Comprehensive inpatient rehabilitation
facility
62 = Comprehensive outpatient rehabilitation
facility
65 = End stage renal disease treatment facility
71 = State or local public health clinic
72 = Rural health clinic
81 = Independent laboratory
99 = Other unlisted facility

1 LINE_PLV_SRVC_TB Line Place Of Service Table

1 LINE_PMT_IND_TB Line Payment Indicator Table
<table>
<thead>
<tr>
<th>Line Processing Indicator Table</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>Allowed</td>
</tr>
<tr>
<td>B</td>
<td>Benefits exhausted</td>
</tr>
<tr>
<td>C</td>
<td>Noncovered care</td>
</tr>
<tr>
<td>D</td>
<td>Denied (existed prior to 1991; from BMAD)</td>
</tr>
<tr>
<td>I</td>
<td>Invalid data</td>
</tr>
<tr>
<td>L</td>
<td>CLIA (eff 9/92)</td>
</tr>
<tr>
<td>M</td>
<td>Multiple submittal--duplicate line item</td>
</tr>
<tr>
<td>N</td>
<td>Medically unnecessary</td>
</tr>
<tr>
<td>O</td>
<td>Other</td>
</tr>
<tr>
<td>P</td>
<td>Physician ownership denial (eff 3/92)</td>
</tr>
<tr>
<td>Q</td>
<td>MSP cost avoided (contractor #88888) -- voluntary agreement (eff. 1/96)</td>
</tr>
<tr>
<td>R</td>
<td>Reprocessed--adjustments based on subsequent reprocessing of claim</td>
</tr>
<tr>
<td>S</td>
<td>Secondary payer</td>
</tr>
<tr>
<td>T</td>
<td>MSP cost avoided -- IEQ contractor (eff. 7/76)</td>
</tr>
<tr>
<td>U</td>
<td>MSP cost avoided -- HMO rate cell adjustment (eff. 7/96)</td>
</tr>
<tr>
<td>V</td>
<td>MSP cost avoided -- litigation settlement (eff. 7/96)</td>
</tr>
<tr>
<td>LINE_PRVDR_PRTCPTG_IND_TB</td>
<td>Line Provider Participating Indicator Table</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>1 = Participating</td>
<td></td>
</tr>
<tr>
<td>2 = All or some covered and allowed expenses applied to deductible Participating</td>
<td></td>
</tr>
<tr>
<td>3 = Assignment accepted/non-participating</td>
<td></td>
</tr>
<tr>
<td>4 = Assignment not accepted/non-participating</td>
<td></td>
</tr>
<tr>
<td>5 = Assignment accepted but all or some covered and allowed expenses applied to deductible Non-participating.</td>
<td></td>
</tr>
<tr>
<td>6 = Assignment not accepted and all covered and allowed expenses applied to deductible non-participating.</td>
<td></td>
</tr>
<tr>
<td>7 = Participating provider not accepting assignment.</td>
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<thead>
<tr>
<th>NCH_CLM_TYPE_TB</th>
<th>NCH Claim Type Table</th>
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<tbody>
<tr>
<td>10 = HHA claim</td>
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<tr>
<td>20 = Non swing bed SNF claim</td>
<td></td>
</tr>
<tr>
<td>30 = Swing bed SNF claim</td>
<td></td>
</tr>
<tr>
<td>40 = Outpatient claim</td>
<td></td>
</tr>
<tr>
<td>41 = Outpatient 'Full-Encounter' claim (available in NMUD)</td>
<td></td>
</tr>
<tr>
<td>42 = Outpatient 'Abbreviated-Encounter' claim (available in NMUD)</td>
<td></td>
</tr>
<tr>
<td>50 = Hospice claim</td>
<td></td>
</tr>
<tr>
<td>60 = Inpatient claim</td>
<td></td>
</tr>
<tr>
<td>61 = Inpatient 'Full-Encounter' claim</td>
<td></td>
</tr>
<tr>
<td>62 = Inpatient 'Abbreviated-Encounter claim (available in NMUD)</td>
<td></td>
</tr>
<tr>
<td>71 = RIC O local carrier non-DMEPOS claim</td>
<td></td>
</tr>
<tr>
<td>72 = RIC O local carrier DMEPOS claim</td>
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</tbody>
</table>
73 = Physician 'Full-Encounter' claim
(available in NMUD)
81 = RIC M DMEPOS non-DMEPOS claim
82 = RIC M DMEPOS DMEPOS claim

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A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
A000 = (C) REIMB > $100,000 OR UNITS > 150
A002 = (C) CLAIM IDENTIFIER (CAN)
A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
A004 = (C) PATIENT SURNAME BLANK
A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
A006 = (C) DATE OF BIRTH IS NOT NUMERIC
A007 = (C) INVALID GENDER (0, 1, 2)
A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
A1X1 = (C) PERCENT ALLOWED INDICATOR
A1X2 = (C) DT>97273, DGI=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 DMEC SERVICE AREA
D4X3 = (C) DME STATE CODE INVALID
D5X1 = (C) TOS INVALID FOR DME HCPCS
D5X2 = (C) DME HCPCS NDC & NDC DESCRIPT MISSING
D5X3 = (C) DME INVALID USE OF MS MODIFIER
D5X4 = (C) TOS NDC REQD WHEN HCPCS OMITTED
D5X5 = (C) TOS NDC REQD FOR Q0127=130 HCPCS
D5X6 = (C) TOS NDC/DIAGNOSIS CODE INVALID
D6X1 = (C) DME SUPPLIER NUMBER MISSING
D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
D919 = (C) CAPPED/PEN PUMPS, NUM OF SRVCS > 1
D921 = (C) SHOE HCPCS W/O MOD RT, LT REQ U-2/4/6
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<tr>
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<th>Description</th>
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<td>SYS DUPL: HOST/BATCH/QUERY-CODE</td>
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<td>Y001</td>
<td>HCPCS R0075/UNITS&gt;1/SERVICES=1</td>
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<tr>
<td>Y002</td>
<td>HCPCS R0075/UNITS=1/SERVICES&gt;1</td>
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<tr>
<td>Y003</td>
<td>HCPCS R0075/UNITS-SERVICES</td>
</tr>
<tr>
<td>Y010</td>
<td>TOB=13X/14X AND T.C.&gt;$7,500</td>
</tr>
<tr>
<td>Y011</td>
<td>INF CLAIM/REIM &gt; $75,000</td>
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<tr>
<td>Z001</td>
<td>KVNU 820-859 REQ COND CODE 71-76</td>
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<tr>
<td>Z002</td>
<td>CC M2 PRESENT/REIMB &gt; $150,000</td>
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<td>Z003</td>
<td>CC M2 PRESENT/UNITS &gt; 150</td>
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<tr>
<td>Z004</td>
<td>CC M2 PRESENT/UNITS &amp; REIM &lt; MAX</td>
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<tr>
<td>Z005</td>
<td>REIMB&gt;99999 AND REIMB&lt;150000</td>
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<td>Z006</td>
<td>UNITS&gt;99 AND UNITS&lt;150</td>
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<tr>
<td>Z237</td>
<td>HOSPICE OVERLAP - DATE ZERO</td>
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<tr>
<td>0011</td>
<td>ACTION CODE INVALID</td>
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<tr>
<td>0013</td>
<td>CABLE/FOCE AND VALID ADMIT DATE</td>
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<tr>
<td>0014</td>
<td>DEMO NUM NOT=01-06,08,15,31</td>
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<tr>
<td>0015</td>
<td>ESRD PLAN BUT DEMO ID NOT = 15</td>
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<tr>
<td>0016</td>
<td>INVALID VA CLAIM</td>
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<tr>
<td>0017</td>
<td>DEMO=31,TOB&lt;&gt;11 OR SPEC&lt;&gt;08</td>
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<tr>
<td>0018</td>
<td>DEMO=31,ACT CD&lt;&gt;1/5 OR ENT CD&lt;&gt;1/5</td>
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<tr>
<td>0020</td>
<td>CANCEL ONLY CODE INVALID</td>
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<tr>
<td>0021</td>
<td>DEMO COUNT &gt; 1</td>
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<tr>
<td>0301</td>
<td>INVALID HI CLAIM NUMBER</td>
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1  NCH_EDIT_TB  NCH EDIT TABLE

<table>
<thead>
<tr>
<th>Error Code</th>
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<tbody>
<tr>
<td>0302</td>
<td>BENE IDEN CDE (BIC) INVALID OR BLK</td>
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<tr>
<td>04A1</td>
<td>PATIENT SURNAME BLANK (PHYS/SUP)</td>
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<td>04B1</td>
<td>PATIENT 1ST INITIAL NOT-ALPHABETIC</td>
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<tr>
<td>0401</td>
<td>BILL TYPE/PROVIDER INVALID</td>
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<tr>
<td>0402</td>
<td>BILL TYPE/REV CODE/PROVR RANGE</td>
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<tr>
<td>0406</td>
<td>MAMMOGRAPHY WITH NO HCPCS 76092</td>
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<tr>
<td>0407</td>
<td>RESPITE CARE BILL TYPE 34X,NO REV 66</td>
</tr>
<tr>
<td>0408</td>
<td>REV CODE 403 /TYPE 71X/ PROV3800-974</td>
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<tr>
<td>0410</td>
<td>IMMUNE DRUG OCCR-36,NO REV-25 OR 636</td>
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<tr>
<td>0412</td>
<td>BILL TYPE XX5 HAS ACCOM. REV. CODES</td>
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<tr>
<td>0413</td>
<td>CABLE/FOCE BUT TOB = HHA,OUT,HOS</td>
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<tr>
<td>0414</td>
<td>VALU CD 61,MSA AMOUNT MISSING</td>
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<tr>
<td>0415</td>
<td>HOME HEALTH INCORRECT ALPHA RIC</td>
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<tr>
<td>05X4</td>
<td>UFIR REQUIRED FOR TYPE-OF-SERVICE</td>
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<tr>
<td>05X5</td>
<td>UFIR REQUIRED FOR DME HCPCS</td>
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<tr>
<td>0501</td>
<td>UNIQUE PHY IDEN. (UPIN) BLANK</td>
</tr>
<tr>
<td>0502</td>
<td>UNIQUE PHY IDEN. (UPIN) INVALID</td>
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</table>
2308 - (C) NOPAY = R WHEN UTIL DAYS = ZERO
2401 - (C) NON-UTIL DAYS INVALID
2501 - (C) CLAIM RCV DT OR COINSURANCE INVALID
2502 - (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
2503 - (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
2504 - (C) COINSURANCE AMOUNT EXCESSIVE
2505 - (C) COINSURANCE RATE > ALLOWED AMOUNT
2506 - (C) COINSURANCE DAYS/AMOUNT INCONSIST
2507 - (C) COIN+LR DAYS > TOTAL DAYS FOR YR
2508 - (C) COINSURANCE DAYS INVALID FOR TRAN
2601 - (C) CLAIM PAID DT INVALID OR LIFE RES
2602 - (C) LR-DYS, NO VAL 08,10/PP/DEN>CUR+27
2603 - (C) LIFE RESERVE > RATE FOR CAL YEAR
2604 - (C) FPS 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+46+9 NOT = NONUTIL DAYS
28XM - (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN - (C) INVALID OCC CODE
28XO - (C) BENE EXH DATE OUTSIDE SERVICE DATES
28X1 - (C) OCCUR DATE INVALID
28X2 - (C) OCCUR = 20 AND TRANS = 4
28X3 - (C) OCCUR 20 DATE < ADMIT DATE
28X4 - (C) OCCUR 20 DATE > ADMIT + 12
28X5 - (C) OCCUR 20 AND ADMIT NOT = FROM
28X6 - (C) OCCUR 20 DATE < BENE EXH DATE
28X7 - (C) OCCUR 20 DATE UTIL<COIN>COVERAGE
28X8 - (C) OCCUR 22 DATE < FROM OR > THRU
28X9 - (C) UTIL > FROM - THRU LESS NCOV
33X1 - (C) QUAL STAY DAYS INVALID (SPAN=70)
33X2 - (C) QS FROM DATE NOT < THRU (SPAN=70)
33X3 - (C) QS DAYS/ADMISSION ARE INVALID
33X4 - (C) QS THRU DATE > ADMIT DATE (SPAN=70)
33X5 - (C) SPAN 70 INVALID FOR DATE OF SERVICE
33X6 - (C) TOB>=18/21/28/51,COND<>WO, HMO<>90091
33X7 - (C) TOB<=18/21/28/51,COND=WO
33X8 - (C) TOB=18/21/28/51,CO=WO,ADM DT<97001
33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT
34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN
3401 = (C) DEMO ID = 04 AND RIC NOT = 1
35X1 = (C) E0, 61, 66 & NON-PPS / 65 & PPS
35X2 = (C) COND = 60 OR 61 AND NO VALU 17
35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0
36X1 = (C) SURG DATE < STAY FROM / > STAY THRU
3701 = (C) ASSIGN CODE INVALID
3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA
3706 = (C) INVALID IDE NUMBER-NOT IN FILE
3710 = (C) NUM OF IDE# > REV 0624
3715 = (C) NUM OF IDE# < REV 0624
3720 = (C) IDE AND LINO ITEM NUMBER > 2
3801 = (C) AMT BENE PD INVALID
4001 = (C) BLOOD PINTS FURNISHED INVALID
4002 = (C) BLOOD FURNISHED/REPLACED INVALID

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4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
4201 = (C) BLOOD PINTS UNREPLACED INVALID
4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED
4203 = (C) INVALID CPO PROVIDER NUMBER
4301 = (C) BLOOD DEDUCTABLE INVALID
4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
4304 = (C) BLOOD DEDUCT > 3 - REPLACED
4501 = (C) PRIMARY DIAGNOSIS INVALID
46XA = (C) MSP VET AND VET AT MEDICARE
46XB = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
46XC = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
46XG = (C) VALU CODE 20 INVALID
46XN = (C) VALUE CODE 37,38,39 INVALID
46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSING
46XP = (C) BLD UNREP VS REV CDS AND/OR UNITS
46XQ = (C) VALUE CDE 37-39 AND 38 IS PRESENT
46XR = (C) BLD FIELDS VS REV CDE 380,381,382
46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT
46XT = (C) CABG/PCOR,VO<>Y1,Y2,Y3,Y4,VA NOT=0
46X1 = (C) VALUE AMOUNT INVALID
46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61
46X7 = (C) OUTLIER (VAL 17) > REIMB + VAL6-16
46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
46X9 = (C) DEMO ID=03, REQUIRED HCPCS NOT SHOWN
46XO = (C) CAPITAL TOTAL NOT = CAP VALUES
46X1 = (C) CAGB/PCOE, MSP CODE PRESENT
46X2 = (C) DEMO ID = 03 AND RIC NOT=6,7
4901 = (C) PCOE/CAGB, DEN CD NOT D
4902 = (C) PCOE/CAGB BUT DME
50X1 = (C) RVCD=54, TOB<13,23,32,33,34,83,85
50X2 = (C) REV CD=054X, MOD NOT = QM,QN
50X3 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
50X4 = (E) EDB: NOMATCH ON MASTER-ID RECORD
50X5 = (E) EDB: NOMATCH ON CLAIM-NUMBER
51X1 = (C) HCPCS EYEWARE & REV CODE NOT 274
51X2 = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51X3 = (C) HCPCS REQUIRES UNITS > ZERO
51X4 = (C) HCPCS REQUIRES REVENUE CODE 636
51X5 = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51X6 = (C) HCPCS REQUIRES DIAG OF HEMOPHILIA
51X7 = (C) TOB 21X/PB2=2/3/4; REV CD<9001,>9044
51X8 = (C) TOB 21X/PB2=<2/3/4; REV CD>8999<9045
51X9 = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
51X10 = (C) REV 0762/UNIT>48, TOB NOT=12,13,85,83
51X11 = (C) TOB, RC>9041/<9045,RC<=4/234
51X12 = (C) TOB, RC>9032/<9042,RC<=4/234
51X13 = (C) HHA RC DATE OF SRVC MISSING
51X14 = (C) NO RC 0636 OR DTE INVALID
51X15 = (C) DEMO ID=01, RIC NOT=2
51X16 = (C) DEMO ID=01, RUGS<>2,3,4 OR BILL<>21
51X17 = (C) REV CENTER CODE INVALID
51X18 = (C) REV CODE CHECK

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51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
51X3 = (C) UNITS MUST BE > 0
51X4 = (C) INF:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR
51X5 = (C) REVENUE NON-COVERED > TOTAL CHARGE
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
51X9 = (C) HCPCS/REV CODE/BILL TYPE
5100 = (U) TRANSITION SPELL / SNF
5160 = (U) LATE CHG HSP BILL STAY DAYS > 0
5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
5167 = (U) PROVIDER 1 NE 2; FROM DT < START DT
5169 = (U) PROVIDER NE TO WORK PROVIDER
5177 = (U) PROVIDER NE TO WORK PROVIDER
5178 = (U) HOSPICE BILL THRU < DOLBA
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
5200 = (E) ENTITLEMENT EFFECTIVE DATE
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
5202 = (U) HOSPICE TRAILER ERROR
5203 = (E) ENTITLEMENT HOSPICE PERIODS
5203 = (U) HOSPICE START DATE ERROR
5204 = (U) HOSPICE DATE DIFFERENCE NE 90
5205 = (U) HOSPICE DATE DISCREPANCY
5206 = (U) HOSPICE DATE DISCREPANCY
5207 = (U) HOSPICE THRU > TERM DATE 2ND
5208 = (U) HOSPICE PERIOD NUMBER BLANK
5209 = (U) HOSPICE DATE DISCREPANCY
5210 = (E) ENTITLEMENT FROM/TRU/END DATES
5211 = (E) ENTITLEMENT DATE DEATH/THRU
5212 = (E) ENTITLEMENT DATE DEATH/THRU
5213 = (E) ENTITLEMENT DATE DEATH MBR
5220 = (E) ENTITLEMENT FROM/EFF DATES
5225 = (E) ENT INP PPS SPAN 70 DATES
5232 = (E) ENTL HMO NO HMO OVERRIDE CDE
5233 = (E) ENTITLEMENT HMO PERIODS
5234 = (E) ENTITLEMENT HMO NUMBER NEEDED
5235 = (E) ENTITLEMENT HMO HOSP+NO CC07
5236 = (E) ENTITLEMENT HMO HOSP + CC07
5237 = (E) ENTITLEMENT HOSP OVERLAP
5238 = (U) HOSPICE CLAIM OVERLAP > 90
5239 = (U) HOSPICE CLAIM OVERLAP > 60
5242 = (E) HOSP OVERLAP NO GVD 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
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<tr>
<td>525Z</td>
<td>(E) HMO/HOSP 6/7 NO OVD NO DEMO</td>
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<td>5250</td>
<td>(U) HOSPICE DOEBA/DOLBA</td>
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<td>5255</td>
<td>(U) HOSPICE DAYS USED</td>
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<td>5256</td>
<td>(U) HOSPICE DAYS USED &gt; 999</td>
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<td>526Y</td>
<td>(E) HMO/HOSP DEMO 5/15 REIMB &gt; 0</td>
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<td>(E) HMO/HOSP DEMO 5/15 REIMB = 0</td>
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<td>527Y</td>
<td>(E) HMO/HOSP DEMO OVD-1 REIMB &gt; 0</td>
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<td>527Z</td>
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<td>(U) HOSPICE PERIOD NUMBER ERROR</td>
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<td>(U) BILL &gt; DOEBA AND IND-1 = 2</td>
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<td>(U) HOSPICE DOEBA/DOLBA SECONDARY</td>
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<td>(U) HOSPICE DAYS USED SECONDARY</td>
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<td>(C) SERVICE DATE &lt; AGE 50</td>
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<td>(U) UTIL DAYS/LIFE PSYCH DAYS</td>
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<td>(U) HH VISITS NE APT PT B TRLR</td>
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<td>(E) SNF LESS THAN PT A EFF DATE</td>
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<td>5600</td>
<td>(D) LOGICAL DUPE, COVERED</td>
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<tr>
<td>5601</td>
<td>(D) LOGICAL DUPE, QRY-CDE, RIC 123</td>
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<td>5602</td>
<td>(D) LOGICAL DUPE, FANDE C, E OR I</td>
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<td>(D) LOGICAL DUPE, COVERED</td>
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<tr>
<td>5605</td>
<td>(D) POSS DUPE, OUTPAT REIMB</td>
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<tr>
<td>5606</td>
<td>(D) POSS DUPE, HOME HEALTH COVERED U</td>
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<tr>
<td>5623</td>
<td>(U) NON-FAY CODE IS P</td>
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<tr>
<td>57X1</td>
<td>(C) PROVIDER SPECIALITY CODE INVALID</td>
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<tr>
<td>57X2</td>
<td>(C) PHYS THERAPY/PROVIDER SPEC INVALID</td>
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<tr>
<td>57X3</td>
<td>(C) PLACE/TYPE/SPECIALTY/REIMB IND</td>
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<td>57X4</td>
<td>(C) SPECIALTY CODE VS. HCPCS INVALID</td>
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<td>5700</td>
<td>(U) LINKED TO THREE SPELLS</td>
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5701 = (C) DEMO ID=02,RIC NOT = 5
5702 = (C) DEMO ID=02,INVALID PROVIDER NUM
58X1 = (C) PROVIDER TYPE INVALID
58X9 = (C) TYPE OF SERVICE INVALID
5802 = (C) REIMB > $150,000
5803 = (C) UNITS/VISITS > 150
5804 = (C) UNITS/VISITS > 99
59XA = (C) PROST ORTH HCPCS/FROM DATE
59XB = (C) HCPCS/FROM DATE/TYPE P OR I
59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE
59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE
59XE = (C) HCPCS/HAMMOGRAPHY-RISK/ DIAGNOSIS
59XG = (C) CAPPED/FREQ-MAINT/FROST HCPCS
59XH = (C) HCPCS E0620/TYPE/DATE
59XI = (C) HCPCS E0627-9/ DATE < 1991
59XL = (C) HCPCS 00104 - TOS/POS
59X1 = (C) INVALID HCPCS/TOS COMBINATION
59X2 = (C) ASC IND/TYPE OF SERVICE INVALID
59X3 = (C) TOS INVALID TO MODIFIER
59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB
59X5 = (C) MAMMOGRAPHY FOR MALE
59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS
59X7 = (C) CAPPED-HCPCS/FROM DATE
59X8 = (C) FREQUENTLY MAINTAINED HCPCS
59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R
5901 = (U) ERROR CODE OF Q
60X1 = (C) ASSIGN IND INVALID

1 NCH_EDIT_TB
----------
NCH EDIT TABLE
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6000 = (U) ADJUSTMENT BILL SPELL DATA
6020 = (U) CURRENT SPELL DOEBA < 1990
6030 = (U) ADJUSTMENT BILL SPELL DATA
6035 = (U) ADJUSTMENT BILL THRU DTE/DOLE
61X1 = (U) PAY PROCESS IND INVALID
61X2 = (U) DENIED CLAIM/NO DENIED LINE
61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
61X4 = (C) RATE MISSING OR NON-NUMERIC
6100 = (C) REV 0001 NOT PRESENT ON CLAIM
6101 = (C) REV COMPUTED CHARGES NOT-TOTAL
6102 = (C) REV COMPUTED NON-COVERED/NON-COV
6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER
62XA = (C) PSYC OT PT/REIM/TYPE
62X1 = (C) DME/DATE/100% OR INVAL REIMB IND
62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED
62X8 = (C) KIDNEY DONO/TYPE/100%
62X9 = (C) PNEUM VACCINE/TYPE/100%
6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV
6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE
6204 = (U) HOSPICE ADJUSTMENT THRU/DOLBA
6260 = (U) HOSPICE ADJUSTMENT STAY DAYS
6261 = (U) HOSPICE ADJUSTMENT DAYS USED
6265 = (U) HOSPICE ADJUSTMENT DAYS USED
6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)
63X1 = (C) DEDUCT IND INVALID
63X2 = (C) DED/HCPA COINS IN PCE/CABG
63X6 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS
63X9 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)
64X1 = (C) PROVIDER IND INVALID
64X0 = (U) PART B DEDUCTABLE CHECK
65X1 = (C) PAYSCREEN IND INVALID
667? = (D) POSS DUPE, CR/DB, DOC-ID
66XX = (D) POSS DUPE, CR/DB, DOC-ID
66X1 = (C) UNITS AMOUNT INVALID
66X2 = (C) UNITS IND > 0; AMT NOT VALID
66X3 = (C) UNITS IND = 0; AMT > 0
66X4 = (C) MT INDICATOR/AMOUNT
6600 = (U) ADJUSTMENT BILL FULL DAYS
6610 = (U) ADJUSTMENT BILL COIN DAYS
6620 = (U) ADJUSTMENT BILL LIFE RESERVE
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
67X1 = (C) UNITS INDICATOR INVALID
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0
67X3 = (C) TOS/HCPCS-AMENST, MTU IND NOT = 2
67X4 = (C) HCPCS - AMBULANCE, MTU IND NOT = 1
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS
68X1 = (C) INVALID HCPCS CODE
68X2 = (C) MAMMOGRAPHY/DATE/PROC NOT 76092
68X3 = (C) TYPE OF SERVICE = G /PROC CODE
68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE
68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC
68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC
68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.
68X8 = (C) LINE ITEM INCORRECT OR DATE INVAL.

1 NCH_EDIT_TB
NCH EDIT TABLE

69X1A = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
69X3 = (C) PROC CODE MOD = LL / TYPE = R
69X6 = (C) PROC CODE MOD/NOT CAPPED
69X8 = (C) SPEC CODE NURSE PRAC'T, MOD INVAL
69X1A = (C) KRON IND AND UTIL DYS EQUALS ZERO
69X1B = (C) KRON IND AND NO-PAY CODE B OR N
69X1C = (C) KRON IND AND INPATIENT DEDUCT = 0
69X1D = (C) KRON IND AND TRANS CODE IS 4
69X1E = (C) REV CODES ON HOME HEALTH
69X1F = (C) REV CODE 274 ON OUTPAT AND HH ONLY
69X2 = (C) REV CODE INVAL FOR PROSTH AND ORTHO
69X3 = (C) REV CODE INVAL FOR OXYGEN
69X4 = (C) REV CODE INVAL FOR DME
69X5 = (C) PURCHASE OF RENT DME INVAL ON DATES
69X6 = (C) PURCHASE OF RENT DME INVAL ON DATES
69X7 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000
69X8 = (C) HCPCS INVAL ON DATE RANGES
69X9 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89
69X10 = (C) HCPCS INVAL ON REV 270/BILL 32-33
69X21 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X
69X22 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274
69X23 = (C) RENTAL OF DME CUSTOMIZE AND REV 291
69X24 = (C) INVAL MODIFIER FOR CAPPED RENTAL
69X25 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X
69X26 = (U) ADJUSTMENT BILL LIFE RESERVE
69X27 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
70X1 = (U) INVALID DOEBA/DOLBA
70X2 = (U) LESS THAN 60/61 BETWEEN SPELLS
70X8 = (E) TOB 85X/ELECTRX PRD; COND CD 07 REQD
71X1 = (C) SUBMITTED CHARGES INVALID
71X2 = (C) MAMMOGRPHY/PROC CODE MOD TC, 26/CHG
72X1 = (C) ALLOWED CHGS INVALID
72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
72X3 = (C) DENIED LINE/ALLOWED CHARGES
73X1 = (C) SS NUMBER INVALID
73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING
74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT
76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL
77X1 = (C) PLACE OF SERVICE INVALID
77X2 = (C) PHYS THERAPY/PLACE
77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE
77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND
77X6 = (C) TOS=F, PL OP SER NOT = 24
7701 = (C) INCORRECT MODIFIER
7777 = (D) POSS DUPE, PART B DOC-ID
78X1 = (C) MAMMOGRAPHY BEFORE 1991
78X3 = (C) FROM DATE GREATER THAN THRU DATE
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY
78X5 = (C) FROM DATE > PAID DATE/TYPE/100%
78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE
79X3 = (C) THRU DATE=RECD DATE/NOT DENTED
79X4 = (C) THRU DATE=PAID DATE/NOT DENTED
8000 = (U) MAIN & 2NDARY DOB/BA < 01/01/90
8028 = (E) NO ENTITLEMENT
8029 = (U) HH BEFORE PERIOD NOT PRESENT
8030 = (U) HH BILL VISITS > PT A REMAINING
8031 = (U) HH PT A REMAINING > 0

1 NCH_EDIT_TAB
-------------

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 DOB/DOB/A in AFT > 0
8060 = (U) HH QUALIFYING INDICATOR NE 1
8061 = (U) HH DATE NE DOLBA IN AFT TLR
8062 = (U) HH NE PT-A VISITS REMAINING
81X1 = (C) NUM OF SERVICES INVALID
83X1 = (C) DIAGNOSIS INVALID
83X2 = (C) HCPCS/GENDER DIAGNOSIS
8302 = (C) HCPCS G0101 V-CODE/SEX CODE
8304 = (C) BILL TYPE INVALID FOR G0123/4
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
84X2 = (C) INVALID DME START DATE
84X3 = (C) INVALID DME START DATE 6/HCPCS
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
84X5 = (C) HCPCS CODE WITH INV DIAG CODE
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
88XX = (D) POSS DUPE, DOC-ID, UNITS, ENT, ALWD
9000 = (U) DOEBA/DOLBA CALC
9005 = (U) FULL/COINS HOSP DAYS CALC
9010 = (U) FULL/COINS SNF DAYS CALC
9015 = (U) LIFE RESERVE DAYS CALC
9020 = (U) LIFE PSYCH DAYS CALC
9030 = (U) INPAT DEDUCTABLE CALC
9040 = (U) DATA INDICATOR 1 SET
9050 = (U) DATA INDICATOR 2 SET
91X1 = (C) PATIENT REIMB/PAY-DENY CODE
92X1 = (C) PATIENT REIMB INVALID
92X2 = (C) PROVIDER REIMB INVALID
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
92X7 = (C) REIMB/PAY-DENY INCONSISTENT
9201 = (C) UPIN REF NAME OR INITIAL MISSING
9202 = (C) UPIN REF FIRST 3 CHAR INVALID
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
93X1 = (C) CASH DEDUCTIBLE INVALID
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
93X4 = (C) FROM DATE/CASH DEDUCTIBLE
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
9300 = (C) UPIN OTHER, NOT PRESENT
9301 = (C) UPIN NME MIS/DEG TOT LI>0 FR DEN CLM
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
94A1 = (C) NON-COVERED FROM DATE INVALID
94A2 = (C) NON-COVERED FROM > THRU DATE
94A3 = (C) NON-COVERED THRU DATE INVALID
94A4 = (C) NON-COVERED THRU DATE > ADMIT
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
94C1 = (C) FR-PSYCH DAYS INVALID
94C3 = (C) FR-PSYCH DAYS > PROVIDER LIMIT
94F1 = (C) REIMBURSEMENT AMOUNT INVALID
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
94G1 = (C) NO-PAY CODE INVALID
94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
94G4 = (C) NO PAY CODE = R & REIMB PRESENT
94X1 = (C) BLOOD LIMIT INVALID
94X2 = (C) TYPE/BLOOD DEDUCTIBLE
94X3 = (C) TYPE/DATE/LIMIT AMOUNT
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
9401 = (C) BLOOD DEDUCTIBLE AMT > 3
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
9404 = (C) INVALID GENDER CODE ON PRO-PAY
9407 = (C) INVALID DRG NUMBER
9408 = (C) INVALID DRG NUMBER (GLOBAL)
9409 = (C) HCFA DRG<>DRG ON BILL
9410 = (C) CABG/PCEO, INVALID DRG
95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
95X2 = (C) MSP AMOUNT APPLIED INVALID
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
95X5 = (C) MSP CODE = G/DATE BEFORE 1987
95X6 = (C) MSP CODE = X AND NOT AVOIDED
95X7 = (C) MSP CODE VALID, CABG/PCEO
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/TOKEN AMT/ALLOW/CSH
98X4 = (C) DATE/MSF/TYPE/CASH DED/ALLOW/COI
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSF/TP
99XX = (D) POSS DUPR, PART B DOC-ID
9901 = (C) REV CODE INVALID OR TRAILER CNT-0
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
9903 = (C) NO CLINIC VISITS FOR RHC
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE
991X = (C) NO DATE OF SERVICE
9910 = (C) EDIT 9910 (NEW)
9911 = (C) BLOOD VERIFIED INVALID
9920 = (C) EDIT 9920 (NEW)
9930 = (C) EDIT 9930 (NEW)
9931 = (C) OUTPAT COINSURANCE VALUES
9933 = (C) RATE EXCEEDS MAMMOGRAPHY LIMIT
9940 = (C) EDIT 9940 (NEW)
9942 = (C) EDIT 9942 (NEW)
9944 = (C) STAY FROM>97273, DIAG<>V103, 163, 7612
9945 = (C) SERVICE DATE < 98001
9946 = (C) INVALID DIAGNOSIS CODE
9947 = (C) INVALID DIAGNOSIS CODE
9948 = (C) STAY FROM>96365, DIAG=V725
9960 = (C) MED CHOICE BUT HMO DATA MISSING
9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER

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

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

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

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

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

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

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

1 NCH_PATCH_TB

---

NCH Patch Table

invalid '0', '1', '2', '3' or '4' (caused by erroneous logic in HCFA program code, which was corrected on 11/1/95).

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

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

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

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

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

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
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<td>PRVDR_NUM_TB</td>
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- First two positions are the GEO SSA State Code.  
Exception: 55 = California  
67 = Texas  
68 = Florida

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

0001-0879 Short-term (general and specialty) hospitals where TOB = 11X; ESRD clinic where TOB = 72X
0880-0899 Reserved for hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB = 72X
0900-0999 Multiple hospital component in a medical complex (numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1000-1199 Reserved for future use
1200-1224 Alcohol/drug hospitals (excluded from PPS-numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1225-1299 Medical assistance facilities (Montana project); ESRD clinic where TOB = 72X
1300-1399 Rural Primary Care Hospital (RPCP) - eff. 10/97 changed to Critical Access Hospitals (CAH)
1400-1499 Continuation of 4900-4999 series (CMHC)
1500-1799 Hospices
1800-1989 Federally Qualified Health Centers (FQHC) where TOB = 73X; SNF (IP PTB) where TOB = 22X; HHA where TOB = 32X, 33X, 34X
1990-1999 Christian Science Sanatoria (hospital services)
2000-2299 Long-term hospitals (excluded from PPS)
2300-2499 Chronic renal disease facilities (hospital based)
2500-2899 Non-hospital renal disease treatment centers
2900-2999 Independent special purpose renal dialysis facility (1)
3000-3024 Formerly tuberculosis hospitals (numbers retired)
3025-3099 Rehabilitation hospitals (excluded from PPS)
3100-3199 Continuation of Subunits of Nonprofit and Proprietary Home Health Agencies (7300-7399) Series (3) (eff. 4/96)
3200-3299 Continuation of 4800-4899 series (CORF)

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3300-3399 Children’s hospitals (excluded from PPS)
where TOB = 11X; ESRD clinic where TOB = 72X
3400-3499 Continuation of rural health clinics (provider-based) (3975-3999)
3500-3699 Renal disease treatment centers (hospital satellites)
3700-3799 Hospital based special purpose renal dialysis facility (1)
3800-3974 Rural health clinics (free-standing)
3975-3999 Rural health clinics (provider-based)
4000-4499 Psychiatric hospitals (excluded from PPS)
4500-4599 Comprehensive Outpatient Rehabilitation Facilities (CORF)
4600-4799 Community Mental Health Centers (CMHC); 9/30/91 - 3/31/97 used for clinic OPT where TOB = 74X
4800-4899 Continuation of 4500-4599 series (CORF) (eff. 10/95)
4900-4999 Continuation of 4600-4799 series (CMHC) (eff. 10/95); 9/30/91 - 3/31/97 used for clinic OPT where TOB = 74X
5000-6499 Skilled Nursing Facilities
6500-6989 CMHC / Outpatient physical therapy services where TOB = 74X; CORF where TOB =
75X

6990-6999 Christian Science Sanatoria (skilled nursing services)
7000-7299 Home Health Agencies (HHA) (2)
7300-7399 Subunits of 'nonprofit' and 'proprietary' Home Health Agencies (3)
7400-7799 Continuation of 7000-7299 series
7800-7999 Subunits of state and local governmental Home Health Agencies (3)
8000-8499 Continuation of 7400-7799 series (HHA)
8500-8899 Continuation of rural health center (provider based) (3400-3499)
8900-8999 Continuation of rural health center (free-standing) (3800-3974)
9000-9499 Continuation of 8000-8499 series (HHA) (eff. 10/95)
9500-9999 Reserved for future use (eff. 8/1/98)

NOTE: 10/95-7/98 this series was assigned to HHA's but rescinded - no HHA's were ever assigned a number from this series.

Exception:

P001-P999 Organ procurement organization

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

(2) The 6400-6499 series of provider numbers in Iowa (16), South Dakota (43) and Texas (45)

have been used in reducing acute care costs (RACC) experiments.

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

(4) Parent agency must have a number in the
7000-7299, 7400-7799 or 8000-8499 series.

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

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

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Discharged to home/self care (routine charge).</td>
</tr>
<tr>
<td>02</td>
<td>Discharged/transferred to other short term general hospital for inpatient care.</td>
</tr>
<tr>
<td>03</td>
<td>Discharged/transferred to skilled nursing facility (SNF) - (For hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF.</td>
</tr>
</tbody>
</table>
04 = Discharged/transferred to intermediate care facility (ICF).
05 = Discharged/transferred to another type of institution for inpatient care (including distinct parts).
06 = Discharged/transferred to home care of organized home health service organization.
07 = Left against medical advice or discontinued care.
08 = Discharged/transferred to home under care of a home IV drug therapy provider.
09 = Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
10 = Expired (did not recover - Christian Science patient).
30 = Still patient.
40 = Expired at home (hospice claims only)
41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
42 = Expired - place unknown (Hospice claims only)
50 = Hospice - home (eff. 10/96)
51 = Hospice - medical facility (eff. 10/96)
61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (to be implemented in 1999)
71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (to be implemented in 1999).
72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (to be implemented in 1999).
*******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 authorization 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 Compensation Carrier.
20 = Claim denied because this injury/illness is covered by the liability carrier.
21 = Claim denied because this injury/illness is the liability of the no-fault carrier.
22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.
23 = Claim adjusted because charges have been paid by another payer.
24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
25 = Payment denied. Your Stop loss deductible has not been met.
26 = Expenses incurred prior to coverage.
27 = Expenses incurred after coverage terminated.
28 = Coverage not in effect at the time the service was provided.
29 = The time limit for filing has expired.
30 - Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31 - Claim denied as patient cannot be identified as our insured.
32 - Our records indicate that this dependent is not an eligible dependent as defined.
33 - Claim denied. Insured has no dependent coverage.
34 - Claim denied. Insured has no coverage for newborns.
35 - Benefit maximum has been reached.
36 - Balance does not exceed copayment amount.
37 - Balance does not exceed deductible amount.
38 - Services not provided or authorized by designated (network) providers.
39 - Services denied at the time authorization/pre-certification was requested.
40 - Charges do not meet qualifications for emergency/urgent care.
41 - Discount agreed to in Preferred Provider contract.
42 - Charges exceed our fee schedule or maximum allowable amount.
43 - Gramm-Rudman reduction.
44 - Prompt-pay discount.
45 - Charges exceed your contracted/legislated fee arrangement.
46 - This (these) service(s) is(are) not covered.
47 - This (these) diagnosis(es) is(are) not covered, missing, or are invalid.
48 - This (these) procedure(s) is(are) not covered.
49 - These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer.
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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>83</td>
<td>Total visits. INACTIVE</td>
</tr>
<tr>
<td>84</td>
<td>Capital adjustments. INACTIVE</td>
</tr>
<tr>
<td>85</td>
<td>Interest amount. INACTIVE</td>
</tr>
<tr>
<td>86</td>
<td>Statutory adjustment. INACTIVE</td>
</tr>
<tr>
<td>87</td>
<td>Transfer amounts.</td>
</tr>
<tr>
<td>88</td>
<td>Adjustment amount represents collection against receivable created in prior overpayment.</td>
</tr>
<tr>
<td>89</td>
<td>Professional fees removed from charges.</td>
</tr>
<tr>
<td>90</td>
<td>Ingredient cost adjustment.</td>
</tr>
<tr>
<td>91</td>
<td>Dispensing fee adjustment.</td>
</tr>
<tr>
<td>92</td>
<td>Claim paid in full. INACTIVE</td>
</tr>
<tr>
<td>93</td>
<td>No claim level adjustment. INACTIVE</td>
</tr>
<tr>
<td>94</td>
<td>Process in excess of charges.</td>
</tr>
<tr>
<td>95</td>
<td>Benefits adjusted. Plan procedures not followed.</td>
</tr>
<tr>
<td>96</td>
<td>Non-covered charges.</td>
</tr>
<tr>
<td>97</td>
<td>Payment is included in allowance for another service/procedure.</td>
</tr>
<tr>
<td>98</td>
<td>The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE</td>
</tr>
<tr>
<td>99</td>
<td>Medicare Secondary Payer Adjustment Amount. INACTIVE</td>
</tr>
<tr>
<td>100</td>
<td>Payment made to patient/insured/responsible party.</td>
</tr>
<tr>
<td>101</td>
<td>Predetermination: anticipated payment upon completion of services or claim adjudication.</td>
</tr>
<tr>
<td>102</td>
<td>Major medical adjustment.</td>
</tr>
<tr>
<td>103</td>
<td>Provider promotional discount (i.e. Senior citizen discount).</td>
</tr>
<tr>
<td>104</td>
<td>Managed care withholding.</td>
</tr>
<tr>
<td>105</td>
<td>Tax withholding.</td>
</tr>
<tr>
<td>106</td>
<td>Patient payment option/election not in effect.</td>
</tr>
<tr>
<td>107</td>
<td>Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.</td>
</tr>
<tr>
<td>108</td>
<td>Claim/service reduced because rent/purchase guidelines were not met.</td>
</tr>
<tr>
<td>109</td>
<td>Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.</td>
</tr>
<tr>
<td>110</td>
<td>Billing date predates service date.</td>
</tr>
<tr>
<td>111</td>
<td>Not covered unless the provider accepts assignment.</td>
</tr>
<tr>
<td>112</td>
<td>Claim/service adjusted as not furnished directly to the patient and/or not documented.</td>
</tr>
<tr>
<td>113</td>
<td>Claim denied because service/procedure was provided.</td>
</tr>
</tbody>
</table>
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.

### Revenue Center ANSI Code Table

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

0001 = Photochemotherapy
0002 = Fine needle Biopsy/Aspiration
0003 = Bone Marrow Biopsy/Aspiration
0004 = Level I Needle Biopsy/Aspiration Except Bone Marrow
0005 = Level II Needle Biopsy /Aspiration Except Bone Marrow
0006 = Level I Incision & Drainage
0007 = Level II Incision & Drainage
0008 = Level III Incision & Drainage
0009 = Nail Procedures
0010 = Level I Destruction of Lesion
0011 = Level II Destruction of Lesion
0012 = Level I Debridement & Destruction
0013 = Level II Debridement & Destruction
0014 = Level III Debridement & Destruction
0015 = Level IV Debridement & Destruction
0016 = Level V Debridement & Destruction
0017 = Level VI Debridement & Destruction
0018 = Biopsy Skin, Subcutaneous Tissue or Mucous Membrane
0019 = Level I Excision/ Biopsy
0020 = Level II Excision/ Biopsy
0021 = Level III Excision/ Biopsy
0022 = Level IV Excision/ Biopsy
0023 = Exploration Penetrating Wound
0024 = Level I Skin Repair
0025 = Level II Skin Repair
0026 = Level III Skin Repair
0027 = Level IV Skin Repair
0029 = Incision/Excision Breast
0030 = Breast Reconstruction/Mastectomy
0031 = Hyperbaric Oxygen
0032 = Placement Transvenous Catheters/Arterial Cutdown
0033 = Partial Hospitalization
0040 = Arthrocentesis & Ligament/Tendon Injection
0041 = Arthroscopy
0042 = Arthroscopically-Aided Procedures
0043 = Closed Treatment Fracture Finger/Toe/Trunk
0044 = Closed Treatment Fracture/Dislocation Except Finger/Toe/Trunk
0045 = Bone/Joint Manipulation Under Anesthesia
0046 = Open/Percutaneous Treatment Fracture or Dislocation
0047 = Arthroplasty without Prosthesis
0048 = Arthroplasty with Prosthesis
0049 = Level I Musculoskeletal Procedures Except Hand and Foot
0050 = Level II Musculoskeletal Procedures Except Hand and Foot
0051 = Level III Musculoskeletal Procedures Except Hand and Foot
0052 = Level IV Musculoskeletal Procedures Except Hand
and Foot
0053 = Level I Hand Musculoskeletal Procedures
0054 = Level II Hand Musculoskeletal Procedures
0055 = Level I Foot Musculoskeletal Procedures
0056 = Level II Foot Musculoskeletal Procedures
0057 = Bunion Procedures

0058 = Level I Strapping and Cast Application
0059 = Level II Strapping and Cast Application
0060 = Manipulation Therapy
0070 = Thoracentesis/Lavage Procedures
0071 = Level I Endoscopy Upper Airway
0072 = Level II Endoscopy Upper Airway
0073 = Level III Endoscopy Upper Airway
0074 = Level IV Endoscopy Upper Airway
0075 = Level V Endoscopy Upper Airway
0076 = Endoscopy Lower Airway
0077 = Level I Pulmonary Treatment
0078 = Level II Pulmonary Treatment
0079 = Ventilation Initiation and Management
0080 = Diagnostic Cardiac Catheterization
0081 = Non-Coronary Angioplasty or Atherectomy
0082 = Coronary Atherectomy
0083 = Coronary Angiosplasty
0084 = Level I Electrophysiologic Evaluation
0085 = Level II Electrophysiologic Evaluation
0086 = Ablate Heart Dysrhythm Focus
0087 = Cardiac Electrophysiologic Recording/Mapping
0088 = Thrombectomy
0089 = Level I Implantation/Removal/Revision of Pacemaker, AICD Vascular Device
0090 = Level II Implantation/Removal/Revision of Pacemaker, AICD Vascular Device
0091 = Level I Vascular Ligation
0092 = Level II Vascular Ligation
0093 = Vascular Repair/ Fistula Construction
0094 = Resuscitation and Cardioversion
0095 = Cardiac Rehabilitation
0096 = Non-Invasive Vascular Studies
0097 = Cardiovascular Stress Test
0098 = Injection of Sclerosing Solution
0099 = Continuous Cardiac Monitoring
0100 = Continuous ECG
0101 = Tilt Table Evaluation
0102 = Electronic Analysis of Pacemakers/other Devices
0109 = Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant
0110 = Transfusion
0111 = Blood Product Exchange
0112 = Extracorporeal Photopheresis
0113 = Excision Lymphatic System
0114 = Thyroid/Lymphadenectomy Procedures
0116 = Chemotherapy Administration by Other Technique
          Except Infusion
0117 = Chemotherapy Administration by Infusion Only
0118 = Chemotherapy Administration by Both Infusion and Other Technique
0120 = Infusion Therapy Except Chemotherapy
0121 = Level I Tube changes and Repositioning
0122 = Level II Tube changes and Repositioning
0123 = Level III Tube changes and Repositioning
0130 = Level I Laparoscopy
0131 = Level II Laparoscopy
0132 = Level III Laparoscopy
0140 = Esophageal Dilation without Endoscopy

1   REV_CNTR_APC_TB
    Revenue Center Ambulatory Payment Classification (APC)

0141 = Upper GI Procedures
0142 = Small Intestine Endoscopy
0143 = Lower GI Endoscopy
0144 = Diagnostic Anoscopy
0145 = Therapeutic Anoscopy
0146 = Level I Sigmoidoscopy
0147 = Level II Sigmoidoscopy
0148 = Level I Anal/Rectal Procedure
0149 = Level II Anal/Rectal Procedure
0150 = Level III Anal/Rectal Procedure
0151 = Endoscopic Retrograde Cholangio-Pancreatography (ERCP)
0152 = Percutaneous Biliary Endoscopic Procedures
0153 = Peritoneal and Abdominal Procedures
0154 = Hernia/Hydrocele Procedures
0157 = Colorectal Cancer Screening: Barium Enema
          (Not subject to National coinsurance)
0158 - Colorectal Cancer Screening: Colonoscopy
Not subject to National coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. Payment rate is lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

0159 - Colorectal Cancer Screening: Flexible Sigmoidoscopy
Not subject to National coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. Payment rate is lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

0160 - Level I Cystourethroscopy and other Genitourinary Procedures

0161 - Level II Cystourethroscopy and other Genitourinary Procedures

0162 - Level III Cystourethroscopy and other Genitourinary Procedures

0163 - Level IV Cystourethroscopy and other Genitourinary Procedures

0164 - Level I Urinary and Anal Procedures

0165 - Level II Urinary and Anal Procedures

0166 - Level I Urethral Procedures

0167 - Level II Urethral Procedures

0168 - Level III Urethral Procedures

0169 - Lithotripsy

0170 - Dialysis for Other Than ESRD Patients

0180 - Circumcision

0181 - Penile Procedures

0182 - Insertion of Penile Prosthesis

0183 - Testes/Epididymis Procedures

0184 - Prostate Biopsy

0190 - Surgical Hysterectomy

0191 - Level I Female Reproductive Procedures

0192 - Level II Female Reproductive Procedures

0193 - Level III Female Reproductive Procedures

0194 - Level IV Female Reproductive Procedures

0195 - Level V Female Reproductive Procedures

0196 - Dilatation & Curettage

0197 - Infertility Procedures

0198 - Pregnancy and Neonatal Care Procedures

0199 - Vaginal Delivery

0200 - Therapeutic Abortion

0201 - Spontaneous Abortion

1 REV_CNTR_APC_TB Revenue Center Ambulatory Payment Classification (APC)
0210 = Spinal Tap
0211 = Level I Nervous System Injections
0212 = Level II Nervous System Injections
0213 = Extended EEG Studies and Sleep Studies
0214 = Electroencephalogram
0215 = Level I Nerve and Muscle Tests
0216 = Level II Nerve and Muscle Tests
0217 = Level III Nerve and Muscle Tests
0220 = Level I Nerve Procedures
0221 = Level II Nerve Procedures
0222 = Implantation of Neurological Device
0223 = Level I Revision/Removal Neurological Device
0224 = Level II Revision/Removal Neurological Device
0225 = Implantation of Neurostimulator Electrodes
0230 = Level I Eye Tests
0231 = Level II Eye Tests
0232 = Level I Anterior Segment Eye
0233 = Level II Anterior Segment Eye
0234 = Level III Anterior Segment Eye Procedures
0235 = Level I Posterior Segment Eye Procedures
0236 = Level II Posterior Segment Eye Procedures
0237 = Level III Posterior Segment Eye Procedures
0238 = Level I Repair and Plastic Eye Procedures
0239 = Level II Repair and Plastic Eye Procedures
0240 = Level III Repair and Plastic Eye Procedures
0241 = Level IV Repair and Plastic Eye Procedures
0242 = Level V Repair and Plastic Eye Procedures
0243 = Strabismus/Muscle Procedures
0244 = Corneal Transplant
0245 = Cataract Procedures without IOL Insert
0246 = Cataract Procedures with IOL Insert
0247 = Laser Eye Procedures Except Retinal
0248 = Laser Retinal Procedures
0250 = Nasal Cauterization/Packing
0251 = Level I ENT Procedures
0252 = Level II ENT Procedures
0253 = Level III ENT Procedures
0254 = Level IV ENT Procedures
0256 = Level V ENT Procedures
0257 = Implantation of Cochlear Device
0258 = Tonsil and Adenoid Procedures
0260 = Level I Plain Film Except Teeth
0261 = Level II Plain Film Except Teeth Including Bone Density Measurement
0262 = Plain Film of Teeth
0263 = Level I Miscellaneous Radiology Procedures
0264 = Level II Miscellaneous Radiology Procedures
0265 = Level I Diagnostic Ultrasound Except Vascular
0266 = Level II Diagnostic Ultrasound Except Vascular
0267 = Vascular Ultrasound
0268 = Guidance Under Ultrasound
0269 = Echocardiogram Except Transesophageal
0270 = Transesophageal Echocardiogram
0271 = Mammography
0272 = Level I Fluoroscopy
0273 = Level II Fluoroscopy
0274 = Myelography
0275 = Arthrography

0276 = Level I Digestive Radiology
0277 = Level II Digestive Radiology
0278 = Diagnostic Urography
0279 = Level I Diagnostic Angiography and Venography Except Extremity
0280 = Level II Diagnostic Angiography and Venography Except Extremity
0281 = Venography of Extremity
0282 = Level I Computerized Axial Tomography
0283 = Level II Computerized Axial Tomography
0284 = Magnetic Resonance Imaging
0285 = Positron Emission Tomography (PET)
0286 = Myocardial Scans
0290 = Standard Non-Imaging Nuclear Medicine
0291 = Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans
0292 = Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans
0294 = Level I Therapeutic Nuclear Medicine
0295 = Level II Therapeutic Nuclear Medicine
0296 = Level I Therapeutic Radiologic Procedures
0297 = Level II Therapeutic Radiologic Procedures
0300 = Level I Radiation Therapy
0301 = Level II Radiation Therapy
0302 = Level III Radiation Therapy
0303 = Treatment Device Construction
0304 = Level I Therapeutic Radiation Treatment Preparation
0305 = Level II Therapeutic Radiation Treatment Preparation
0310 = Level III Therapeutic Radiation Treatment Preparation
0311 = Radiation Physics Services
0312 = Radioelement Applications
0313 = Brachytherapy
0314 = Hyperthermic Therapies
0320 = Electroconvulsive Therapy
0321 = Biofeedback and Other Training
0322 = Brief Individual Psychotherapy
0323 = Extended Individual Psychotherapy
0324 = Family Psychotherapy
0325 = Group Psychotherapy
0330 = Dental Procedures
0340 = Minor Ancillary Procedures
0341 = Immunology Tests
0342 = Level I Pathology
0343 = Level II Pathology
0344 = Level III Pathology
0354 = Administration of Influenza Vaccine (Not subject to national coinsurance)
0355 = Level I Immunizations
0356 = Level II Immunizations
0357 = Level III Immunizations
0358 = Level IV Immunizations
0359 = Injections
0360 = Level I Alimentary Tests
0361 = Level II Alimentary Tests
0362 = Fitting of Vision Aids
0363 = Otorhinolaryngologic Function Tests
0364 = Level I Audiometry
0365 = Level II Audiometry
0366 = Electrocardiogram (ECG)
0367 = Level I Pulmonary Test
0368 - Level II Pulmonary Test
0369 - Level III Pulmonary Test
0370 - Allergy Tests
0371 - Allergy Injections
0372 - Therapeutic Phlebotomy
0373 - Neuropsychological Testing
0374 - Monitoring Psychiatric Drugs
0600 - Low Level Clinic Visits
0601 - Mid Level Clinic Visits
0602 - High Level Clinic Visits
0603 - Interdisciplinary Team Conference
0610 - Low Level Emergency Visits
0611 - Mid Level Emergency Visits
0612 - High Level Emergency Visits
0620 - Critical Care
0701 - Strontium (eligible for pass-through payments)
0702 - Samarium (eligible for pass-through payments)
0704 - Satumomab Pendetide (eligible for pass-through payments)
0705 - Tc99 Tetrofosmin (eligible for pass-through payments)
0725 - Leucovorin Calcium (eligible for pass-through payments)
0726 - Dexrazoxane Hydrochloride (eligible for pass-through payments)
0727 - Injection, Etidronate Disodium (eligible for pass-through payments)
0728 - Filgrastim (G-CSF) (eligible for pass-through payments)
0730 - Pamidronate Disodium (eligible for pass-through payments)
0731 - Sargramostim (GM-CSF) (eligible for pass-through payments)
0732 - Mesna (eligible for pass-through payments)
0733 - Epoetin Alpha (eligible for pass-through payments)
0750 - Dolasetron Mesylate 10 mg (eligible for pass-through payments)
0754 - Metoclopramide HCL (eligible for pass-through payments)
0755 - Thiethylperazine Maleate (eligible for pass-through payments)
0761 - Oral Substitute for IV Antiemtic (eligible for pass-
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Classification (APC)</th>
</tr>
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<tbody>
<tr>
<td>0762</td>
<td>Dronabinol (eligible for pass-through payments)</td>
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<tr>
<td>0763</td>
<td>Dolasetron Mesylate 100 mg Oral (eligible for pass-through payments)</td>
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<tr>
<td>0764</td>
<td>Granisetron HCL, 100 mcg (eligible for pass-through payments)</td>
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<td>0765</td>
<td>Granisetron HCL, 1mg Oral (eligible for pass-through payments)</td>
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<td>0768</td>
<td>Ondansetron Hydrochloride per 1 mg Injection (eligible for pass-through payments)</td>
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<td>0769</td>
<td>Ondansetron Hydrochloride 8 mg oral (eligible for pass-through payments)</td>
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<td>0800</td>
<td>Leuprolide Acetate per 3.75 mg (eligible for pass-through payments)</td>
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<td>0801</td>
<td>Cyclophosphamide (eligible for pass-through payments)</td>
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<td>0802</td>
<td>Etoposide (eligible for pass-through payments)</td>
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<tr>
<td>0803</td>
<td>Melphalan (eligible for pass-through payments)</td>
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<td>0807</td>
<td>Aldesleukin single use vial (eligible for pass-through payments)</td>
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<td>0809</td>
<td>BCG (Intravesical) one vial (eligible for pass-through payments)</td>
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<tr>
<td>0810</td>
<td>Goserelin Acetate Implant, per 3.6 mg (eligible for pass-through payments)</td>
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<tr>
<td>0811</td>
<td>Carboplatin 50 mg (eligible for pass-through payments)</td>
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<tr>
<td>0812</td>
<td>Carmustine 100 mg (eligible for pass-through payments)</td>
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<td>0813</td>
<td>Cisplatin 10 mg (eligible for pass-through payments)</td>
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<tr>
<td>0814</td>
<td>Asparaginase, 10,000 units (eligible for pass-through payments)</td>
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<tr>
<td>0815</td>
<td>Cyclophosphamide 100 mg (eligible for pass-through payments)</td>
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<tr>
<td>0816</td>
<td>Cyclophosphamide, Lyophilized 100 mg (eligible for pass-through payments)</td>
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</tr>
<tr>
<td>0817</td>
<td>Cytrabine 100 mg (eligible for pass-through payments)</td>
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</tr>
<tr>
<td>0818</td>
<td>Dactinomycin 0.5 mg (eligible for pass-through payments)</td>
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</tbody>
</table>
0819 = Dacarbazine 100 mg (eligible for pass-through payments)
0820 = Daunorubicin HCl 10 mg (eligible for pass-through payments)
0821 = Daunorubicin Citrate, Liposomal Formulation, 10 mg (eligible for pass-through payments)
0822 = Diethylstilbestrol Diphosphate 250 mg (eligible for pass-through payments)
0823 = Docetaxel 20 mg (eligible for pass-through payments)
0824 = Etoposide 10 mg (eligible for pass-through payments)
0826 = Methotrexate Oral 2.5 mg (eligible for pass-through payments)
0827 = Flurouridine 500 mg (eligible for pass-through payments)
0828 = Gemcitabine HCL 200 mg (eligible for pass-through payments)
0830 = Irinotecan 20 mg (eligible for pass-through payments)
0831 = Ifosfamide per 1 gram (eligible for pass-through payments)
0832 = Idarubicin Hydrochloride 5 mg (eligible for pass-through payments)
0833 = Interferon Alfacon-1, Recombinant, 1 mcg (eligible for pass-through payments)
0834 = Interferon, Alfa-2A, Recombinant 3 million units (eligible for pass-through payments)
0836 = Interferon, Alfa-2B, Recombinant, 1 million units (eligible for pass-through payments)
0838 = Interferon, Gamma 1-B, 3 million units (eligible for pass-through payments)
0839 = Mechlorethamine HCl 10 mg (eligible for pass-through payments)
0840 = Melphalan HCl 50 mg (eligible for pass-through payments)
0841 = Methotrexate Sodium 5 mg (eligible for pass-through payments)
0842 = Fludarabine Phosphate 50 mg (eligible for pass-through payments)
0843 = Pegasparagase per single dose vial (eligible for pass-through payments)
0844 = Pentostatin 10 mg (eligible for pass-through payments)
0847 = Doxorubicin HCL 10 mg (eligible for pass-through payments)
0849 = Rituximab, 100 mg (eligible for pass-through payments)
0850 = Streptozocin 1 gm (eligible for pass-through payments)
0851 = Thiotepa 15 mg (eligible for pass-through payments)
0852 = Topotecan 4 mg (eligible for pass-through payments)
0853 = Vinblastine Sulfate 1 mg (eligible for pass-through payments)
0854 = Vinristine Sulfate 1 mg (eligible for pass-through payments)
0855 = Vinorelbine Tartrate per 10 mg (eligible for pass-through payments)
0856 = Pormimer Sodium 75 mg (eligible for pass-through payments)
0857 = Bleomycin Sulfate 15 units (eligible for pass-through payments)
0858 = Cladribine, 1mg (eligible for pass-through payments)
0859 = Fluorouracil (eligible for pass-through payments)
0860 = Plicamycin 2.5 mg (eligible for pass-through payments)
0861 = Leuprolide Acetate 1 mg (eligible for pass-through payments)
0862 = Mitomycin, 5mg (eligible for pass-through payments)
0863 = Paclitaxel, 30mg (eligible for pass-through payments)
0864 = Mitoxantrone HCL, per 5mg (eligible for pass-through payments)
0865 = Interferon alfa-N3, 250,000 IU (eligible for pass-through payments)
0864 = 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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Payment Status</th>
<th>National Coinsurance Status</th>
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<tbody>
<tr>
<td>0890</td>
<td>Lymphocyte Immune Globulin 50 mg/ml, 5 ml each</td>
<td>(Not subject to national coinsurance)</td>
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<tr>
<td>0891</td>
<td>Tacrolimus per 1 mg oral</td>
<td>(Not subject to national coinsurance)</td>
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<tr>
<td>0892</td>
<td>Daclizumab, Parenteral, 25 mg</td>
<td>(eligible for pass-through payments)</td>
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</tr>
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<td>0900</td>
<td>Injection, Alglucerase per 10 units</td>
<td>(eligible for pass-through payments)</td>
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</tr>
<tr>
<td>0901</td>
<td>Alpha 1, Proteinase Inhibitor, Human per 10mg</td>
<td>(eligible for pass-through payments)</td>
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<td>0902</td>
<td>Botulinum Toxin, Type A per unit</td>
<td>(eligible for pass-through payments)</td>
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<td>0903</td>
<td>CMV Immune Globulin</td>
<td>(eligible for pass-through payments)</td>
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<tr>
<td>0905</td>
<td>Immune Globulin per 500 mg</td>
<td>(eligible for pass-through payments)</td>
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<td>0906</td>
<td>RSV Immune Globulin</td>
<td>(eligible for pass-through payments)</td>
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<td>0907</td>
<td>Ganciclovir Sodium 500 mg injection</td>
<td>(Not subject to national coinsurance)</td>
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<td>0908</td>
<td>Tetanus Immune Globulin, Human, up to 250 units</td>
<td>(Not subject to national coinsurance)</td>
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<td>0909</td>
<td>Interferon Beta - 1a 33 mcg (eligible for pass-through payments)</td>
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<td>0910</td>
<td>Interferon Beta - 1b 0.25 mg (eligible for pass-through payments)</td>
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<td>0911</td>
<td>Streptokinase per 250,000 iu</td>
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<td>0913</td>
<td>Ganciclovir 4.5 mg, Implant (eligible for pass-through payments)</td>
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<td>0914</td>
<td>Reteplase, 37.6 mg (Two Single Use Vials)</td>
<td>(Not subject to national coinsurance)</td>
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<td>0915</td>
<td>Alteplase recombinant, 10mg</td>
<td>(Not subject to national coinsurance)</td>
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<td>0916</td>
<td>Imiglucerase per unit (eligible for pass-through payments)</td>
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<tr>
<td>0917</td>
<td>Dipyramidole, 10mg / Adenosine 6MG</td>
<td>(Not subject to national coinsurance)</td>
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<td>0918</td>
<td>Brachytherapy Seeds, Any type, Each (eligible</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>0925</td>
<td>Factor VIII (Antihemophilic Factor, Human) per iu (eligible for pass-through payments)</td>
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<td>0926</td>
<td>Factor VIII (Antihemophilic Factor, Porcine) per iu (eligible for pass-through payments)</td>
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<tr>
<td>0927</td>
<td>Factor VIII (Antihemophilic Factor, Recombinant) per iu (eligible for pass-through payments)</td>
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<td>0928</td>
<td>Factor IX, Complex (eligible for pass-through payments)</td>
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<tr>
<td>0929</td>
<td>Other Hemophilia Clotting Factors per iu (eligible for pass-through payments)</td>
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<td>0930</td>
<td>Antithrombin III (Human) per iu (eligible for pass-through payments)</td>
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<tr>
<td>0931</td>
<td>Factor IX (Antihemophilic Factor, Purified, Non-Recombinant) (eligible for pass-through payments)</td>
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<tr>
<td>0932</td>
<td>Factor IX (Antihemophilic Factor, Recombinant) (eligible for pass-through payments)</td>
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<td>0949</td>
<td>Plasma, Pooled Multiple Donor, Solvent/Detergent Treated, Frozen (not subject to national coinsurance)</td>
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<td>0950</td>
<td>Blood (Whole) For Transfusion (not subject to national coinsurance)</td>
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<td>0952</td>
<td>Cryoprecipitate (not subject to national coinsurance)</td>
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<td>0953</td>
<td>Fibrinogen Unit (not subject to national coinsurance)</td>
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<td>0954</td>
<td>Leukocyte Poor Blood (not subject to national coinsurance)</td>
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<td>0955</td>
<td>Plasma, Fresh Frozen (not subject to national coinsurance)</td>
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<td>0956</td>
<td>Plasma Protein Fraction (not subject to national coinsurance)</td>
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<td>0957</td>
<td>Platelet Concentrate (not subject to national coinsurance)</td>
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<td>0958</td>
<td>Platelet Rich Plasma (not subject to national coinsurance)</td>
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<tr>
<td>0959</td>
<td>Red Blood Cells (not subject to national coinsurance)</td>
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<td>0960</td>
<td>Washed Red Blood Cells (not subject to national coinsurance)</td>
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<td>0961</td>
<td>Infusion, Albumin (Human) 5%, 500 ml (not subject to national coinsurance)</td>
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<td>0962</td>
<td>Infusion, Albumin (Human) 25%, 50 ml (not subject to national coinsurance)</td>
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<td>Code</td>
<td>Description</td>
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<td>Note</td>
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<td>0970</td>
<td>New Technology - Level I</td>
<td>($0 - $50)</td>
<td>(not subject to national coinsurance)</td>
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<td>0971</td>
<td>New Technology - Level II</td>
<td>($50 - $100)</td>
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<td>0972</td>
<td>New Technology - Level III</td>
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<td>New Technology - Level IV</td>
<td>($200 - $300)</td>
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<td>New Technology - Level V</td>
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<td>New Technology - Level VI</td>
<td>($500 - $750)</td>
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<td>New Technology - Level VIII</td>
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<td>New Technology - Level IX</td>
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<td>New Technology - Level X</td>
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<td>New Technology - Level XI</td>
<td>($1750 - $2000)</td>
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<td>0981</td>
<td>New Technology - Level XII</td>
<td>($2000 - $2500)</td>
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<td>0982</td>
<td>New Technology - Level XIII</td>
<td>($2500 - $3500)</td>
<td>(not subject to national coinsurance)</td>
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<td>0983</td>
<td>New Technology - Level XIV</td>
<td>($3500 - $5000)</td>
<td>(not subject to national coinsurance)</td>
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<tr>
<td>0984</td>
<td>New Technology - Level XV</td>
<td>($5000 - $6000)</td>
<td>(not subject to national coinsurance)</td>
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<td>7000</td>
<td>Amifostine, 500 mg (eligible for pass-through payments)</td>
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<td>7001</td>
<td>Amphotericin B lipid complex, 50 mg, Inj</td>
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<td>(eligible for pass-through payments)</td>
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<td>7002</td>
<td>Clonidine, HCl, 1 MG (eligible for pass-through payments)</td>
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<tr>
<td>7003</td>
<td>Epoprostenol, 0.5 MG, inj (eligible for pass-through payments)</td>
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<tr>
<td>7004</td>
<td>Immune globulin intravenous human 5g, inj</td>
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</tr>
</tbody>
</table>

1. REV_CNTR_APC_TB

Revenue Center Ambulatory Payment Classification (APC)

Nicely formatted, tabular representation of the document content.
7005 = Gonadorelin hcI, 100 mcg (eligible for pass-through payments)
7007 = Milrinone lactate, per 5 ml, inj (not subject to national coinsurance)
7010 = Morphine sulfate concentrate (preservative free) per 10 mg (eligible for pass-through payments)
7011 = Oprelevekin, inj, 5 mg (eligible for pass-through payments)
7012 = Pentamidine isethionate, 300 mg (eligible for pass-through payments)
7014 = Pentanyl citrate, inj, up to 2 ml (eligible for pass-through payments)
7015 = Busulfan, oral 2 mg (eligible for pass-through payments)
7019 = Aprotinin, 10,000 kiu (eligible for pass-through payments)
7021 = Baclofen, intrathecal, 50 mcg (eligible for pass-through payments)
7022 = Elliotts B Solution, per ml (eligible for pass-through payments)
7023 = Treatment for bladder calculi, i.e. Renacidin per 500 ml (eligible for pass-through payments)
7024 = Corticorelin ovine triflutate, 0.1 mg (eligible for pass-through payments)
7025 = Digoxin immune FAB (Ovine), 10 mg (eligible for pass-through payments)
7026 = Ethanolamine oleate, 1000 ml (eligible for pass-through payments)
7027 = Fomepizole, 1.5 G (eligible for pass-through payments)
7028 = Phosphenytoin, 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

7036 = Urokinase, inj, IV, 250,000 I.U.

7037 = Urofollitropin, 30 I.U.

7038 = Muromonab-CD3, 5 mg

7039 = Pegagamab bovine inj 25 I.U.

7040 = Pentastarch 10% inj, 100 ml

7041 = Tirofiban HCL, 0.5 mg

1 REV_CNTR_APC_TB
Revenue Center Ambulatory Payment Classification (APC)

(not subject to national coinsurance)

7042 = Capecitabine, oral 150 mg

7043 = Infliximab, 10 MG (eligible for pass-through payments)

7045 = Trimetrexate Glucuronate (eligible for pass-through payments)

7046 = Doxorubicin HCl Liposome (eligible for pass-through payments)

1 REV_CNTR_DDCTBL_COINSRNC_TB
Revenue Center Deductible Coinsurance Code

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

For revenue center code 0001, the following MSP override values may be present:
M = Override code; EGHP services involved
   (eff 12/90 for non-institutional claims;
    10/93 for institutional claims)

N = Override code; non-EGHP services involved
   (eff 12/90 for non-institutional claims;
    10/93 for institutional claims)

X = Override code; MSP cost avoided
   (eff 12/90 for non-institutional claims;
    10/93 for institutional claims)

---

1 REV_CNTR_PMT_MTHD_IND_TB

Revenue Center Payment Method Indicator Table

**********Service Indicator**********
********** 1st position **************
 A = Services not paid under OPPS
 C = Inpatient procedure
 E = Noncovered items or services
 F = Corneal issue acquisition
 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 F)
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)

A = A valid HCPCS code not subject to a fee schedule payment. Reimbursement is calculated on provider submitted charges.
B = A valid HCPCS code subject to the fee schedule payment. Reimbursement is the lesser of provider submitted charges or the fee schedule amount.
D = A valid radiology HCPCS code subject to the Radiology Pricer and the rate is reflected as zeroes on the HCPCS file and cost report. The Radiology Pricer treats this HCPCS as a non-covered service. Reimbursement is calculated on provider submitted charges.
E = A valid ASC HCPCS code subject to the ASC Pricer. The rate is reflected as zeroes on the HCPCS file. The ASC Pricer determines the ASC payment rate and is reported on the cost report.
F = A valid ESRD HCPCS code subject to the parameter rate. Reimbursement is the lesser of provider submitted charges or the fee schedule amount for non-dialysis HCPCS. Reimbursement is calculated on the provider file rates for dialysis HCPCS.
G - A valid HCPCS, code is subject to a fee schedule, but the rate is no longer present on the HCPCS file. Reimbursement is calculated on provider submitted charges.

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

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

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

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

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

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

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

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

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

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Revenue Center Pricing Indicator Table

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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.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001</td>
<td>Total charge</td>
</tr>
<tr>
<td>0022</td>
<td>SNF claim paid under PPS submitted as TOB 21X, effective for cost reporting periods beginning on or after 7/1/98 (dates of service after 6/30/98). NOTE: This code may appear multiple times on a claim to identify different HIPPS Rate Code/assessment periods.</td>
</tr>
<tr>
<td>0023</td>
<td>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).</td>
</tr>
<tr>
<td>0100</td>
<td>All inclusive rate-room and board plus ancillary</td>
</tr>
<tr>
<td>0101</td>
<td>All inclusive rate-room and board</td>
</tr>
<tr>
<td>0110</td>
<td>Private medical or general-general classification</td>
</tr>
<tr>
<td>0111</td>
<td>Private medical or general-medical/surgical/GYN</td>
</tr>
<tr>
<td>0112</td>
<td>Private medical or general-OB</td>
</tr>
<tr>
<td>0113</td>
<td>Private medical or general-pediatric</td>
</tr>
<tr>
<td>0114</td>
<td>Private medical or general-psychiatric</td>
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<tr>
<td>0115</td>
<td>Private medical or general-hospice</td>
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<tr>
<td>0116</td>
<td>Private medical or general-detoxification</td>
</tr>
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<td>0117</td>
<td>Private medical or general-oncology</td>
</tr>
<tr>
<td>0118</td>
<td>Private medical or general-rehabilitation</td>
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<tr>
<td>0119</td>
<td>Private medical or general-other</td>
</tr>
<tr>
<td>0120</td>
<td>Semi-private 2 bed (medical or general)</td>
</tr>
<tr>
<td>0121</td>
<td>Semi-private 2 bed (medical or general) medical/surgical/GYN</td>
</tr>
<tr>
<td>0122</td>
<td>Semi-private 2 bed (medical or general)-OB</td>
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<td>Semi-private 2 bed (medical or general) detoxification</td>
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<td>Semi-private 2 bed (medical or general)-oncology</td>
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<td>0128</td>
<td>Semi-private 2 bed (medical or general) rehabilitation</td>
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<td>Semi-private 2 bed (medical or general)-other</td>
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<tr>
<td>0130</td>
<td>Semi-private 3 and 4 beds-general classification</td>
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<tr>
<td>0131</td>
<td>Semi-private 3 and 4 beds-medical/surgical/GYN</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<td>0132</td>
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<td>Semi-private 3 and 4 beds-oncology</td>
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<td>Semi-private 3 and 4 beds-other</td>
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<td>medical/surgical/GYN</td>
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<td>Room&amp;Board ward (medical or general)-detoxification</td>
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<td>Room&amp;Board ward (medical or general)-rehabilitation</td>
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<td>Other Room&amp;Board-general classification</td>
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<td>Other Room&amp;Board-sterile environment</td>
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<td>Nursery-newborn level I (routine)</td>
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<td>Nursery-premature</td>
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<td>newborn-level II (continuing care)</td>
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<td>0173</td>
<td>Nursery-newborn-level III (intermediate care)</td>
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<td>Code</td>
<td>Description</td>
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<td>0174</td>
<td>Nursery-newborn-level IV (intensive care)</td>
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<td>0175</td>
<td>Nursery-neonatal ICU (obsolete eff 10/96)</td>
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<td>Leave of absence-patient convenience charges billable</td>
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<td>Leave of absence-therapeutic leave</td>
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<td>Leave of absence-ICF mentally retarded-any reason</td>
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<td>Leave of absence-nursing home (hospitalization)</td>
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<td>Leave of absence-other leave of absence</td>
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<td>Subacute care - general classification (eff. 10/97)</td>
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<td>Subacute care - level I (eff. 10/97)</td>
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<td>Subacute care - level II (eff. 10/97)</td>
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<td>Subacute care - level IV (eff. 10/97)</td>
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<td>Intensive care-psychiatric</td>
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<td>0206</td>
<td>Intensive care-post ICU; redefined as intermediate ICU (eff 10/96)</td>
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<td>Intensive care-burn care</td>
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<td>0208</td>
<td>Intensive care-trauma</td>
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<td>Intensive care-other intensive care</td>
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<td>Coronary care-general classification</td>
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<td>0211</td>
<td>Coronary care-myocardial infarction</td>
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<td>Coronary care-pulmonary care</td>
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<td>0213</td>
<td>Coronary care-heart transplant</td>
</tr>
<tr>
<td>0214</td>
<td>Coronary care-post CCU; redefined as intermediate CCU (eff 10/96)</td>
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<td>Coronary care-other coronary care</td>
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<td>Special charges-general classification</td>
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<tr>
<td>0221</td>
<td>Special charges-admission charge</td>
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<td>0222</td>
<td>Special charges-technical support charge</td>
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<tr>
<td>0223</td>
<td>Special charges-UR service charge</td>
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</tbody>
</table>
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-speciality
0249 = All inclusive ancillary-other inclusive ancillary
0250 = Pharmacy-general classification
0251 = Pharmacy-generic drugs
0252 = Pharmacy-nongeneric drugs
0253 = Pharmacy-take home drugs
0254 = Pharmacy-drugs incident to other diagnostic service-subject to payment limit
0255 = Pharmacy-drugs incident to radiology-subject to payment limit
0256 = Pharmacy-experimental drugs
0257 = Pharmacy-non-prescription
0258 = Pharmacy-IV solutions
0259 = Pharmacy-other pharmacy
0260 = IV therapy-general classification
0261 = IV therapy-infusion pump
0262 = IV therapy-pharmacy services (eff 10/94)
0263 = IV therapy-drug supply/delivery (eff 10/94)
0264 = IV therapy-supplies (eff 10/94)
0269 = IV therapy-other IV therapy
0270 = Medical/surgical supplies-general classification (also see 062X)
0271 = Medical/surgical supplies-nonsterile supply
0272 = Medical/surgical supplies-sterile supply
0273 = Medical/surgical supplies-take home supplies
0274 = Medical/surgical supplies-prosthetic/orthotic devices
0275 = Medical/surgical supplies-pace maker
0276 = Medical/surgical supplies-intraocular lens
0277 = Medical/surgical supplies-oxygen-take home
0278 = Medical/surgical supplies-other implants
0279 = Medical/surgical supplies-other devices
0280 = Oncology-general classification
0289 = Oncology-other oncology
0290 = DME (other than renal)-general classification
0291 = DME (other than renal)-rental
0292 = DME (other than renal)-purchase of new DME
0293 = DME (other than renal)-purchase of used DME
0294 = DME (other than renal)-related to and listed as DME
0299 = DME (other than renal)-other
0300 = Laboratory-general classification
0301 = Laboratory-chemistry
0302 = Laboratory-immunology
0303 = Laboratory-renal patient (home)
0304 = Laboratory-non-routine dialysis
0305 = Laboratory-hematology
0306 = Laboratory-bacteriology & microbiology
0307 = Laboratory-urology
0309 = Laboratory-other laboratory
0310 = Laboratory pathological-general classification
0311 = Laboratory pathological-cytology
0312 = Laboratory pathological-histology
0314 = Laboratory pathological-biopsy
0319 = Laboratory pathological-other
0320 = Radiology diagnostic-general classification
0321 = Radiology diagnostic-angiography
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
<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>0341</td>
<td>Nuclear medicine-diagnostic</td>
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<tr>
<td>0342</td>
<td>Nuclear medicine-therapeutic</td>
</tr>
<tr>
<td>0349</td>
<td>Nuclear medicine-other</td>
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<tr>
<td>0350</td>
<td>Computed tomographic (CT) scan-general classification</td>
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<td>CT scan-head scan</td>
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<tr>
<td>0352</td>
<td>CT scan-body scan</td>
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<td>0359</td>
<td>CT scan-other CT scans</td>
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<td>0360</td>
<td>Operating room services-general classification</td>
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<tr>
<td>0361</td>
<td>Operating room services-minor surgery</td>
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<tr>
<td>0362</td>
<td>Operating room services-organ transplant, other than kidney</td>
</tr>
<tr>
<td>0367</td>
<td>Operating room services-kidney transplant</td>
</tr>
<tr>
<td>0369</td>
<td>Operating room services-other operating room services</td>
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<tr>
<td>0370</td>
<td>Anesthesia-general classification</td>
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<td>0371</td>
<td>Anesthesia-incident to RAD and subject to the payment limit</td>
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<tr>
<td>0372</td>
<td>Anesthesia-incident to other diagnostic service and subject to the payment limit</td>
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<tr>
<td>0374</td>
<td>Anesthesia-acupuncture</td>
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<td>Anesthesia-other anesthesia</td>
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<td>Blood-general classification</td>
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<td>Blood-packed red cells</td>
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<td>Blood-whole blood</td>
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<td>0383</td>
<td>Blood-plasma</td>
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<td>0384</td>
<td>Blood-platelets</td>
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<td>0385</td>
<td>Blood-leukocytes</td>
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<tr>
<td>0386</td>
<td>Blood-other components</td>
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<td>0387</td>
<td>Blood-other derivatives (cryoprecipitats)</td>
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<td>0389</td>
<td>Blood-other blood</td>
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<td>0390</td>
<td>Blood storage and processing-general classification</td>
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<td>Blood storage and processing-blood administration</td>
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<td>Blood storage and processing-other</td>
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<td>Other imaging services-general classification</td>
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<td>Other imaging services-diagnostic mammography</td>
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<tr>
<td>0402</td>
<td>Other imaging services-ultrasound</td>
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<tr>
<td>0403</td>
<td>Other imaging services-screening mammography</td>
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</table>
(eff 1/1/91)
0404 = Other imaging services-positron emission
tomography (eff 10/94)
0409 = Other imaging services-other
0410 = Respiratory services-general classification
0412 = Respiratory services-inhalation services
0413 = Respiratory services-hyperbaric oxygen therapy
0419 = Respiratory services-other
0420 = Physical therapy-general classification
0421 = Physical therapy-visit charge
0422 = Physical therapy-hourly charge
0423 = Physical therapy-group rate
0424 = Physical therapy-evaluation or re-evaluation
0429 = Physical therapy-other
0430 = Occupational therapy-general classification
0431 = Occupational therapy-visit charge
0432 = Occupational therapy-hourly charge
0433 = Occupational therapy-group rate
0434 = Occupational therapy-evaluation or re-evaluation
0439 = Occupational therapy-other (may include
restorative therapy)
0440 = Speech language pathology-general classification
0441 = Speech language pathology-visit charge
0442 = Speech language pathology-hourly charge
0443 = Speech language pathology-group rate
0444 = Speech language pathology-evaluation or
re-evaluation
0449 = Speech language pathology-other
0450 = Emergency room-general classification
0451 = Emergency room-entala emergency medical screening
services (eff 10/96)
0452 = Emergency room-ER beyond entala 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

Revenue Center Table

0499 = Ambulatory surgical care-other
0500 = Outpatient services-general classification
(deleted 9/93)
0509 = Outpatient services-other (deleted 9/93)
0510 = Clinic-general classification
0511 = Clinic-chronic pain center
0512 = Clinic-dental center
0513 = Clinic-psychiatric
0514 = Clinic-OB-GYN
0515 = Clinic-pediatric
0516 = Clinic-urgent care clinic (eff 10/96)
0517 = Clinic-family practice clinic (eff 10/96)
0519 = Clinic-other
0520 = Free-standing clinic-general classification
0521 = Free-standing clinic-rural health clinic
0522 = Free-standing clinic-rural health home
0523 = Free-standing clinic-family practice
0526 = Free-standing clinic-urgent care (eff 10/96)
0529 = Free-standing clinic-other
0530 = Osteopathic services-general classification
0531 = Osteopathic services-osteopathic therapy
0539 = Osteopathic services-other
0540 = Ambulance-general classification
0541 = Ambulance-supplies
0542 = Ambulance-medical transport
0543 = Ambulance-heart mobile
0544 = Ambulance-oxygen
0545 = Ambulance-air ambulance
0546 = Ambulance-neo-natal ambulance
0547 = Ambulance-pharmacy
0548 = Ambulance-telephone transmission EKG
0549 = Ambulance-other
0550 = Skilled nursing-general classification
0551 = Skilled nursing-visit charge
0552 = Skilled nursing-hourly charge
0559 = Skilled nursing-other
0560 = Medical social services-general classification
0561 = Medical social services-visit charge
0562 = Medical social services-hourly charges
0570 = Home health aid (home health)-general classification
0571 = Home health aid (home health)-visit charge
0572 = Home health aid (home health)-hourly charge
0579 = Home health aid (home health)-other
0580 = Other visits (home health)-general classification (under HHPPS, not allowed as covered charges)
0581 = Other visits (home health)-visit charge (under HHPPS, not allowed as covered charges)
0582 = Other visits (home health)-hourly charge (under HHPPS, not allowed as covered charges)
0589 = Other visits (home health)-other (under HHPPS, not allowed as covered charges)
0590 = Units of service (home health)-general classification (under HHPPS, not allowed as covered charges)
0599 = Units of service (home health)-other
1 REV_CNTR_TB

Revenue Center Table

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0600 = Oxygen-general classification
0601 = Oxygen-stat or port equip/supply or count
0602 = Oxygen-stat/equip/under 1 LPM
0603 = Oxygen-stat/equip/over 4 LPM
0604 = Oxygen-stat/equip/portable add-on
0610 = Magnetic resonance technology (MRT)-general classification
0611 = MRT/MRI-brain (including brainstem)
0612 = MRT/MRI-spinal cord (including spine)
0614 = MRT/MRI-other
0615 = MRT/MRA-Head and Neck
0616 = MRT/MRA-Lower Extremities
0618 = MRT/MRA-other
0619 = MRT/Other MRI
0621 = Medical/surgical supplies-incident to radiology-subject to the payment limit - extension of 027X
0622 = Medical/surgical supplies-incident to other
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Effective Date</th>
</tr>
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<tbody>
<tr>
<td>0623</td>
<td>Medical/surgical supplies-surgical dressings</td>
<td>eff 1/95</td>
</tr>
<tr>
<td>0624</td>
<td>Medical/surgical supplies-medical investigational devices and procedures with FDA approved IDE's</td>
<td>eff 10/96</td>
</tr>
<tr>
<td>0630</td>
<td>Drugs requiring specific identification-general classification</td>
<td></td>
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<tr>
<td>0631</td>
<td>Drugs requiring specific identification-single drug source</td>
<td>eff 9/93</td>
</tr>
<tr>
<td>0632</td>
<td>Drugs requiring specific identification-multiple drug source</td>
<td>eff 9/93</td>
</tr>
<tr>
<td>0633</td>
<td>Drugs requiring specific identification-restrictive prescription</td>
<td>eff 9/93</td>
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<tr>
<td>0634</td>
<td>Drugs requiring specific identification-EPO under 10,000 units</td>
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<tr>
<td>0635</td>
<td>Drugs requiring specific identification-EPO 10,000 units or more</td>
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<tr>
<td>0636</td>
<td>Drugs requiring specific identification-detailed coding</td>
<td>eff 3/92</td>
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<tr>
<td>0637</td>
<td>Self-administered drugs administered in an emergency situation - not requiring detailed coding</td>
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<tr>
<td>0640</td>
<td>Home IV therapy-general classification</td>
<td>eff 10/94</td>
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<tr>
<td>0641</td>
<td>Home IV therapy-nonroutine nursing</td>
<td>eff 10/94</td>
</tr>
<tr>
<td>0642</td>
<td>Home IV therapy-IV site care, central line</td>
<td>eff 10/94</td>
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<tr>
<td>0643</td>
<td>Home IV therapy-IV start/change peripheral line</td>
<td>eff 10/94</td>
</tr>
<tr>
<td>0644</td>
<td>Home IV therapy-nonroutine nursing, peripheral line</td>
<td>eff 10/94</td>
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<tr>
<td>0645</td>
<td>Home IV therapy-train patient/caregiver, central line</td>
<td>eff 10/94</td>
</tr>
<tr>
<td>0646</td>
<td>Home IV therapy-train disabled patient, central line</td>
<td>eff 10/94</td>
</tr>
<tr>
<td>0647</td>
<td>Home IV therapy-train patient/caregiver, peripheral line</td>
<td>eff 10/94</td>
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</tbody>
</table>
0760 = Treatment or observation room-general
       classification
0761 = Treatment or observation room-treatment room
       (eff 9/93)
0762 = Treatment or observation room-observation room
       (eff 9/93)
0769 = Treatment or observation room-other
0770 = Preventative care services-general classification
       (eff 10/94)
0771 = Preventative care services-vaccine administration
       (eff 10/94)
0779 = Preventative care services-other (eff 10/94)
0780 = Telemedicine - general classification
       (eff 10/97)
0789 = Telemedicine - telemedicine (eff 10/97)

1  REV_CNTR_TB  Revenue Center Table

0790 = Lithotripsy-general classification
0799 = Lithotripsy-other
0800 = Inpatient renal dialysis-general classification
0801 = Inpatient renal dialysis-inpatient hemodialysis
0802 = Inpatient renal dialysis-inpatient peritoneal
       (non-CAPD)
0803 = Inpatient renal dialysis-inpatient CAPD
0804 = Inpatient renal dialysis-inpatient CCPD
0809 = Inpatient renal dialysis-other inpatient dialysis
0810 = Organ acquisition-general classification
0811 = Organ acquisition-living donor (eff 10/94);
       prior to 10/94, defined as living donor kidney
0812 = Organ acquisition-cadaver donor (eff 10/94);
       prior to 10/94, defined as cadaver donor kidney
0813 = Organ acquisition-unknown donor (eff 10/94)
       prior to 10/94, defined as unknown donor kidney
0814 = Organ acquisition - unsuccessful organ search-
       donor bank charges (eff 10/94); prior to 10/94,
       defined as other kidney acquisition
0815 = Organ acquisition-cadaver donor-heart
       (obsolete, eff 10/94)
0816 = Organ acquisition-other heart acquisition
       (obsolete, eff 10/94)
0817 = Organ acquisition-donor-liver
       (obsolete, eff 10/94)
0819 = Organ acquisition-other donor (eff 10/94); prior to 10/94, defined as other
0820 = Hemodialysis OP or home dialysis-general classification
0821 = Hemodialysis OP or home dialysis-hemodialysis-composite or other rate
0822 = Hemodialysis OP or home dialysis-home supplies
0823 = Hemodialysis OP or home dialysis-home equipment
0824 = Hemodialysis OP or home dialysis-maintenance/100%
0825 = Hemodialysis OP or home dialysis-support services
0829 = Hemodialysis OP or home dialysis-other
0830 = Peritoneal dialysis OP or home-general classification
0831 = Peritoneal dialysis OP or home-peritoneal-composite or other rate
0832 = Peritoneal dialysis OP or home-home supplies
0833 = Peritoneal dialysis OP or home 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

1 REV_CNTR_TB  Revenue Center Table

0859 = CCPD outpatient-other
0880 = Miscellaneous dialysis-general classification
0881 = Miscellaneous dialysis-ultrafiltration
0882 = Miscellaneous dialysis-home dialysis aide visit (eff 9/93)
0889 = Miscellaneous dialysis-other
0890 = Other donor bank-general classification; changed to
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>0942</td>
<td>Other therapeutic services-education/training</td>
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<td>(include diabetes diet training)</td>
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<tr>
<td>0943</td>
<td>Other therapeutic services-cardiac rehabilitation</td>
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<tr>
<td>0944</td>
<td>Other therapeutic services-drug rehabilitation</td>
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<tr>
<td>0945</td>
<td>Other therapeutic services-alcohol rehabilitation</td>
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<tr>
<td>0946</td>
<td>Other therapeutic services-routine complex</td>
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<td>medical equipment (eff 3/92)</td>
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<tr>
<td>0947</td>
<td>Other therapeutic services-ancillary complex</td>
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<td>medical equipment (eff 3/92)</td>
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<tr>
<td>0949</td>
<td>Other therapeutic services-other</td>
</tr>
<tr>
<td>0951</td>
<td>Professional fees-athletic training</td>
</tr>
<tr>
<td>0952</td>
<td>Professional fees-kinesitherapy</td>
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<tr>
<td>0960</td>
<td>Professional fees-general classification</td>
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<tr>
<td>0961</td>
<td>Professional fees-psychiatric</td>
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<tr>
<td>0962</td>
<td>Professional fees-ophthalmology</td>
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<tr>
<td>0963</td>
<td>Professional fees-anesthesiologist (MD)</td>
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<tr>
<td>0964</td>
<td>Professional fees-anesthetist (CRNA)</td>
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<tr>
<td>0969</td>
<td>Professional fees-other</td>
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<tr>
<td>0971</td>
<td>Professional fees-laboratory</td>
</tr>
<tr>
<td>0972</td>
<td>Professional fees-radiology diagnostic</td>
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<tr>
<td>0973</td>
<td>Professional fees-radiology therapeutic</td>
</tr>
<tr>
<td>0974</td>
<td>Professional fees-nuclear medicine</td>
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<tr>
<td>0975</td>
<td>Professional fees-operating room</td>
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<tr>
<td>0976</td>
<td>Professional fees-respiratory therapy</td>
</tr>
<tr>
<td>0977</td>
<td>Professional fees-physical therapy</td>
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<tr>
<td>0978</td>
<td>Professional fees-occupational therapy</td>
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<tr>
<td>0979</td>
<td>Professional fees-speech pathology</td>
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<tr>
<td>0981</td>
<td>Professional fees-emergency room</td>
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<tr>
<td>0982</td>
<td>Professional fees-outpatient services</td>
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<tr>
<td>0983</td>
<td>Professional fees-clinic</td>
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<td>0984</td>
<td>Professional fees-medical social services</td>
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<td>0985</td>
<td>Professional fees-EKG</td>
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<tr>
<td>0986</td>
<td>Professional fees-EEG</td>
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<tr>
<td>0987</td>
<td>Professional fees-hospital visit</td>
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<tr>
<td>0988</td>
<td>Professional fees-consultation</td>
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<tr>
<td>0989</td>
<td>Professional fees-private duty nurse</td>
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<tr>
<td>0990</td>
<td>Patient convenience items-general classification</td>
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<tr>
<td>0991</td>
<td>Patient convenience items-cafeteria/guest tray</td>
</tr>
<tr>
<td>0992</td>
<td>Patient convenience items-private linen service</td>
</tr>
<tr>
<td>Revenue Code</td>
<td>Description</td>
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<td>--------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>0993</td>
<td>Patient convenience items-telephone/telegraph</td>
</tr>
<tr>
<td>0994</td>
<td>Patient convenience items-tv/radio</td>
</tr>
<tr>
<td>0995</td>
<td>Patient convenience items-nonpatient room rentals</td>
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<tr>
<td>0996</td>
<td>Patient convenience items-late discharge charge</td>
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<tr>
<td>0997</td>
<td>Patient convenience items-admission kits</td>
</tr>
<tr>
<td>0998</td>
<td>Patient convenience items-beauty shop/barber</td>
</tr>
<tr>
<td>0999</td>
<td>Patient convenience items-other</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>9000</td>
<td>RUGS-no MDS assessment available</td>
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<tr>
<td>9001</td>
<td>Reduced physical functions-</td>
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<tr>
<td></td>
<td>RUGS PA1/ADL index of 4-5</td>
</tr>
<tr>
<td>9002</td>
<td>Reduced physical functions-</td>
</tr>
<tr>
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<td>RUGS PA2/ADL index of 4-5</td>
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<tr>
<td>9003</td>
<td>Reduced physical functions-</td>
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<tr>
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<td>RUGS PB1/ADL index of 6-8</td>
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<tr>
<td>9004</td>
<td>Reduced physical functions-</td>
</tr>
<tr>
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<td>RUGS PB2/ADL index of 6-8</td>
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<tr>
<td>9005</td>
<td>Reduced physical functions-</td>
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<tr>
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<td>RUGS PC1/ADL index of 9-10</td>
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<tr>
<td>9006</td>
<td>Reduced physical functions-</td>
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<td>RUGS PC2/ADL index of 9-10</td>
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<tr>
<td>9007</td>
<td>Reduced physical functions-</td>
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<td>RUGS PD1/ADL index of 11-15</td>
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<tr>
<td>9008</td>
<td>Reduced physical functions-</td>
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<td>RUGS PD2/ADL index of 11-15</td>
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<tr>
<td>9009</td>
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<td>RUGS PE1/ADL index of 16-18</td>
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<td>9010</td>
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<td>RUGS PE2/ADL index of 16-18</td>
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<tr>
<td>9011</td>
<td>Behavior only problems-</td>
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<td>RUGS BA1/ADL index of 4-5</td>
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<tr>
<td>9012</td>
<td>Behavior only problems-</td>
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<td>RUGS BA2/ADL index of 4-5</td>
</tr>
<tr>
<td>9013</td>
<td>Behavior only problems-</td>
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<tr>
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<td>RUGS BB1/ADL index of 6-10</td>
</tr>
<tr>
<td>9014</td>
<td>Behavior only problems-</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>
RUGS BB2/ADL index of 6-10
9015 = Impaired cognition-
RUGS IA1/ADL index of 4-5
9016 = Impaired cognition-
RUGS IA2/ADL index of 4-5
9017 = Impaired cognition-
RUGS IB1/ADL index of 6-10
9018 = Impaired cognition-
RUGS IB2/ADL index of 6-10
9019 = Clinically complex-
RUGS CA1/ADL index of 4-5
9020 = Clinically complex-
RUGS CA2/ADL index of 4-5d
9021 = Clinically complex-
RUGS CB1/ADL index of 6-10
9022 = Clinically complex-
RUGS CB2/ADL index of 6-10d
9023 = Clinically complex-
RUGS CC1/ADL index of 11-16
9024 = Clinically complex-
RUGS CC2/ADL index of 11-16d
9025 = Clinically complex-
RUGS CD1/ADL index of 17-18
9026 = Clinically complex-
RUGS CD2/ADL index of 17-18d
9027 = Special care-
RUGS SSA/ADL index of 7-13
9028 = Special care-
RUGS SSB/ADL index of 14-16
9029 = Special care-
RUGS SSC/ADL index of 17-18
9030 = Extensive services-
RUGS SE1/1 procedure
9031 = Extensive services-
RUGS SE2/2 procedures
9032 = Extensive services-
RUGS SE3/3 procedures
9033 = Low rehabilitation-
RUGS RL1/ADL index of 4-11
9034 = Low rehabilitation-
RUGS RL2/ADL index of 12-18
9035 = Medium rehabilitation-
RUGS RM1/ADL index of 4-7
<table>
<thead>
<tr>
<th>Revenue Center Table</th>
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<tbody>
<tr>
<td>9036 = Medium rehabilitation-</td>
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<tr>
<td>1 REV_CNTR_TB</td>
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<tr>
<td>9037 = Medium rehabilitation-</td>
</tr>
<tr>
<td>9038 = High rehabilitation-</td>
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<tr>
<td>9039 = High rehabilitation-</td>
</tr>
<tr>
<td>9040 = High rehabilitation-</td>
</tr>
<tr>
<td>9041 = High rehabilitation-</td>
</tr>
<tr>
<td>9042 = Very high rehabilitation-</td>
</tr>
<tr>
<td>9043 = Very high rehabilitation-</td>
</tr>
<tr>
<td>9044 = Very high rehabilitation-</td>
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</table>

RUGS RMB/ADL index of 8-15

RUGS RMC/ADL index of 16-18

RUGS RHA/ADL index of 4-7

RUGS RHB/ADL index of 8-11

RUGS RHC/ADL index of 12-14

RUGS RHD/ADL index of 15-18

RUGS RVA/ADL index of 4-7

RUGS RVB/ADL index of 8-13

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 CCI/ADL index of 17-18

9024 = Clinically complex-

RUGS CCI2/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
<table>
<thead>
<tr>
<th>Code</th>
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<th>Revenue Center Table</th>
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<tr>
<td>9028</td>
<td>Extensive services-</td>
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<td>RUGS SE1/ADL index 7-18/1 procedure</td>
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</tr>
<tr>
<td>9029</td>
<td>Extensive services-</td>
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</tr>
<tr>
<td></td>
<td>RUGS SE2/ADL index 7-18/2 procedures</td>
<td></td>
</tr>
<tr>
<td>9030</td>
<td>Extensive services-</td>
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<tr>
<td></td>
<td>RUGS SE3/ADL index 7-18/3 procedures</td>
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<tr>
<td>9031</td>
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<td>RUGS RLA/ADL index of 4-13</td>
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<tr>
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<td>RUGS RLB/ADL index of 14-18</td>
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<td>RUGS RMA/ADL index of 4-7</td>
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<td>RUGS RHC/ADL index of 13-18</td>
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<td>RUGS RVB/ADL index of 9-15</td>
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<td>RUGS RVC/ADL index of 16</td>
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<td>RUGS RUA/ADL index of 4-8</td>
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<td>RUGS RUB/ADL index of 9-15</td>
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<td>Ultra high rehabilitation-</td>
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<td>RUGS RUC/ADL index of 16-18</td>
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