CMS RIF REPORT FOR RECORD: FI_HHA_CLM_REC, STATUS: PROD, VERSION: 21104
PRINTED: 04/26/2021, USER: F43D, DATA SOURCE: CA REPOSITORY ON DB2T

NAME	LENGTH	BEG	END	CONTENTS

*** FI HHA Claim Record (NCH)
VAR 1 30921 REC

STANDARD ALIAS : FI_HHA_CLM_REC
SYSTEM ALIAS : UTLHHAL

1. FI HHA Claim Fixed Group
1822 1 1822 GRP

2. Claim Record Identification Group
8 1 8 GRP

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

STANDARD ALIAS : CLM_REC_IDENT_GRP

3. Record Length Count
3 1 3 PACK

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

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

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

LENGTH : 5 SIGNED : Y

SOURCE : NCH

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

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

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

LENGTH : 1

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

SOURCE : NCH

CODE TABLE : NCH_NEAR_LINE_REC_VRSN_TB

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

A code defining the type of claim record being processed.

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

LENGTH : 1

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

SOURCE : NCH

CODE TABLE : NCH_NEAR_LINE_RIC_TB

6. NCH MQA RIC Code
1 6 6 CHAR

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

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

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

LENGTH : 1

SOURCE : NCH QA PROCESS

CODE TABLE : NCH_MQA_RIC_TB

7. NCH Claim Type Code
2 7 8 CHAR

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

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

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

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

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

LENGTH : 2

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

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

DERIVATION RULES:

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

2. PMT_EDIT_RIC_CD EQUAL 'F'
3. CLM_TRANS_CD EQUAL '5'

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

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

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

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

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

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

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

4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (Medicare Advantage IME/GME CLAIMS - 10/1/05 - FORWARD)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '0'
2. CLM_RLT_COND_CD = '04' & '69'
3. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT ENROLLMENT PERIODS

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

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

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

SET CLM_TYPE_CD TO 64 (HMO CLAIMS PAID AS FFS)
WHERE THE FOLLOWING CONDITIONS ARE MET:
CLAIMS PROCESSED on or after 10/6/08
1. CLM_RLT_COND_CD = '04'
2. MCO_CNTRCT_NUM
MCO_OPTN_CD = '1', '2' OR '4'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT

ENROLLMENT PERIODS

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

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

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

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

SOURCE : NCH

LIMITATIONS :

REFER TO :
NCH_CLM_TYPE_CD_LIM

CODE TABLE : NCH_CLM_TYPE_TB

8. Fiscal Intermediary Claim Link Group
125 9 133 GRP

Effective with Version 'I', this group contains those fields necessary to keep segments together (a claim may have up 10 segments due to the increase in number of revenue center trailers (up to 450). It is also used to house fields necessary for sorting and the final action process.

STANDARD ALIAS : FI_CLM_LINK_GRP

9. Claim Locator Number Group
11 9 19 GRP

This number uniquely identifies the beneficiary in the NCH Nearline.

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

10. Beneficiary Claim Account Number
9 9 17 CHAR

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

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

LENGTH : 9

SOURCE : SSA,RRB

LIMITATIONS :

REFER TO :
CLM_ACNT_NUM_LIM

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

The code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner.

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

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

LENGTH : 2

COMMENTS :
Prior to Version H this field was named:

CTGRY_EQTBL_BENE_IDENT_CD.

SOURCE : BIC EQUATE MODULE

CODE TABLE : CTGRY_EQTBL_BENE_IDENT_TB

12. Beneficiary Identification Code
2 20 21 CHAR

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

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

LENGTH : 2

SOURCE : SSA/RRB

EDIT RULES :
EDB REQUIRED FIELD

CODE TABLE : BENE_IDENT_TB

13. NCH State Segment Code
1 22 22 CHAR

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

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

LENGTH : 1

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

SOURCE : NCH

CODE TABLE : NCH_STATE_SGMT_TB

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

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

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

LENGTH : 2

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

SOURCE : SSA/EDB

EDIT RULES :
OPTIONAL: MAY BE BLANK

CODE TABLE : GEO_SSA_STATE_TB

15. Claim From Date
8 25 32 NUM

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

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

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

16. Claim Through Date
8 33 40 NUM

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

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

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

17. NCH Weekly Claim Processing Date
8 41 48 NUM

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

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

LENGTH : 8 SIGNED : N

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

SOURCE : NCH

EDIT RULES :
YYYYMMDD

18. CWF Claim Accretion Date
8 49 56 NUM

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

diary or carrier.

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

19. CWF Claim Accretion Number
2 57 58 PACK

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

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

LENGTH : 3 SIGNED : Y

SOURCE : CWF

20. FI Document Claim Control Number
23 59 81 CHAR

Unique control number assigned by an intermediary to an institutional claim.

COMMON ALIAS : ICN
DB2 ALIAS : DOC_CLM_CNTL_NUM
SAS ALIAS : CLM_CNTL
STANDARD ALIAS : FI_DOC_CLM_CNTL_NUM
TITLE ALIAS : ICN

LENGTH : 23

SOURCE : CWF

21. FI Original Claim Control Number
23 82 104 CHAR

Effective with Version G, the original intermediary control number (ICN) which is present on adjustment claims, representing the ICN of the original transaction now being adjusted.

COMMON ALIAS : ORIGINAL_ICN
DB2 ALIAS : ORIG_CLM_CNTL_NUM
SAS ALIAS : ORIGCNTL
STANDARD ALIAS : FI_ORIG_CLM_CNTL_NUM
TITLE ALIAS : ORIGINAL_ICN

LENGTH : 23

SOURCE : CWF

22. Claim Query Code
1 105 105 CHAR

Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator).

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM_QUERY_TB

23. Provider Number
6 106 111 CHAR

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

NOTE: Effective October 1, 2007 the OSCAR Provider Number has been renamed the CMS Certification Number (CCN). The name was changed to avoid confusion with the National Provider Identifier (NPI). The CCN (OSCAR Provider Number) will continue to play a critical role in verifying that a provider has been Medicare certified and for what type of services.

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

LENGTH : 6

CODE TABLE : PRVDR_NUM_TB

24. NCH Daily Process Date
8 112 119 NUM

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

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

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

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

LENGTH : 8 SIGNED : N

SOURCE : NCH

LIMITATIONS :

REFER TO :
NCH_DAILY_PROC_DT_LIM

EDIT RULES :
YYYYMMDD

25. NCH Segment Link Number
5 120 124 PACK

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

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

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

LENGTH : 9 SIGNED : Y

SOURCE : NCH

26. Claim Total Segment Count
2 125 126 NUM

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

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

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

LENGTH : 2 SIGNED : N

SOURCE : CWF

27. Claim Segment Number
2 127 128 NUM

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

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

DB2 ALIAS : CLM_SGMT_NUM
SAS ALIAS : SGMT_NUM
STANDARD ALIAS : CLM_SGMT_NUM

TITLE ALIAS : SEGMENT_NUMBER

LENGTH : 2 SIGNED : N

SOURCE : CWF

28. Claim Total Line Count
3 129 131 NUM

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

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

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

LENGTH : 3 SIGNED : N

SOURCE : CWF

29. Claim Segment Line Count
2 132 133 NUM

Effective with Version I, the count used to identify the number of lines on a record/ segment.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991).
The maximum line count per record/segment on the revenue center trailer is 45. The maximum number of lines on carrier and DMERC claims are 13.

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

LENGTH : 2 SIGNED : N

SOURCE : CWF

30. FI CLAIM COMMON GROUP

1091 134 1224 GRP
ALPHANUM

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

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

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

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : PMT_EDIT_RIC_TB

32. Claim Transaction Code
1 135 135 CHAR

The code derived by CWF to indicate the type of claim submitted by an institutional provider.

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

LENGTH : 1

SOURCE : CWF

LIMITATIONS :

REFER TO :
CLM_TRANS_CD_LIM

CODE TABLE : CLM_TRANS_TB

33. Claim Bill Type Group
2 136 137 GRP

Effective with Version H, the claim facility type code plus the claim service classification type code. (The first two positions of the ('type of bill'). During the Version H conversion, this grouping was created throughout history.

NOTE: Effective 4/1/2002, TOB code 'XX0' was

implemented to identify those claims that are totally non-covered.

STANDARD ALIAS : CLM_BILL_TYPE_CD_GRP

CODE TABLE : CLM_BILL_TYPE_TB

34. Claim Facility Type Code
1 136 136 CHAR

The first digit of the type of bill (TOB1) submitted on an institutional claim used to identify the type of facility that provided care to the beneficiary.

COMMON ALIAS : TOB1
DB2 ALIAS : CLM_FAC_TYPE_CD
SAS ALIAS : FAC_TYPE
STANDARD ALIAS : CLM_FAC_TYPE_CD
TITLE ALIAS : TOB1

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM_FAC_TYPE_TB

35. Claim Service Classification Type Code
1 137 137 CHAR

The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification of the type of service provided to the beneficiary.

COMMON ALIAS : TOB2
DB2 ALIAS : SRVC_CLSFCTN_CD
SAS ALIAS : TYPESRVC
STANDARD ALIAS : CLM_SRVC_CLSFCTN_TYPE_CD
TITLE ALIAS : TOB2

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM_SRVC_CLSFCTN_TYPE_TB

36. Claim Frequency Code
1 138 138 CHAR

The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care.

COMMON ALIAS : TOB3
DB2 ALIAS : CLM_FREQ_CD

SAS ALIAS : FREQ_CD
STANDARD ALIAS : CLM_FREQ_CD
TITLE ALIAS : FREQUENCY_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM_FREQ_TB

37. FILLER
1 139 139 CHAR

DB2 ALIAS : FILLER
STANDARD ALIAS : FILLER

LENGTH : 1

38. NCH MQA Query Patch Code
1 140 140 CHAR

Effective with Version H, a code used (for internal editing purposes) to indicate that the CWFMQA process changed the query code submitted on the claim record.

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

DB2 ALIAS : MQA_QUERY_PATCH_CD
SAS ALIAS : MQAQUERY
STANDARD ALIAS : NCH_MQA_QUERY_PATCH_CD
TITLE ALIAS : MQA_QUERY_PATCH_IND

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH_MQA_QUERY_PATCH_TB

39. Claim Disposition Code
2 141 142 CHAR

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

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

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_DISP_TB

40. NCH Edit Disposition Code
2 143 144 CHAR

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

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

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

LENGTH : 2

SOURCE : NCH QA Process

CODE TABLE : NCH_EDIT_DISP_TB

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

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

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

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

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH_CLM_BIC_MDFY_TB

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

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

DB2 ALIAS : BENE_SSA_CNTY_CD
SAS ALIAS : CNTY_CD

STANDARD ALIAS : BENE_RSDNC_SSA_STD_CNTY_CD
TITLE ALIAS : BENE_COUNTY_CD

LENGTH : 3

SOURCE : SSA/EDB

EDIT RULES :
OPTIONAL: MAY BE BLANK

43. FI Claim Receipt Date
8 149 156 NUM

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

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

LENGTH : 8 SIGNED : N

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

SOURCE : CWF

EDIT RULES :
YYYYMMDD

44. FI Claim Scheduled Payment Date
8 157 164 NUM

The scheduled date of payment to the 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.

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

LENGTH : 8 SIGNED : N

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

SOURCE : CWF

EDIT RULES :
YYYYMMDD

45. CWF Forwarded Date

8 165 172 NUM

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

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

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

46. FI Number

5 173 177 CHAR

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

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

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

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

LENGTH : 5

COMMENTS :

Prior to Version H this field was named:
FICARR_IDENT_NUM.

SOURCE : CWF

CODE TABLE : FI_NUM_TB

47. CWF Claim Assigned Number
8 178 185 CHAR

Effective with Version H, the number assigned to an institutional claim record by CWF (used for internal editing purposes).

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

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

LENGTH : 8

SOURCE : CWF

48. CWF Transmission Batch Number
4 186 189 CHAR

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

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

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

LENGTH : 4

SOURCE : CWF

49. Beneficiary Mailing Contact ZIP Code
9 190 198 CHAR

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

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

LENGTH : 9

SOURCE : EDB

50. Beneficiary Sex Identification Code
1 199 199 CHAR

The sex of a beneficiary.

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

LENGTH : 1

SOURCE : SSA,RRB,EDB

EDIT RULES :
REQUIRED FIELD

CODE TABLE : BENE_SEX_IDENT_TB

51. Beneficiary Race Code
1 200 200 CHAR

The race of a beneficiary.

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

LENGTH : 1

SOURCE : SSA

CODE TABLE : BENE_RACE_TB

52. Beneficiary Birth Date
8 201 208 NUM

The beneficiary's date of birth.

COMMON ALIAS : DOB
DB2 ALIAS : BENE_BIRTH_DT
SAS ALIAS : BENE_DOB

STANDARD ALIAS : BENE_BIRTH_DT
TITLE ALIAS : BENE_BIRTH_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

53. CWF Beneficiary Medicare Status Code
2 209 210 CHAR

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

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

LENGTH : 2

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

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

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

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

SOURCE : CWF

CODE TABLE : BENE_MDCR_STUS_TB

54. Claim Patient 6 Position Surname
6 211 216 CHAR

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

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

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

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

LENGTH : 6

SOURCE : CWF

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

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

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

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

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

LENGTH : 1

SOURCE : CWF

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

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

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

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

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

LENGTH : 1

SOURCE : CWF

57. Beneficiary CWF Location Code
1 219 219 CHAR

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

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : BENE_CWF_LOC_TB

58. Claim Principal Diagnosis Group
8 220 227 GRP

Effective with Version 'J', the group used to identify

the principal diagnosis code.
This group contains the principal diagnosis code
and the principal diagnosis version code.

STANDARD ALIAS : CLM_PRNCPAL_DGNS_GRP

59. Claim Principal Diagnosis Version Code
1 220 220 CHAR

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

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

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

LENGTH : 1

CODE TABLE : CLM_DGNS_VRSN_TB

60. Claim Principal Diagnosis Code
7 221 227 CHAR

The diagnosis code identifying the diagnosis,
condition, problem or other reason for the
admission/encounter/visit shown in the medical
record to be chiefly responsible for the services
provided.

NOTE: Effective with Version H, this data is also
redundantly stored as the first occurrence of the
diagnosis trailer.

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

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

LENGTH : 7

SOURCE : CWF

EDIT RULES :
ICD-9-CM

61. FILLER
1 228 228 CHAR

DB2 ALIAS : FILLER
STANDARD ALIAS : FILLER

LENGTH : 1

62. Claim Medicare Non Payment Reason Code
2 229 230 CHAR

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

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

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

NOTE3: Effective with Version 'J', the field has been expanded on the NCH claim to 2 bytes. With this expansion the NCH will no longer use the character values to represent the official two byte values being sent in by CWF since 4/2002.

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

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

LENGTH : 2

CODE TABLE : CLM_MDCR_NPMT_RSN_TB

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

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

DB2 ALIAS : EXCPTD_NEXCPTD_CD

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM_EXCPTD_NEXCPTD_TRTMT_TB

64. Claim Payment Amount
6 232 237 PACK

Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. ***NOTE: In some situations, a negative claim payment amount may be present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)

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

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

Under IRFPPS, inpatient rehabilitation services are paid based on a predetermined rate per discharge, using the Case Mix Group (CMG) classification system and the PRICER program. From the CMG on the IRF PPS claim, payment is

based on a standard payment amount for operating and capital cost for that facility (including routine and ancillary services). The payment is adjusted for wage, the % of low-income patients (LIP), locality, transfers, interrupted stays, short stay cases, deaths, and high cost outliers. Some or all of these adjustments could apply. The CMG payment does NOT include certain pass-through costs (i.e. bad debts, approved education activities); beneficiary-paid amounts, other payer reimbursement,and other services outside of the scope of PPS.

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

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

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

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

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

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

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

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

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

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

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

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

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

LIMITATIONS :

REFER TO :
PMT_AMT_EXCEDG_CHRG_AMT_LIM

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

65. NCH Primary Payer Claim Paid Amount

6 238 243 PACK

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

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

LENGTH : 9.2 SIGNED : Y

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

SOURCE : NCH

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

66. NCH Primary Payer Code
1 244 244 CHAR

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

DB2 ALIAS : NCH_PRMRY_PYR_CD
SAS ALIAS : PRPAY_CD
STANDARD ALIAS : NCH_PRMRY_PYR_CD
TITLE ALIAS : PRIMARY_PAYER_CD

LENGTH : 1

DERIVATIONS :
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES

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

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

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

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

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

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

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

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

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

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

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

SOURCE : NCH

CODE TABLE : BENE_PRMRY_PYR_TB

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

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

DB2 ALIAS : RQST_CNCL_RSN_CD
SAS ALIAS : CANCELCD
STANDARD ALIAS : FI_RQST_CLM_CNCL_RSN_CD
TITLE ALIAS : CANCEL_CD

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : FI_RQST_CLM_CNCL_RSN_TB

68. FI Claim Action Code
1 246 246 CHAR

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

DB2 ALIAS : FI_CLM_ACTN_CD
SAS ALIAS : ACTIONCD
STANDARD ALIAS : FI_CLM_ACTN_CD
TITLE ALIAS : ACTION_CD

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : FI_CLM_ACTN_TB

69. FI Claim Process Date
8 247 254 NUM

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

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

70. NCH Provider State Code
2 255 256 CHAR

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

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

DB2 ALIAS : NCH_PRVDR_STATE_CD
SAS ALIAS : PRSTATE
STANDARD ALIAS : NCH_PRVDR_STATE_CD
TITLE ALIAS : PROVIDER_STATE_CD

LENGTH : 2

DERIVATIONS :
DERIVED FROM:
NCH PRVDR_NUM

DERIVATION RULES:

SET NCH_PRVDR_STATE_CD TO
PRVDR_NUM POS1-2.
FOR PRVDR_NUM POS1-2 EQUAL '55' OR '75'
OR '92' OR 'A0'
OR 'A1' OR 'B2'
SET NCH_PRVDR_STATE_CD TO '05'.

FOR PRVDR_NUM POS1-2 EQUAL '67' OR '74'
OR '97' OR 'A9'
SET NCH_PRVDR_STATE_CD TO '45'.

FOR PRVDR_NUM POS1-2 EQUAL '68' OR '69'
OR 'A2'
SET NCH_PRVDR_STATE_CD TO '10'.

FOR PRVDR_NUM POS1-2 EQUAL '78'
SET NCH_PRVDR_STATE_CD TO '14'

FOR PRVDR_NUM POS1-2 EQUAL TO '76'
SET NCH_PRVDR_STATE_CD TO '16'

FOR PRVDR_NUM POS1-2 EQUAL '70'
SET NCH_PRVDR_STATE_CD TO '17'

FOR PRVDR_NUM POS1-2 EQUAL '71' OR '95'
OR 'A3'
SET NCH_PRVDR_STATE_CD TO '19'

FOR PRVDR_NUMBER POS1-2 EQUAL '77'
SET NCH_PRVDR_STATE_CD TO '24'

FOR PRVDR_NUM POS1-2 EQUAL TO '72' OR 'A6'
SET NCH_PRVDR_STATE_CD TO '36'

FOR PRVDR_NUM POS1-2 EQUAL TO '73' OR 'A7'
SET NCH_PRVDR_STATE_CD TO '39'

FOR PRVDR_NUM POS1-2 EQUAL TO '81'
SET NCH_PRVDR_STATE_CD TO '07'

FOR PRVDR_NUM POS1-2 EQUAL TO '82'
SET NCH_PRVDR_STATE_CD TO '22'

FOR PRVDR_NUM POS1-2 EQUAL TO '83'
SET NCH_PRVDR_STATE_CD TO '31'

FOR PRVDR_NUM POS1-2 EQUAL TO '84'
SET NCH_PRVDR_STATE_CD TO '40'

FOR PRVDR_NUM POS1-2 EQUAL TO '85'
SET NCH_PRVDR_STATE_CD TO '11'

FOR PRVDR_NUM POS1-2 EQUAL TO '86'
SET NCH_PRVDR_STATE_CD TO '34'

FOR PRVDR_NUM POS1-2 EQUAL TO '87'
SET NCH_PRVDR_STATE_CD TO '42'

FOR PRVDR_NUM POS1-2 EQUAL TO '88' OR 'A8'
SET NCH_PRVDR_STATE_CD TO '44'

FOR PRVDR_NUM POS1-2 EQUAL TO '89'
SET NCH_PRVDR_STATE_CD TO '04'

FOR PRVDR_NUM POS1-2 EQUAL TO '90'
SET NCH_PRVDR_STATE_CD TO '37'

FOR PRVDR_NUM POS1-2 EQUAL TO '91'
SET NCH_PRVDR_STATE_CD TO '06'

FOR PRVDR_NUM POS1-2 EQUAL TO '93'
SET NCH_PRVDR_STATE_CD TO '38'

FOR PRVDR_NUM POS1-2 EQUAL TO '94'
SET NCH_PRVDR_STATE_CD TO '50'

FOR PRVDR_NUM POS1-2 EQUAL TO '96'
SET NCH_PRVDR_STATE_CD TO '32'

FOR PRVDR_NUM POS1-2 EQUAL TO '00'
SET NCH_PRVDR_STATE_CD TO '03'

FOR PRVDR_NUM POS1-2 EQUAL TO '54'
SET NCH_PRVDR_STATE_CD TO '13'

FOR PRVDR_NUM POS1-2 EQUAL TO '57'
SET NCH_PRVDR_STATE_CD TO '33'

FOR PRVDR_NUM POS1-2 EQUAL TO '58' OR 'B1'
SET NCH_PRVDR_STATE_CD TO '51'

FOR PRVDR_NUM POS1-2 EQUAL TO '79'
SET NCH_PRVDR_STATE_CD TO '26'

FOR PRVDR_NUM POS1-2 EQUAL TO '80'
SET NCH_PRVDR_STATE_CD TO '21'

FOR PRVDR_NUM POS1-2 EQUAL TO 'A4'
SET NCH_PRVDR_STATE_CD TO '23'

FOR PRVDR_NUM POS1-2 EQUAL TO 'A5'
SET NCH_PRVDR_STATE_CD TO '25'

FOR PRVDR_NUM POS1-2 EQUAL TO 'B0'
SET NCH_PRVDR_STATE_CD TO '18'

SOURCE : NCH

CODE TABLE : GEO_SSA_STATE_TB

71. Organization NPI Number
10 257 266 CHAR

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

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

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

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

LENGTH : 10

SOURCE : CWF

72. Attending Physician ID Group
24 267 290 GRP

Name and identification numbers associated
with the primary care physician.

STANDARD ALIAS : ATNDG_PHYSN_ID_GRP

73. Claim Attending Physician UPIN Number
6 267 272 CHAR

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

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

LENGTH : 6

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

SOURCE : CWF

74. Claim Attending Physician NPI Number
10 273 282 CHAR

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

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

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

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

LENGTH : 10

SOURCE : CWF

75. Claim Attending Physician Surname
6 283 288 CHAR

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

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

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

LENGTH : 6

SOURCE : CWF

76. Claim Attending Physician Given Name
1 289 289 CHAR

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

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

spaces in this field.

DB2 ALIAS : ATNDG_GVN_NAME
SAS ALIAS : AT_GVNNM
STANDARD ALIAS : CLM_ATNDG_PHYSN_GVN_NAME
TITLE ALIAS : ATNDG_PHYSN_FIRSTNAME

LENGTH : 1

SOURCE : CWF

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

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

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

DB2 ALIAS : ATNDG_MI_NAME
SAS ALIAS : AT_MDL
STANDARD ALIAS : CLM_ATNDG_PHYSN_MDL_INITL_NAME
TITLE ALIAS : ATNDG_PHYSN_MI

LENGTH : 1

SOURCE : CWF

78. Operating Physician ID Group
24 291 314 GRP

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

STANDARD ALIAS : OPRTG_PHYSN_ID_GRP

79. Claim Operating Physician UPIN Number
6 291 296 CHAR

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

DB2 ALIAS : OPRTG_UPIN
SAS ALIAS : OP_UPIN

STANDARD ALIAS : CLM_OPRTG_PHYSN_UPIN_NUM
TITLE ALIAS : OPRTG_UPIN

LENGTH : 6

COMMENTS :
Prior to Version H this field was named:
CLM_PRNCPAL_PRCDR_PHYSN_NUM and contained
10 positions (6-position UPIN and 4-position
physician surname.

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

SOURCE : CWF

80. Claim Operating Physician NPI Number
10 297 306 CHAR

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

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

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

DB2 ALIAS : OPRTG_NPI
SAS ALIAS : OP_NPI

STANDARD ALIAS : CLM_OPRTG_PHYSN_NPI_NUM
TITLE ALIAS : OPRTG_NPI

LENGTH : 10

SOURCE : CWF

81. Claim Operating Physician Surname
6 307 312 CHAR

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

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

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

LENGTH : 6

SOURCE : CWF

82. Claim Operating Physician Given Name
1 313 313 CHAR

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

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

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

LENGTH : 1

SOURCE : CWF

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

Effective with Version H, the middle initial of the operating physician (used for internal

editing purposes in CMS' CWFMQA system.)

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

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

LENGTH : 1

SOURCE : CWF

84. Other Operating Physician ID Group
24 315 338 GRP

Name and identification numbers associated with the other physician.

STANDARD ALIAS : OTHR_OPRTG_PHYSN_ID_GRP

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

85. Claim Other Physician UPIN Number
6 315 320 CHAR

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

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

LENGTH : 6

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

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

SOURCE : CWF

86. Claim Other Physician NPI Number
10 321 330 CHAR

On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the other physician associated with the institutiohal claim.

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

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

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

LENGTH : 10

SOURCE : CWF

87. Claim Other Physician Surname
6 331 336 CHAR

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

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

spaces in this field.

DB2 ALIAS : OTHR_SRNM
SAS ALIAS : OT_SRNM
STANDARD ALIAS : CLM_OTHR_PHYSN_SRNM_NAME
TITLE ALIAS : OTH_PHYSN_SURNAME

LENGTH : 6

SOURCE : CWF

88. Claim Other Physician Given Name
1 337 337 CHAR

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

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

DB2 ALIAS : OTHR_GVN_NAME
SAS ALIAS : OT_GVN
STANDARD ALIAS : CLM_OTHR_PHYSN_GVN_NAME
TITLE ALIAS : OTH_PHYSN_FIRSTNAME

LENGTH : 1

SOURCE : CWF

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

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

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

DB2 ALIAS : OTHR_MI_NAME
SAS ALIAS : OT_MDL
STANDARD ALIAS : CLM_OTHR_PHYSN_MDL_INITL_NAME
TITLE ALIAS : OTH_PHYSN_MI

LENGTH : 1

SOURCE : CWF

90. Medicaid Provider Identification Number

13 339 351 CHAR

A unique identification number assigned to each provider by the state Medicaid agency. This unique provider number is used to ensure proper payment of providers and to maintain claims history on individual providers for surveillance and utilization review.

DB2 ALIAS : MDCD_PRVDR_NUM
SAS ALIAS : MDCD_PRV
STANDARD ALIAS : MDCD_PRVDR_IDENT_NUM
TITLE ALIAS : MEDICAID_PROVIDER

LENGTH : 13

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

SOURCE : CWF

91. Claim Medicaid Information Code
4 352 355 CHAR

Effective with Version G, code identifying Medicaid information supplied by the contractor to Medicaid.

DB2 ALIAS : CLM_MDCD_INFO_CD
SAS ALIAS : MDCDINFO
STANDARD ALIAS : CLM_MDCD_INFO_CD
TITLE ALIAS : MEDICAID_INFO

LENGTH : 4

SOURCE : CWF

CODE TABLE : CLM_MDCD_INFO_TB

92. Claim MCO Paid Switch
1 356 356 CHAR

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

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

LENGTH : 1

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

SOURCE : CWF

LIMITATIONS :

REFER TO :
MCO_PD_SW_LIM

CODE TABLE : CLM_MCO_PD_TB

93. Claim Treatment Authorization Number
18 357 374 CHAR

The number assigned by the medical reviewer and reported by the provider to identify the medical review (treatment authorization) action taken after review of the beneficiary's case. It designates that treatment covered by the bill has been authorized by the payer. This number is used by the intermediary and the Peer Review Organization.

NOTE1: 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.

NOTE2: Treatment authorization codes should be missing for any HH claim with a From Date after 1/1/2020. This is a change to billing instructions that is part of the HH Patient-Driving Groupings Model. The Admission Date will also be missing because it was derived from information that was encoded from the Treatment Authorization Code.

COMMON ALIAS : TAN
DB2 ALIAS : TRTMT_AUTHRZTN_NUM
SAS ALIAS : AUTHRZTN
STANDARD ALIAS : CLM_TRTMT_AUTHRZTN_NUM
TITLE ALIAS : TREATMENT_AUTHORIZATION

LENGTH : 18

SOURCE : CWF

94. Patient Control Number
20 375 394 CHAR

The unique alphanumeric identifier assigned by the provider to the institutional claim to facilitate

retrieval of individual case records and posting of payments.

DB2 ALIAS : PTNT_CNTL_NUM
SAS ALIAS : PTNTCNTL
STANDARD ALIAS : PTNT_CNTL_NUM
TITLE ALIAS : PATIENT_CONTROL_NUM

LENGTH : 20

SOURCE : CWF

95. Claim Medical Record Number
17 395 411 CHAR

The number assigned by the provider to the beneficiary's medical record to assist in record retrieval.

DB2 ALIAS : CLM_MDCL_REC_NUM
SAS ALIAS : MDCL_REC
STANDARD ALIAS : CLM_MDCL_REC_NUM
TITLE ALIAS : MEDICAL_RECORD_NUM

LENGTH : 17

SOURCE : CWF

96. Claim PRO Control Number
12 412 423 CHAR

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

DB2 ALIAS : CLM_PRO_CNTL_NUM
SAS ALIAS : PRO_CNTL
STANDARD ALIAS : CLM_PRO_CNTL_NUM
TITLE ALIAS : PRO_CONTROL_NUM

LENGTH : 12

SOURCE : CWF

97. Claim PRO Process Date
8 424 431 NUM

Effective with Version H, the date the claim was used in the PRO review process.

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

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

98. Patient Discharge Status Code
2 432 433 CHAR

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

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

LENGTH : 2

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

SOURCE : CWF

CODE TABLE : PTNT_DSCHRG_STUS_TB

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

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

STANDARD ALIAS : CLM_1ST_DGNS_E_CD_GRP

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

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

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

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

LENGTH : 1

CODE TABLE : CLM_DGNS_VRSN_TB

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

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

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

DB2 ALIAS : CLM_1ST_DGNS_E_CD
SAS ALIAS : DGNS_E
STANDARD ALIAS : CLM_1ST_DGNS_E_CD

LENGTH : 7

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

SOURCE : CWF

EDIT RULES :
ICD-9-CM

102. Claim PPS Indicator Code
1 442 442 CHAR

Effective with Version H, the code indicating whether or not the (1) claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee (MQGE).

NOTE: Beginning with NCH weekly process date 10/3/97 through 5/29/98, this field was 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.

DB2 ALIAS : CLM_PPS_IND_CD
SAS ALIAS : PPS_IND

STANDARD ALIAS : CLM_PPS_IND_CD
TITLE ALIAS : PPS_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM_PPS_IND_TB

103. Claim Total Charge Amount
6 443 448 PACK

Effective with Version G, the total charges for all services included on the institutional claim. This field is redundant with revenue center code 0001/total charges.

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

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

LIMITATIONS :

REFER TO :
TOT_CHRG_AMT_LIM

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

104. Claim Pricer Return Code
2 449 450 CHAR

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

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

The error return code identifies a condition in a claim that prevents the PRICER software from

calculating a correct payment.

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

DB2 ALIAS : CLM_PRCR_RTRN_CD
SAS ALIAS : PRCRRTRN
STANDARD ALIAS : CLM_PRCR_RTRN_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_PRCR_RTRN_TB

105. Claim Business Segment Identifier Code
4 451 454 CHAR

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

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

LENGTH : 4

SOURCE : CWF

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

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

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

LENGTH : 1

CODE TABLE : CLM_RAC_ADJSTMT_TB

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

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

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

LENGTH : 1

CODE TABLE : CLM_WC_IND_TB

108. Claim Service Facility Zip Code
9 457 465 CHAR

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

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

LENGTH : 9

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

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

DB2 ALIAS : CLM_PWK_CD
STANDARD ALIAS : CLM_PWK_CD

LENGTH : 2

CODE TABLE : CLM_PWK_TB

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

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

DB2 ALIAS : CARE_MODEL_1_CD

SAS ALIAS : CMODEL1
STANDARD ALIAS : CLM_CARE_IMPRVMT_MODEL_1_CD

LENGTH : 2

CODE TABLE : CLM_CARE_IMPRVMT_MODEL_TB

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

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

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

LENGTH : 2

CODE TABLE : CLM_CARE_IMPRVMT_MODEL_TB

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

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

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

LENGTH : 2

CODE TABLE : CLM_CARE_IMPRVMT_MODEL_TB

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

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

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

LENGTH : 2

CODE TABLE : CLM_CARE_IMPRVMT_MODEL_TB

114. Rendering Physician ID Group
26 476 501 GRP

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

STANDARD ALIAS : RNDRNG_PHYSN_ID_GRP

115. Claim Rendering Physician UPIN Number
6 476 481 CHAR

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

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

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

LENGTH : 6

116. Claim Rendering Physician NPI Number
10 482 491 CHAR

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

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

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

LENGTH : 10

117. Claim Rendering Physician Surname Name
6 492 497 CHAR

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

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

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

LENGTH : 6

118. Claim Rendering Physician Given Name
1 498 498 CHAR

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

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

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

LENGTH : 1

119. Claim Rendering Physician Middle Name
1 499 499 CHAR

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

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

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

LENGTH : 1

120. Claim Rendering Physician Specialty Code
2 500 501 CHAR

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

NOTE: A 10 percent initiative payment will be provided to primary care practitioners, identified as: (1) in the case of physicians, enrolled in Medicare with a primary specialty code designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics; or (2) in the case of non-physician practitioners, enrolled in Medicare with a primary care speciality code designation of 50-nurse practitioner, 89-certified clinical nurse specialist, or 97-physician assistant; and (3) for whom the primary care services displayed in the above table accounted for at least 60 perent of the allowed charged under the PFS (excluding hospital inpatient care and emergency department visits)for such practitioners.

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

LENGTH : 2

CODE TABLE : CMS_PRVDR_SPCLTY_TB

121. Claim Patient Relationship Code
2 502 503 CHAR

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

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

LENGTH : 2

COMMENTS :
CMS CR7523

CODE TABLE : CLM_PTNT_RLTNSHP_TB

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

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

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

LENGTH : 2

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

123. Claim FPS Reason Code
3 506 508 CHAR

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

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

LENGTH : 3

CODE TABLE : CLM_ADJ_RSN_TB

124. Claim FPS Remarks Code
5 509 513 CHAR

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

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

LENGTH : 5

CODE TABLE : CLM_RMTNC_ADVC_TB

125. Claim FPS MSN 1 Code
5 514 518 CHAR

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

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

LENGTH : 5

CODE TABLE : CLM_FPS_MSN_CD_TB

126. Claim FPS MSN 2 Code
5 519 523 CHAR

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

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

LENGTH : 5

CODE TABLE : CLM_FPS_MSN_CD_TB

127. Claim Mass Adjustment Indicator Code
1 524 524 CHAR

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

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

LENGTH : 1

CODE TABLE : CLM_MASS_ADJSTMT_IND_CD_TB

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

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

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

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

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : NG_ACO_IND_TB

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

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

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

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

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : NG_ACO_IND_TB

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

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

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

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

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : NG_ACO_IND_TB

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

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

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

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

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : NG_ACO_IND_TB

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

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

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

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

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : NG_ACO_IND_TB

133. Claim Residual Payment Indicator Code
1 530 530 CHAR

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

allow CWF to make an exception to its normal routine.

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : RSDL_PMT_IND_TB

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

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

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

LENGTH : 10

COMMENTS :
(CMS CR9468) - CWF July 2016 Release

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

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

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

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

LENGTH : 11

COMMENTS :
SSNRI Project
CWF October 2017 Release

136. Claim Beneficiary Identifier Type Code
1 552 552 CHAR

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

HICN or MBI.

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

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

LENGTH : 1

COMMENTS :
(SSNRI Project)
CWF October 2017 Release

CODE TABLE : CLM_BENE_ID_TYPE_TB

137. Claim Provider Validation Code
2 553 554 CHAR

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

DB2 ALIAS : UNDEFINED
SAS ALIAS : CVLDTNCD

LENGTH : 2

CODE TABLE : CLM_PRVDR_VLDTN_TB

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

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

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

DB2 ALIAS : UNDEFINED
SAS ALIAS : CEXCLSN

LENGTH : 1

CODE TABLE : CLM_RRB_EXCLSN_IND_TB

139. Claim Model Reimbursement Amount
6 556 561 PACK

Effective with CR#16, this Claim Level Field will be used to

identify the "Net Reimbursement Amount" of what Medicare would have paid for Global Budget Services from a hospital participating in the particular model. If the claim only includes global services, the reimbursement amount (CLM_ PMT_AMT) will reflect $0 (zero). If the claim includes global services and non-global services, the reimbursement amount will reflect the amount Medicare actually paid for the non-global services.

Note: This field will be used with future models and not just the Pennsylvania Rural Health Model (PARHM) (CR11355). A demo code (CLM_DEMO_ID_NUM) will be assigned for future models. CLM_RLT_COND_CD = M6 and CLM_VAL_CD = Q4 have been created to identify the PARH model.

DB2 ALIAS : UNDEFINED
SAS ALIAS : CMODELAM
STANDARD ALIAS : CLM_MODEL_REIMBRSMT_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

140.
663 562 1224 CHAR

DB2 ALIAS : H_FILLER_3

LENGTH : 663

141. HHA NCH Edit Code Count
2 1225 1226 NUM

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.

DB2 ALIAS : HHA_EDIT_CD_CNT
SAS ALIAS : HHEDCNT
STANDARD ALIAS : HHA_NCH_EDIT_CD_CNT

LENGTH : 2 SIGNED : N

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

SOURCE : NCH

142. HHA NCH Patch Code Count
2 1227 1228 NUM

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.

DB2 ALIAS : HHA_PATCH_CD_CNT
SAS ALIAS : HHPATCNT
STANDARD ALIAS : HHA_NCH_PATCH_CD_I_CNT

LENGTH : 2 SIGNED : N

SOURCE : NCH

143. HHA MCO Period Count
1 1229 1229 NUM

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

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

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

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 2

144. HHA Claim Demonstration ID Count
1 1230 1230 NUM

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.

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

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 5

145. FILLER
2 1231 1232 NUM

DB2 ALIAS : FILLER
STANDARD ALIAS : FILLER

LENGTH : 2 SIGNED : N

146. FILLER
2 1233 1234 NUM

DB2 ALIAS : FILLER
STANDARD ALIAS : FILLER

LENGTH : 2 SIGNED : N

147. HHA Claim Diagnosis Code Count
2 1235 1236 NUM

The count of the number of diagnosis codes (both principal and secondary) reported on a Home Health Agency (HHA) claim. The purpose of this count is to indicate how many claim diagnosis trailers are present.

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

NOTE1: During the Version 'J' conversion, the diagnosis 'E' codes were removed from the diagnosis trailer and put in the newly created diagnosis 'E' code trailer. Effective with Version 'J', 'E' codes can be found in the diagnosis trailer as secondary diagnosis codes.

DB2 ALIAS : HHA_DGNS_CD_CNT
SAS ALIAS : HHDGNCNT
STANDARD ALIAS : HHA_CLM_DGNS_CD_J_CNT

LENGTH : 2 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 25

148. HHA Claim Diagnosis E Code Count
2 1237 1238 NUM

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

DB2 ALIAS : DGNS_E_TRLR_CNT
STANDARD ALIAS : HHA_CLM_DGNS_E_CD_CNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

EDIT RULES :
RANGE: 0 TO 12

149. FILLER
2 1239 1240 NUM

DB2 ALIAS : FILLER
STANDARD ALIAS : FILLER

LENGTH : 2 SIGNED : N

150. HHA Claim Related Condition Code Count
2 1241 1242 NUM

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.

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

LENGTH : 2 SIGNED : N

COMMENTS :
Prior to Version H this field was named:

CLM_RLT_COND_CD_CNT.

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 30

151. HHA Claim Related Occurrence Code Count
2 1243 1244 NUM

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.

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

LENGTH : 2 SIGNED : N

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

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 30

152. HHA Claim Occurrence Span Code Count
2 1245 1246 NUM

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.

DB2 ALIAS : HHA_OCRNC_SPAN_CNT
SAS ALIAS : HHSPNCNT
STANDARD ALIAS : HHA_CLM_OCRNC_SPAN_CD_CNT

LENGTH : 2 SIGNED : N

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

SOURCE : NCH

153. HHA Claim Value Code Count
2 1247 1248 NUM

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.

DB2 ALIAS : HHA_CLM_VAL_CD_CNT
SAS ALIAS : HHVALCNT
STANDARD ALIAS : HHA_CLM_VAL_CD_CNT

LENGTH : 2 SIGNED : N

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

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 36

154. HHA Revenue Center Code Count
2 1249 1250 NUM

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.

DB2 ALIAS : HHA_REV_CNTR_CNT
SAS ALIAS : HHREVCNT
STANDARD ALIAS : HHA_REV_CNTR_CD_I_CNT

LENGTH : 2 SIGNED : N

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

NOTE: During the Version 'I' conversion the number of occurrences changed to 45 (per segment - 450 total for claim). For claims prior to Version 'I' the number of occurrences was 58.

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 45

155. FILLER
4 1251 1254 CHAR

DB2 ALIAS : FILLER
STANDARD ALIAS : FILLER

LENGTH : 4

156.
568 1255 1822

157. Claim HHA Low Utilization Payment Adjustment (LUPA) Indicator Code
1 1255 1255 CHAR

Effective with Version I, the code used
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

LENGTH : 1

SOURCE : CWF

LIMITATIONS :

REFER TO :
HHA_PPS_LUPA_IND_CD_LIM

CODE TABLE : CLM_HHA_LUPA_IND_TB

158. Claim HHA Referral Code
1 1256 1256 CHAR

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
TITLE ALIAS : HHA_REFERRAL_CODE

LENGTH : 1

SOURCE : CWF

LIMITATIONS :

REFER TO :
HHA_RFRL_CD_LIM

CODE TABLE : CLM_HHA_RFRL_TB

159. Claim HHA Total Visit Count
2 1257 1258 PACK

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.

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

LENGTH : 3 SIGNED : Y

SOURCE : CWF

LIMITATIONS :

REFER TO :
HHA_TOT_VISIT_CNT_LIM

160. NCH Qualified Stay From Date
8 1259 1266 NUM

Effective with Version H, the beginning date of the beneficiary's qualifying stay (used for internal CWFMQA editing purposes). For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization to benefits. For

SNF claims, the date relates to a qualifying stay
from a hospital that is at least two days in a row
if the source of admission is an 'A', or at least
three days in a row if the source of admission
is other than 'A'.

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

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

LENGTH : 8 SIGNED : N

DERIVATIONS :
DERIVED FROM:
CLM_OCRNC_SPAN_CD
CLM_OCRNC_SPAN_FROM_DT

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

SOURCE : NCH QA Process

EDIT RULES :
YYYYMMDD

161. NCH Qualify Stay Through Date
8 1267 1274 NUM

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

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

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

LENGTH : 8 SIGNED : N

DERIVATIONS :
DERIVED FROM:
CLM_OCRNC_SPAN_CD
CLM_OCRNC_SPAN_THRU_DT

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

SOURCE : NCH QA Process

EDIT RULES :
YYYYMMDD

162. NCH Beneficiary Discharge Date
8 1275 1282 NUM

Effective with Version H, on an inpatient and
HHA claim, the date the beneficiary was discharged
from the facility or died (used for internal CWFMQA
editing purposes.)

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

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

LENGTH : 8 SIGNED : N

DERIVATIONS :
DERIVED FROM:
NCH_PTNT_STUS_IND_CD
CLM_THRU_DT

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

SOURCE : NCH QA Process

EDIT RULES :
YYYYMMDD

163. Claim HHA Care Start Date
8 1283 1290 NUM

Effective with Version H, the date care started
for the HHA services reported on the institutional
claim with a from date greater than 3/31/98.
The Balanced Budget Act (BBA) required that
this field be present on all HHA claims.

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

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

NOTE3: The HH Care Start Date will be missing
after 1/1/2020 because it was derived from information
in the Treatment Authorization Code field. Due to
billing instruction changes that is part of the Patient-
Driven Groupings Model the Treatment Authorization
Code is no longer being populated as of 1/1/2020.

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

LIMITATIONS :

REFER TO :
CLM_HHA_CARE_STRT_DT_LIM

EDIT RULES :
YYYYMMDD

164. Claim Attending Physician Specialty Code
2 1291 1292 CHAR

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

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

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

LENGTH : 2

CODE TABLE : CMS_PRVDR_SPCLTY_TB

165. Claim Operating Physician Specialty Code
2 1293 1294 CHAR

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

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

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

LENGTH : 2

CODE TABLE : CMS_PRVDR_SPCLTY_TB

166. Claim Other Physician Specialty Code
2 1295 1296 CHAR

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

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

DB2 ALIAS : CLM_OTHR_SPCLTY_CD
SAS ALIAS : OTSPCLTY

STANDARD ALIAS : CLM_OTHR_PHYSN_SPCLTY_CD

LENGTH : 2

CODE TABLE : CMS_PRVDR_SPCLTY_TB

167. Referring Physician ID Group
26 1297 1322 GRP

Hospice agencies are required to report the physician that certified the hospice patient's terminal illness on the claim when the certifying physician differs from the attending physician. The certifying physician is reported on the UB_04 claim in the "Other Physician" field. With the implementation of the electronic claim 837I version of the 5010A2 format the field for "other physician" is mapped to three possible physician fields. Hospices will report the physician certifying the terminal illness on the claim when different than the attending physician in the referring physician 2310F loop of the 837I version 5010A2. Note: Even though the CR is Hospice specific, CMM wants us to add this group to all institutional claim types for future use (at this time we are unable to add this group to the inpatient/SNF claim type because we don't have enough FILLER to accommodate. We will add in the near future when we expand the record to include additional FILLER).

STANDARD ALIAS : RFRG_PHYSN_ID_GRP

COMMENTS :
ADD NEW GROUP AND FIELDS TO OUTPATIENT, HOME HEALTH AND HOSPICE CLAIM TYPES AT THE CLAIM LEVEL. (CMS CR7755)

168. Claim Referring Physician UPIN Number
6 1297 1302 CHAR

Effective with CR#7, the unique physician identification number (UPIN) of the referring physician who certified the hospice patient's terminal illness when the certifying physician differs from the attending physician.

NOTE: The business requirement for CR7755 is specific to hospice claims but is being added to all claim types because the business owner of the CR does not know when a business need for the other claim types will be implemented so they want the space their for future uses.

DB2 ALIAS : RFRG_UPIN
SAS ALIAS : RF-UPIN
STANDARD ALIAS : CLM_RFRG_PHYSN_UPIN_NUM

LENGTH : 6

169. Claim Referring Physician NPI Number
10 1303 1312 CHAR

Effective with CR#7, the national provider identifier (NPI) number assigned to uniquely identify the referring physician that certified the hospice patient's terminal illness when the certifying physician differs from the attending physician.

NOTE: The business requirement for CR7755 is specific to hospice claims but is being added to all claim types because the business owner of the CR does not know when a business need for the other claim types will be implemented so they want the space their for future uses.

DB2 ALIAS : RFRG_NPI
SAS ALIAS : RF-NPI
STANDARD ALIAS : CLM_RFRG_PHYSN_NPI_NUM

LENGTH : 10

170. Claim Referring Physician Surname Name
6 1313 1318 CHAR

Effective with CR#7, the last name of the referring physician that certified the hospice patient's terminal illness when the certifying physician differs from the attending physician.

NOTE: The business requirement for CR7755 is specific to hospice claims but is being added to all claim types because the business owner of the CR does not know when a business need for the other claim types will be implemented so they want the space their for future uses.

DB2 ALIAS : UNDEFINED
SAS ALIAS : RF-SRNM
STANDARD ALIAS : CLM_RFRG_PHYSN_SRNM_NAME

LENGTH : 6

171. Claim Referring Physician Given Name
1 1319 1319 CHAR

Effective with CR#7, the first name of the referring

physician that certified the hospice patient's
terminal illness when the certifying physician
differs from the attending physician.

NOTE: The business requirement for CR7755 is specific
to hospice claims but is being added to all claim
types because the business owner of the CR does not
know when a business need for the other claim types
will be implemented so they want the space their for
future uses.

DB2 ALIAS : UNDEFINED
SAS ALIAS : RF-GVN
STANDARD ALIAS : CLM_RFRG_PHYSN_GVN_NAME

LENGTH : 1

172. Claim Referring Physician Middle Name
1 1320 1320 CHAR

Effective with CR#7, the middle initial of the referring
physician that certified the hospice patient's
terminal illness when the certifying physician
differs from the attending physician.

NOTE: The business requirement for CR7755 is specific
to hospice claims but is being added to all claim
types because the business owner of the CR does not
know when a business need for the other claim types
will be implemented so they want the space their for
future uses.

DB2 ALIAS : UNDEFINED
SAS ALIAS : RF-MDL
STANDARD ALIAS : CLM_RFRG_PHYSN_MDL_NAME

LENGTH : 1

173. Claim Referring Physician Specialty Code
2 1321 1322 CHAR

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

NOTE: The business requirement for CR7755 is specific
to hospice claims but is being added to all claim
types because the business owner of the CR does not
know when a business need for the other claim types
will be implemented so they want the space there for
future use.

DB2 ALIAS : RFRG_SPCLTY_CD
SAS ALIAS : RFSPCLTY
STANDARD ALIAS : CLM_RFRG_PHYSN_SPCLTY_CD

LENGTH : 2

CODE TABLE : CMS_PRVDR_SPCLTY_TB

174. Claim Service Location NPI Number
10 1323 1332 CHAR

Effective with CR#8, the field used to identify the National Provider Identifier (NPI) of the location where the services were provided.

NOTE: This data element will not be implemented in CWF until the January 2014 release, which means you will not begin to see data in this field in the NCH until the January implementation. We are adding the field with the NCH CR#8 October release because we will not be doing a January 2014 release.

DB2 ALIAS : SRVC_LOC_NPI_NUM
SAS ALIAS : SRVCNPI
STANDARD ALIAS : SRVC_LOC_NPI_NUM

LENGTH : 10

175. Claim PPS Standard Value Payment Amount
6 1333 1338 PACK

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

NOTE: This field was added to Inpatient claims with CR#9 (October 2014 release) and to Home Health claims with the Part A expanstion changes (January 2019 release).

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

LENGTH : 9.2 SIGNED : Y

176. FILLER
484 1339 1822 CHAR

DB2 ALIAS : H_FILLER_8
STANDARD ALIAS : FILLER

LENGTH : 484

177.
VAR 1823 30921

178. NCH Edit Group
65 1823 1887 GRP

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

STANDARD ALIAS : NCH_EDIT_GRP

OCCURS MIN: 0 OCCURS MAX: 13

DEPENDING ON : HHA_NCH_EDIT_CD_CNT

179. NCH Edit Trailer Indicator Code
1 1823 1823 CHAR

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

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

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

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH_EDIT_TRLR_IND_TB

180. NCH Edit Code
4 1824 1827 CHAR

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

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

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

LENGTH : 4

SOURCE : NCH QA EDIT PROCESS

CODE TABLE : NCH_EDIT_TB

181. NCH Patch Group
330 1888 2217 GRP

STANDARD ALIAS : NCH_PATCH_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : HHA_NCH_PATCH_CD_I_CNT

182. NCH Patch Trailer Indicator Code
1 1888 1888 CHAR

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

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

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

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_PATCH_TRLR_IND_TB

183. NCH Patch Code
2 1889 1890 CHAR

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

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

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

LENGTH : 2

SOURCE : NCH

CODE TABLE : NCH_PATCH_TB

184. NCH Patch Applied Date
8 1891 1898 NUM

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

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

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :
YYYYMMDD

185. MCO Period Group
74 2218 2291 GRP

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

STANDARD ALIAS : MCO_PRD_GRP

OCCURS MIN: 0 OCCURS MAX: 2

DEPENDING ON : HHA_MCO_PRD_CNT

186. NCH MCO Trailer Indicator Code
1 2218 2218 CHAR

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

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

DB2 ALIAS : MCO_TRLR_IND_CD
SAS ALIAS : MCOIND

STANDARD ALIAS : NCH_MCO_TRLR_IND_CD
TITLE ALIAS : MCO_INDICATOR

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH_MCO_TRLR_IND_TB

187. MCO Contract Number

5 2219 2223 CHAR

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

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

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

LENGTH : 5

SOURCE : CWF

188. MCO Option Code

1 2224 2224 CHAR

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

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

DB2 ALIAS : MCO_OPTN_CD
SAS ALIAS : MCOOPTN
STANDARD ALIAS : MCO_OPTN_CD
TITLE ALIAS : MCO_OPTION_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : MCO_OPTN_TB

189. MCO Period Effective Date

8 2225 2232 NUM

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

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

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

190. MCO Period Termination Date
8 2233 2240 NUM

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

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

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

191. MCO Health PLANID Number
14 2241 2254 CHAR

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

MCO_PAYERID_NUM.

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

LENGTH : 14

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

SOURCE : CWF

192. Claim Demonstration Identification Group
90 2292 2381 GRP

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

STANDARD ALIAS : CLM_DEMO_ID_GRP

OCCURS MIN: 0 OCCURS MAX: 5

DEPENDING ON : HHA_CLM_DEMO_ID_CNT

193. NCH Demonstration Trailer Indicator Code
1 2292 2292 CHAR

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

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

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

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_DEMO_TRLR_IND_TB

194. Claim Demonstration Identification Number
2 2293 2294 CHAR

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

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

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

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

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

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

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

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

03 = Telemedicine Demo -- testing covering tradi- tionally noncovered physician services for medical consultation furnished via two-way, inter- active video systems (i.e. teleconsultation) in 4 states. The claims contain line items

with 'QQ' HCPCS code.

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

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

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

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

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

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

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

06 = Coronary Artery Bypass Graft (CABG) Demo -- testing bundled payment (all-inclusive global pricing) for hospital + physician services related to CABG surgery in 7 hospitals in 7 states. The inpatient claims contain a DRG

'106' or '107'.

NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit Date no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID '06' on the claim. The FI adds the ID to the claim based on the presence of DRG '106' or '107' from specific providers for specified time periods; the carrier adds the ID to the claim based on receiving 'Daily Census List' from participating hospitals. ***Demo terminated in 1998.***

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

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

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

'07' demo number.

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

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

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

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

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

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

31 = VA Pricing Special Processing (SPN) -- not really a demo but special request from VA due to court settlement; not Medicare services but VA inpatient and physician services submitted

to FI 00400 and Carrier 00900 to obtain
Medicare pricing -- CWF WILL PROCESS VA
CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL
NOT TRANSMIT TO HCFA (not in Nearline File).

37 = Medicare Coordinated Care Demonstration -- to test
whether coordinated care services furnished to
certain beneficiaries improves outcome of care
and reduces Medicare expenditures under Part A and
Part B. There will be at least 14 Coordinated
Care Entities (CCEs). The selected entities will
be assigned a provider number specifically for the
demonstration services.

NOTE: All claims will be processed by carriers;
no FI processing (except for Georgetown site)

37 = Medicare Disease Management (DMD) -- the purpose
of this demonstration is to study the impact on costs
and health outcomes of applying disease management
services supplemented with coverage for prescription
drugs for certain Medicare beneficiaries with diag-
nosed, advanced-stage congestive heart failure,
diabetes, or coronary heart disease. Three demon-
stration sites will be used for this demonstration
and it will last for 3 years. (Effective 4/1/2003).

NOTE: All claims will be processed by NHIC-California
(Carrier). FIs will only serve as a conduit for trans-
mitting information to and from CWF about the NOEs.

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

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

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

NOTE: Effective October, 2000 for carrier claims.

40 = Payment of Physician and Nonphysician Services
in certain Indian Providers -- the purpose of
this demo is to extend payment for services of

physician and nonphysician practitioners furnished in hospitals and ambulatory care clinics. Prior to the legislation change in BIPA, reimbursement for Medicare services provided in IHS facilities was limited to services provided in hospitals and skilled nursing facilities. This change will allow payment for IHS, Tribe and Tribal Organization providers under the Medicare physician fee schedule.

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

45 = Chiropractic

48 = Medical Adult Day-Care Services -- the purpose of this demonstration is to provide, as part of the episode of care for home health services, medical adult day care services to Medicare beneficiaries as a substitute for a portion of home health services that would otherwise be provided in the beneficiaries home. This demo would last approx. 3 years in not more than 5 sites. Payment for each home health service episode of care will be set at 95% of the amount that would otherwise be paid for home health services provided entirely in the home.

NOTE: Effective July 5, 2005 for HHA claims.

49 = Hemodialysis

53 = Extended Stay

54 = ACE Demo

56 = ACA 3113 Lab Demo

58 = used to identify the Multi-payer Advanced Primary Care Practice (MAPCP) demonstration.
(eff. 7/2/12 - CR7693/7283)

59 = ACO Pioneer Demonstration
(CMS CR8140) - eff. 1/2014

60 = Power Motorized Device (PMD)

61 = CLM-CARE-IMPRVMT-MODEL-1

62 = CLM-CARE-IMPRVMT-MODEL-2

63 = CLM-CARE-IMPRVMT-MODEL-3

64 = CLM-CARE-IMPRVMT-MODEL-4

65 = rebilled claims due to auditor denials -- code being implemented for a demonstration to determine the efficiency of allowing providers to rebill for all outpatient services, minus a penalty, when an inpatient claim is denied in full because of medical review because the beneficiary did not require inpatient services. (eff. 7/2/12 -- CR7738)

66 = rebilled claims due to provider self-audit after claim submission/payment -- code being implemented for a demonstration to determine the efficiency of allowing providers to rebill for all outpatient services, minus a penalty, when an inpatient claim is denied in full because of medical review because the beneficiary did not require inpatient services. (eff. 7/2/12 -- CR7738)

67 = rebilled claims due to provider self-audit after the patient has been discharged,but prior to payment -- code being implemented for a demonstration to determine the efficiency of allowing providers to rebill for all outpatient services, minus a penalty, when an inpatient claim is denied in full because of medical review because the beneficiary did not require inpatient services. (eff. 7/2/12 -- CR7738)

68 = CWF will not apply the 3-day hospital stay requirement when processing a SNF claim.
(CMS CR8215) - eff. 1/2014

70 = used for Electrical Workers Insurance Fund claims. (eff. 7/2/12)
71 = Intravenous Immune Globin (IVIG)
75 = Comprehensive Care for Joint Replacement (CCJR) (eff. 4/2016)
77 = Shared Savings Program (eff. 10/2016)
78 = Comprehensive Primary Care Plus (CPC+) (eff. 4/2017)
79 = Acute Myocardial Infarction (AMI) Episode Payment Model (EPM) ((eff. 1/2018)
80 = Coronary Artery Bypass Graft (CABG) Episode Payment Model (EPM) (eff. 1/2018)
81 = Surgical Hip and Femur Fracture Treatment (SHFFT) Episode Payment Model (EMP) (eff. 1/2018)
82 = Medicare Diabetes Prevention Program (MDPPs) (eff. 4/2018)
83 = Maryland Primary Care Program (MDPCP) (eff. 1/2018)
86 = Bundled Payments for Care Improvement Advanced Model
87 = Prospective Bundled Payments for Radiation Oncology (RO) Model (eff. 1/2020)
89 = Vermont All-Payer- (VT ACO Model) (eff. 1/2019)
91 = Emergency Triage, Treat, and Transport (ET3) Model - is a voluntary, 5-year payment model that will provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare FFS beneficiaries following a 911 call. (eff. 1/2020)

92 = Direct Contracting (DC) Model - Professional and Global Options: Total Care Capitation (TCC), Primary Care Capitation (PCC), Advanced Payment Option (APO), Telehealth Expansion, 3-day SNF Rule Waiver, Post-Discharge and Care-Management Home Visits - The Direct Contracting (DC) Model creates a new opportunity for CMS to test an array of financial risk-sharing arrangements, leveraging lessons learned from other Medicare ACO initiatives. As an ACO-like Model, DC allows participating organizations to take on the financial risk for Medicare Part A and B expenditures for a defined population of fee-for-service Medicare beneficiaries over a defined period of time (5 years, separated into 1-year increments called Performance Years (PYs)). eff. 4/2021
94 = ESRD Treatment Choices (ETC) - eff. 1/2020 - Outpatient and Carrier Only (eff. 1/2020)
95 = Oncology Care Model Plus (OCM+) - eff. 1/2020
96 = New Primary Care First (PCF) model - has two separate but related components: (1) the PCF component and (2) the Seriously Ill Population (SIP) component. Both components will test alternative payments and the provision of technical support to primary care practices. These PCF and/or SIP participants will receive a combination of claims and non-claims-based payments based on their attributed Medicare fee-for-service (FFS) beneficiaries. Every participating practice will be given a unique practice ID by the CMS implementation support contractor. Providers in a practice will be uniquely defined by the combination of each provider's tax ID number (TIN) and national provider identifier (NPI). Eff. 1/2021
97 = Kidney Care Choices (KCC) Kidney Care First (KCF) - For the CMS Kidney Care First (KCF) Option, nephrologists and and nephrology practices will receive adjusted capitated payments for managing beneficiaries with Chronic Kidney Disease (CKD) stages 4 and stages 5 and ESRD (End State Renal Disease), and will be eligible for upward or downward payment adjustments based on the quality of their performance and improvements in their performance over time. This model is designed to emulate the basic design of the Primary Care First (PCF) Model. eff. 4/2021.
98 = Pennsylvania Rural Health Model (PARHM) - The provides provides rural acute care hospitals and Critical Access Hospitals (CAH) the opportunity to participate in hospital global budget payments for all inpatient and outpatient hospital services and CAH swing bed services. CMS reimburses participant rural hospitals according to an annual global budget, which is provided by the Commonwealth of Pennsylvania. Participant rural hospitals also submit claims to CMS, but zero claims payments are made. Eff. 1/2018
99 = Opiod Use Disorder (OUD) Treatment Model - is a 4-year The purpose of Value in OUD Treatment is to "increase access of applicable beneficiaries to opioid use disorder treatment services, improve physical and mental health outcomes for such beneficiaries, and to the extent possible,

reduce Medicare program expenditures." Eff. 4/2021

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

LENGTH : 2

SOURCE : CWF

195. Claim Demonstration Information Text
15 2295 2309 CHAR

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

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

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

LENGTH : 15

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

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

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

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

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

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

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

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

SOURCE : CWF

LIMITATIONS :

REFER TO :
CHOICES_DEMO_LIM

196. Claim Diagnosis Group
225 2382 2606 GRP

The number of claim diagnosis trailers is determined by the claim diagnosis code count. The principal diagnosis is the first occurrence. The principal diagnosis is also stored (redundantly) in the fixed portion of the record.

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

STANDARD ALIAS : CLM_DGNS_GRP

OCCURS MIN: 0 OCCURS MAX: 25

DEPENDING ON : HHA_CLM_DGNS_CD_J_CNT

197. NCH Diagnosis Trailer Indicator Code
1 2382 2382 CHAR

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

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

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

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_DGNS_TRLR_IND_TB

198. Claim Diagnosis Version Code
1 2383 2383 CHAR

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

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

DB2 ALIAS : CLM_DGNS_VRSN_CD
SAS ALIAS : DVRSNCD
STANDARD ALIAS : CLM_DGNS_VRSN_CD

LENGTH : 1

CODE TABLE : CLM_DGNS_VRSN_TB

199. Claim Diagnosis Code
7 2384 2390 CHAR

The diagnosis code identifying the beneficiary's principal or other diagnosis (including E code).

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

CLM_PRNCPAL_DGNS_CD was added as the first occurrence.

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

NOTE2: Effective with Version 'J', the diagnosis E codes are stored in a separate trailer (CLM_DGNS_E_GRP).

DB2 ALIAS : CLM_DGNS_CD
SAS ALIAS : DGNS_CD
STANDARD ALIAS : CLM_DGNS_CD

LENGTH : 7

EDIT RULES :
ICD-9-CM

200. Claim Diagnosis E Group
108 2607 2714 GRP

The number of claim diagnosis E trailers is determined by the claim diagnosis E code count.
This group contains the diagnosis E codes and the diagnosis E version code.

STANDARD ALIAS : CLM_DGNS_E_GRP

OCCURS MIN: 0 OCCURS MAX: 12

DEPENDING ON : HHA_CLM_DGNS_E_CD_CNT

201. NCH Diagnosis E Trailer Indicator Code
1 2607 2607 CHAR

Effective with Version 'J', the code indicating the presence of a diagnosis E trailer.

NOTE: During the Version 'J' conversion, this field was populated throughout history.

DB2 ALIAS : DGNS_E_TRLR_IND_CD
SAS ALIAS : ETRLRIND
STANDARD ALIAS : NCH_DGNS_E_TRLR_IND_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_DGNS_E_TRLR_IND_TB

202. Claim Diagnosis Version Code

1 2608 2608 CHAR

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

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

DB2 ALIAS : UNDEFINED
SAS ALIAS : EVRSNCD
STANDARD ALIAS : CLM_DGNS_E_VRSN_CD

LENGTH : 1

CODE TABLE : CLM_DGNS_VRSN_TB

203. Claim Diagnosis E Code

7 2609 2615 CHAR

Effective with Version J, the code used to identify the external cause of injury, poisoning, or other adverse affect.

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

During the Version 'J' conversion, all 'E' codes in the diagnosis trailer were moved to the diagnosis 'E' trailer.

With the implementation of Version 'J', diagnosis 'E' codes can also be found in the regular diagnosis trailer, reflected as secondary diagnosis codes.

DB2 ALIAS : CLM_DGNS_E_CD
SAS ALIAS : EDGNSCD
STANDARD ALIAS : CLM_DGNS_E_CD

LENGTH : 7

SOURCE : CWF

EDIT RULES :
ICD-9-CM

204. Claim Related Condition Group

90 2715 2804 GRP

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

on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

STANDARD ALIAS : CLM_RLT_COND_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : HHA_CLM_RLT_COND_CD_CNT

205. NCH Condition Trailer Indicator Code
1 2715 2715 CHAR

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

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

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

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_COND_TRLR_IND_TB

206. Claim Related Condition Code
2 2716 2717 CHAR

The code that indicates a condition relating to an institutional claim that may affect payer processing.

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

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_RLT_COND_TB

207. Claim Related Occurrence Group
330 2805 3134 GRP

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

on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

STANDARD ALIAS : CLM_RLT_OCRNC_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : HHA_CLM_RLT_OCRNC_CD_CNT

208. NCH Occurrence Trailer Indicator Code
1 2805 2805 CHAR

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

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

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

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_OCRNC_TRLR_IND_TB

209. Claim Related Occurrence Code
2 2806 2807 CHAR

The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date.

DB2 ALIAS : CLM_RLT_OCRNC_CD
SAS ALIAS : OCRNC_CD
STANDARD ALIAS : CLM_RLT_OCRNC_CD
TITLE ALIAS : OCCURRENCE_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_RLT_OCRNC_TB

210. Claim Related Occurrence Date
8 2808 2815 NUM

The date associated with a significant event related to an institutional claim that may

affect payer processing.

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

211. Claim Occurrence Span Group
190 3135 3324 GRP

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

STANDARD ALIAS : CLM_OCRNC_SPAN_GRP

OCCURS MIN: 0 OCCURS MAX: 10

DEPENDING ON : HHA_CLM_OCRNC_SPAN_CD_CNT

212. NCH Span Trailer Indicator Code
1 3135 3135 CHAR

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

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

DB2 ALIAS : SPAN_TRLR_IND_CD
SAS ALIAS : SPANIND
STANDARD ALIAS : NCH_SPAN_TRLR_IND_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_SPAN_TRLR_IND_TB

213. Claim Occurrence Span Code
2 3136 3137 CHAR

The code that identifies a significant event relating to an institutional claim that may

affect payer processing. These codes are claim-related occurrences that are related to a time period (span of dates).

DB2 ALIAS : CLM_OCRNC_SPAN_CD
SAS ALIAS : SPAN_CD
STANDARD ALIAS : CLM_OCRNC_SPAN_CD
TITLE ALIAS : SPAN_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_OCRNC_SPAN_TB

214. Claim Occurrence Span From Date
8 3138 3145 NUM

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

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

215. Claim Occurrence Span Through Date
8 3146 3153 NUM

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

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

216. Claim Value Group
324 3325 3648 GRP

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

STANDARD ALIAS : CLM_VAL_GRP

OCCURS MIN: 0 OCCURS MAX: 36

DEPENDING ON : HHA_CLM_VAL_CD_CNT

217. NCH Value Trailer Indicator Code
1 3325 3325 CHAR

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

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

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

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_VAL_TRLR_IND_TB

218. Claim Value Code
2 3326 3327 CHAR

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

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

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_VAL_TB

219. Claim Value Amount
6 3328 3333 PACK

The amount related to the condition identified in the CLM_VAL_CD which was used by the intermediary to process the institutional claim.

DB2 ALIAS : CLM_VAL_AMT
SAS ALIAS : VAL_AMT
STANDARD ALIAS : CLM_VAL_AMT
TITLE ALIAS : VALUE_AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

220.
27270 3649 30918

OCCURS MIN: 0 OCCURS MAX: 45

DEPENDING ON : HHA_REV_CNTR_CD_I_CNT

221. NCH Revenue Center Trailer Indicator Code
1 3649 3649 CHAR

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

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

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

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_REV_TRLR_IND_TB

222. Revenue Center Code
4 3650 3653 CHAR

The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a

hospital (e.g., radiology, emergency room, pathology).
EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

DB2 ALIAS : REV_CNTR_CD
SAS ALIAS : REV_CNTR
STANDARD ALIAS : REV_CNTR_CD
TITLE ALIAS : REVENUE_CENTER_CD

LENGTH : 4

SOURCE : CWF

CODE TABLE : REV_CNTR_TB

223. Revenue Center Date
8 3654 3661 NUM

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

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

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

DB2 ALIAS : REV_CNTR_DT
STANDARD ALIAS : REV_CNTR_DT
TITLE ALIAS : REV_CNTR_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

224. Revenue Center 1st ANSI Code
5 3662 3666 CHAR

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

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date
7/7/00, this field will be populated with data.
Claims processed prior to 7/7/00 will contain
spaces in this field.

DB2 ALIAS : REV_CNTR_ANSI1_CD
SAS ALIAS : REVANSI1
STANDARD ALIAS : REV_CNTR_ANSI_1_CD
TITLE ALIAS : ANSI_CD

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV_CNTR_ANSI_TB

225. Revenue Center 2nd ANSI Code
5 3667 3671 CHAR

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

NOTE1: This field is populated for those claims
that are required to process through Outpatient

PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

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

LENGTH : 5

SOURCE : CWF

226. Revenue Center 3rd ANSI Code
5 3672 3676 CHAR

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

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date

7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV_CNTR_ANSI3_CD
SAS ALIAS : REVANSI3
STANDARD ALIAS : REV_CNTR_ANSI_3_CD
TITLE ALIAS : ANSI_CD

LENGTH : 5

SOURCE : CWF

227. Revenue Center 4th ANSI Code
5 3677 3681 CHAR

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

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

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

LENGTH : 5

SOURCE : CWF

228. Revenue Center APC/HIPPS Code
5 3682 3686 CHAR

Effective with Version 'I', this field was created to house two pieces of data. The Ambulatory Payment Classification (APC) code and the HIPPS code. The APC is used to identify groupings of outpatient services. APC codes are used to calculate payment for services under OPPS. The APC is a four byte field. The HIPPS codes are used to identify patient classifications for SNFPPS, HHPPS and IRFPPS that will be used to calculate payment. The HIPPS code is a five byte field.

NOTE1: The APC field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Under SNFPPS, HHPPS & IRFPPS, HIPPS codes are stored in the HCPCS field. **EXCEPTION: if a HHPPS HIPPS code is downcoded/upcoded the downcoded/ upcoded HIPPS will be stored in this field.

NOTE3: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

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

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV_CNTR_APC_TB

229. Revenue Center Healthcare Common Procedure Coding System Code
5 3687 3691 CHAR

Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be

provided to Medicare beneficiaries and to
individuals enrolled in private health
insurance programs. The codes are divided
into three levels, or groups, as described
below:

DB2 ALIAS : REV_CNTR_HCPCS_CD
STANDARD ALIAS : REV_CNTR_HCPCS_CD
TITLE ALIAS : HCPCS_CD

LENGTH : 5

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

NOTE: When revenue center code = '0022' (SNF PPS),
'0023' (HH PPS), or '0024' (IRF PPS); this field
contains the Health Insurance PPS (HIPPS) code.

The HIPPS code for SNF PPS contains the rate code/
assessment type that identifies (1) RUG-III group
the beneficiary was classified into as of the RAI
MDS assessment reference date and (2) the type of
assessment for payment purposes.

The HIPPS code for Home Health PPS identifies
(1) the three case-mix dimensions of the HHRG system,
clinical, functional and utilization, from which a
beneficiary is assigned to one of the 80 HHRG
categories and (2) it identifies whether or not
the elements of the code were computed or derived.
The HHRGs, represented by the HIPPS coding, will be
the basis of payment for each episode.

The HIPPS code (CMG Code) for IRF PPS identifies
the clinical characteristics of the beneficiary.
The HIPPS rate/CMG code (AXXYY - DXXYY) must contain
five digits. The first position of the code is an
A, B, C, or 'D'. The HIPPS code beginning with an
'A' in front of the CMG is defined as without comor-
bidity. The 'B' in front of the CMG is defined as
with comorbidity for Tier 1. The 'C' is defined
as comorbidity for Tier 2 and 'D' is defined as
comorbidity for Tier 3. The 'XX' in the HIPPS
rate code is the Rehabilitation Impairment Code
(RIC). The 'YY' is the sequential number system
within the RIC.

For SNF PPS, HH PPS & IRF PPS HIPPS values see
CLM_HIPPS_TB.

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

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

Level II
Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

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

LIMITATIONS :

REFER TO :
HHA_HCPCS_LIM

CODE TABLE : CLM_HIPPS_TB

230. Revenue Center HCPCS Initial Modifier Code
2 3692 3693 CHAR

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

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

LENGTH : 2

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

SOURCE : CWF

EDIT RULES :
Carrier Information File

231. Revenue Center HCPCS Second Modifier Code
2 3694 3695 CHAR

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

DB2 ALIAS : REV_HCPCS_2ND_CD
STANDARD ALIAS : REV_CNTR_HCPCS_2ND_MDFR_CD
TITLE ALIAS : SECOND_MODIFIER

LENGTH : 2

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

SOURCE : CWF

EDIT RULES :
CARRIER INFORMATION FILE

232. Revenue Center HCPCS Third Modifier Code
2 3696 3697 CHAR

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

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

LENGTH : 2

COMMENTS :

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

SOURCE : CWF

EDIT RULES :
CARRIER INFORMATION FILE

233. Revenue Center HCPCS Fourth Modifier Code
2 3698 3699 CHAR

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

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

LENGTH : 2

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

SOURCE : CWF

EDIT RULES :
CARRIER INFORMATION FILE

234. Revenue Center HCPCS Fifth Modifier Code
2 3700 3701 CHAR

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

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

LENGTH : 2

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

spaces in this field.

SOURCE : CWF

EDIT RULES :
CARRIER INFORMATION FILE

235. Revenue Center Payment Method Indicator Code
2 3702 3703 CHAR

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

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

NOTE3: Effective 10/2005, this field will no longer represent the service indicator and the payment indicator. This field will now house the 2-byte payment indicator. The status indicator will be housed in a new field named: REV_CNTR_STUS_IND_CD.

DB2 ALIAS : REV_PMT_MTHD_CD
SAS ALIAS : PMTMTHD
STANDARD ALIAS : REV_CNTR_PMT_MTHD_IND_CD

TITLE ALIAS : PMT_MTHD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV_CNTR_PMT_MTHD_IND_TB

236. Revenue Center Discount Indicator Code
1 3704 3704 CHAR

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

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

NOTE3: VALUES D, U & T REPRESENT THE FOLLOWING:
D = Discounting fraction (currently 0.5)
U = Number of units
T = Terminated procedure discount (currently 0.5)

DB2 ALIAS : REV_DSCNT_IND_CD
SAS ALIAS : DSCNTIND
STANDARD ALIAS : REV_CNTR_DSCNT_IND_CD
TITLE ALIAS : REV_CNTR_DSCNT_IND_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV_CNTR_DSCNT_IND_TB

237. Revenue Center Packaging Indicator Code
1 3705 3705 CHAR

Effective with Version 'I', the code used to identify those services that are packaged/ bundled with another service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_PACKG_IND_CD
SAS ALIAS : PACKGIND
STANDARD ALIAS : REV_CNTR_PACKG_IND_CD
TITLE ALIAS : REV_CNTR_PACKG_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV_CNTR_PACKG_IND_TB

238. Revenue Center Pricing Indicator Code
2 3706 3707 CHAR

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

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_PRICNG_IND_CD
SAS ALIAS : PRICNG
STANDARD ALIAS : REV_CNTR_PRICNG_IND_CD
TITLE ALIAS : REV_CNTR_PRICNG_IND

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV_CNTR_PRICNG_IND_TB

239. Revenue Center Obligation to Accept As Full (OTAF) Payment Code
1 3708 3708 CHAR

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

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be
populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion
OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated
on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the
dates of service.

DB2 ALIAS : REV_OTAF_IND_CD
SAS ALIAS : OTAF
STANDARD ALIAS : REV_CNTR_OTAF_IND_CD

LENGTH : 1

SOURCE : CWF

EDIT RULES :
Y = provider is obligated to accept the payment
as payment in full for the service.
N or blank = provider is not obligated to accept
the payment, or there is no payment by a prior
payer.

240. Revenue Center IDE, NDC, UPC Number
24 3709 3732 CHAR

Effective with Version H, the exemption number

assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. HCFA established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95. IDE's are always associated with revenue center code '0624'.

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

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

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

LENGTH : 24

SOURCE : CWF

LIMITATIONS :

REFER TO :
REV_CNTR_IDE_NDC_UPC_LIM

241. Revenue Center NDC Quantity Qualifier Code
2 3733 3734 CHAR

Effective with Version 'J', the code used to indicate the unit of measurement for the drug that was administered.

DB2 ALIAS : NDC_QTY_QLFR_CD
SAS ALIAS : QTYQLFR
STANDARD ALIAS : REV_CNTR_NDC_QTY_QLFR_CD

LENGTH : 2

CODE TABLE : REV_CNTR_NDC_QTY_QLFR_TB

242. Revenue Center NDC Quantity
6 3735 3740 PACK

Effective with Version 'J', the quantity dispensed for the drug reflected on the revenue center line item.

DB2 ALIAS : NDC_QTY_NUM
SAS ALIAS : NDCQTY
STANDARD ALIAS : REV_CNTR_NDC_QTY

LENGTH : 7.3 SIGNED : Y

243. Revenue Center Unit Count
4 3741 3744 PACK

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

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

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

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

LENGTH : 7 SIGNED : Y

SOURCE : CWF

244. Revenue Center Rate Amount
6 3745 3750 PACK

Charges relating to unit cost associated with the revenue center code. Exception (encounter data only): If plan (e.g. MCO) does not know

the actual rate for the accommodations, $1 will be reported in the field.

NOTE1: For SNF PPS claims (when revenue center code equals '0022'), CMS has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue center HCPCS code field).

NOTE2: For OP PPS claims, CMS has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index.

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

On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment. In cases of SCICs, there will be more than one '0023' revenue center line, each representing the payment made at each case-mix level.

NOTE4: For IRF PPS claims (when revenue center code equals '0024'), CMS has developed a PRICER to compute the rate based on the HIPPS/CMG (HIPPS code, stored in revenue center HCPCS code field).

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

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

245. Revenue Center Blood Deductible Amount
6 3751 3756 PACK

Effective with Version 'I', the amount of money
for which the intermediary determined the
beneficiary is liable for the blood deductible
for the line item service.

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient
type of bill with a condition code '07' and certain
HCPCS. These claim types could have lines that are
not required to price under OPPS rules so those
lines would not have data in this field.

Additional exception: Virgin Island hospitals and
hospitals that furnish only inpatient Part B services
with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be
populated with data on claims with dates of service
prior to 7/00 (implementation of Claim Line Expansion
OPPS/HHPPS). The original understanding of the new
revenue center fields was that data would be populated
on claims with dates of service 7/00 and forward. Data
has been found in claims with dates of service prior to
7/00 because the Standard Systems have processed any
claim coming in 7/00 and after, meeting the above criteria,
through the Outpatient Code Editor (OCE) regardless of the
dates of service.

DB2 ALIAS : REV_BLOOD_DDCTBL
SAS ALIAS : REVBLOOD
STANDARD ALIAS : REV_CNTR_BLOOD_DDCTBL_AMT
TITLE ALIAS : BLOOD_DDCTBL_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

246. Revenue Center Cash Deductible Amount
6 3757 3762 PACK

Effective with Version 'I' the amount of cash
deductible the beneficiary paid for the line
item service.

NOTE1: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland

providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_CASH_DDCTBL
SAS ALIAS : REVDCTBL
STANDARD ALIAS : REV_CNTR_CASH_DDCTBL_AMT
TITLE ALIAS : CASH_DDCTBL

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

247. Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount
6 3763 3768 PACK

Effective with Version 'I', the amount of coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. The above claim types could have lines that are not required to price under OPPS rules so those

lines would not have data in this field.

NOTE2: This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification.

NOTE3: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : ADJSTD_COINSRNC
SAS ALIAS : WAGEADJ
STANDARD ALIAS : REV_CNTR_WAGE_ADJSTD_COINS_AMT
TITLE ALIAS : WAGE_ADJSTD_COINS

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

248. Revenue Center Reduced Coinsurance Amount
6 3769 3774 PACK

Effective with Version 'I', for all services subject to Outpatient PPS, the amount of coinsurance applicable to the line for a particular service (HCPCS) for which the provider has elected to reduce the coinsurance amount.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those

lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.

NOTE3: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

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

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

249. Revenue Center 1st Medicare Secondary Payer Paid Amount
6 3775 3780 PACK

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

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

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

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

250. Revenue Center 2nd Medicare Secondary Payer Paid Amount
6 3781 3786 PACK

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

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any

claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_MSP2_PD_AMT
SAS ALIAS : REV_MSP2
STANDARD ALIAS : REV_CNTR_MSP2_PD_AMT
TITLE ALIAS : MSP PAID AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

251. Revenue Center Provider Payment Amount
6 3787 3792 PACK

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

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to the present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see Limitations Appendix. The following is how each system handles this field:

FISS: populated correctly with provider payment amount

APASS: provider payment amount plus interest on 1st revenue center line (CMM will instruct APASS not to include interest)

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See

FI_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)
00430 -- Washington/Alaska (until 11/1/2003)
00310 -- North Carolina BC (until 12/1/2003)
00370 -- Rhode Island (until 2/1/2004)
00270 -- New Hampshire/Vermont (until 3/1/2004)
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_PRVDR_PMT_AMT
SAS ALIAS : RPRVDPMT
STANDARD ALIAS : REV_CNTR_PRVDR_PMT_AMT
TITLE ALIAS : REV_PRVDR_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

252. Revenue Center Beneficiary Payment Amount
6 3793 3798 PACK

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

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

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

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

253. Revenue Center Patient Responsibility Payment Amount
6 3799 3804 PACK

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

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see the Limitations Appendix. The following is how each system is handling this field:

FISS: populating correctly (sum of coinsurance and deductible)

APASS: not populating this field

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)
00430 -- Washington/Alaska (until 11/1/2003)
00310 -- North Carolina BC (until 12/1/2003)
00370 -- Rhode Island (until 2/1/2004)
00270 -- New Hampshire/Vermont (until 3/1/2004)
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

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

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

254. Revenue Center Payment Amount
6 3805 3810 PACK

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

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see the Limitations Appendix. The following is how each system is handling this field:

FISS: this field contains provider reimbursement.

APASS: provider payment amount plus coinsurance and deductible (should not include coinsurance and deductible). Users should rely on provider payment amount field for the trust fund payment.

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)
00430 -- Washington/Alaska (until 11/1/2003)
00310 -- North Carolina BC (until 12/1/2003)
00370 -- Rhode Island (until 2/1/2004)
00270 -- New Hampshire/Vermont (until 3/1/2004)
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_CNTR_PMT_AMT
SAS ALIAS : REVPMT
STANDARD ALIAS : REV_CNTR_PMT_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

255. Revenue Center Total Charge Amount
6 3811 3816 PACK

The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided. NOTE: For accommodation revenue center total charges must equal the rate times units (days).

EXCEPTIONS:
(1) For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo).

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

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

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

(5) For Inpatient Rehabilitation Facility (IFR) PPS, when the revenue center code = '0024', the total charges will be zero. For accommodation revenue codes (010X - 021X), total charges must equal the rate times the units.

(6) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be $1 (rate) times units (days).

DB2 ALIAS : REV_TOT_CHRG_AMT
SAS ALIAS : REV_CHRG
STANDARD ALIAS : REV_CNTR_TOT_CHRG_AMT
TITLE ALIAS : REVENUE_CENTER_CHARGES

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

LIMITATIONS :

REFER TO :

MLTPL_REV_CNTR_0001_CD_LIM
REV_CNTR_TOT_CHRG_AMT_LIM

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

256. Revenue Center Non-Covered Charge Amount
6 3817 3822 PACK

The charge amount related to a revenue center code for services that are not covered by Medicare.

NOTE: Prior to Version H the field size was S9(7)V99 and the element was only present on the Inpatient/SNF format. As of NCH weekly process date 10/3/97 this field was added to all institutional claim types.

DB2 ALIAS : REV_NCVR_CHRG_AMT
SAS ALIAS : REV_NCVR
STANDARD ALIAS : REV_CNTR_NCVR_CHRG_AMT
TITLE ALIAS : REV_CENTER_NONCOVERED_CHARGES

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

257. Revenue Center Deductible Coinsurance Code
1 3823 3823 CHAR

Code indicating whether the revenue center charges are subject to deductible and/or coinsurance.

DB2 ALIAS : DDCTBL_COINSRNC_CD
SAS ALIAS : REVDEDCD
STANDARD ALIAS : REV_CNTR_DDCTBL_COINSRNC_CD
TITLE ALIAS : REVENUE_CENTER_DEDUCTIBLE_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV_CNTR_DDCTBL_COINSRNC_TB

258. Revenue Center Consolidated Billing Code
1 3824 3824 CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, this code is reflected on outpatient claims only to identify those line item services (i.e. therapy and nonroutine supply services) that are subject to SNF and Home Health consolidated billing. If the

line item service was paid by an intermediary prior
to the submission of the SNF or home health claim
an adjustment for the outpatient claim will be submitted
identifying those services that are subject to
consolidated billing.

NOTE1: Prior to 10/2005 (implementation of NCH/NMUD
CR#2), this data was stored in position 175 (FILLER)
in the revenue center trailer.

NOTE2: Effective July 2005, this data will no longer
be coming into the NCH. This process is being handled
in the new CWF override processing.

DB2 ALIAS : CNSLDTD_BLG_CD
SAS ALIAS : RCNSLDTD
STANDARD ALIAS : REV_CNTR_CNSLDTD_BLG_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV_CNTR_CNSLDTD_BLG_TB

259. Revenue Center Status Indicator Code
2 3825 3826 CHAR

Effective 10/3/2005 with the implementation of NCH/NMUD
CR#2, the code used to identify the status of the
line item service. This field along with the
payment method indicator field is used to identify
how the service was priced for payment.

NOTE1: This 2-byte indicator is being added due to
an expansion of a field that currently exist on the
revenue center trailer. The status indicator is
currently the 1st position of the Revenue Center
Payment Method Indicator Code. The payment method
indicator code is being split into two 2-byte
fields (payment indicator and status indicator). The
expanded payment indicator will continue to be stored
in the existing payment method indicator field. The
split of the current payment method indicator field
is due to the expansion of both pieces of date from
1-byte to 2-bytes.

NOTE2: This field is populated for those claims
that are required to process through Outpatient
PPS Pricer. The type of bills (TOB) required to
process through are: 12X, 13X, 14X (except Maryland
providers, Indian Health Providers, hospitals located
in American Samoa, Guam and Saipan and Critical
Access Hospitals (CAH)); 76X; 75X and 34X if
certain HCPCS are on the bill; and any outpatient

type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

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

DB2 ALIAS : REV_STUS_IND_CD
SAS ALIAS : RSTUSIND
STANDARD ALIAS : REV_CNTR_STUS_IND_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV_CNTR_STUS_IND_TB

260. Revenue Center Duplicate Claim Check Indicator Code
1 3827 3827 CHAR

Effective 1/1/2009 with the implementation of NCH/NMUD CR#4, the code used to identify an item or service that appeared to be a duuplicate but has been reviewed by an FI or MAC and appropriately approved for payment.

DB2 ALIAS : DUP_CLM_CHK_IND_CD
SAS ALIAS : DUP-CHK
STANDARD ALIAS : REV_CNTR_DUP_CLM_CHK_IND_CD

LENGTH : 1

CODE TABLE : REV_CNTR_DUP_CLM_CHK_IND_TB

261. Revenue Center APC Buffer Code
2 3828 3829 CHAR

APC - Ambulatory Payment Classification
Effective 1/1/2009 with the implementation of CR#4, the code used to identify related line items that make up a composite APC group. This field is only applicable to outpatient PPS claims.

DB2 ALIAS : REV_CNTR_BUFR_CD
SAS ALIAS : APCBUFR
STANDARD ALIAS : REV_CNTR_APC_BUFR_CD

LENGTH : 2

CODE TABLE : REV_CNTR_APC_BUFR_TB

262. Revenue Center Rendering Physician NPI Num
10 3830 3839 CHAR

Effective with Version 'J', the NPI of the rendering physician who performed the service.

DB2 ALIAS : RNDRNG_NPI_NUM
SAS ALIAS : REVNPI
STANDARD ALIAS : REV_CNTR_RNDRNG_PHYSN_NPI_NUM

LENGTH : 10

LIMITATIONS :

REFER TO :
REV_RNDRNG_PHYSN_NPI_NUM_LIM

263. Revenue Center Rendering Physician Surname
6 3840 3845 CHAR

Effective with Version 'J', the 6 position last name of the rendering physician who performed the service.

DB2 ALIAS : RNDRNG_SRNM_NAME
SAS ALIAS : REVSRNM
STANDARD ALIAS : REV_CNTR_RNDRNG_SRNM_NAME

LENGTH : 6

264. Revenue Center Paperwork (PWK) Code
2 3846 3847 CHAR

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

DB2 ALIAS : REV_CNTR_PWK_CD
STANDARD ALIAS : REV_CNTR_PWK_CD

LENGTH : 2

CODE TABLE : REV_CNTR_PWK_TB

265. Rendering Physician Specialty Code
2 3848 3849 CHAR

Effective with CR#7, the code used to identify the CMS specialty code corresponding to the rendering physician at the revenue center line.

NOTE: Medicare needs to identify primary physicians/ practitioners of service not only for use in standard claims transactions but also for review, fraud detection, and planning purposes. In order to do this, CMS must be able to determine the rendering physician/practitioner for each service billed to Medicare and store this information in our databases that serve as the source for data

analysis.

DB2 ALIAS : REV_CNTR_SPCLTY_CD
SAS ALIAS : RSPCLTY
STANDARD ALIAS : REV_CNTR_PHYSN_SPCLTY_CD

LENGTH : 2

COMMENTS :
(CMS CR7578)

LIMITATIONS :

REFER TO :
REV_CNTR_RNDRNG_SPCLTY_CD_LIM

CODE TABLE : CMS_PRVDR_SPCLTY_TB

266. Revenue Center Therapy CAP Indicator 1 Code
1 3850 3850 CHAR

Effective with Version 'K', the field used to
identify whether the claim line is subject to a therapy cap.

DB2 ALIAS : REV_THRPY_CAP_1_CD
SAS ALIAS : RTHRPY1
STANDARD ALIAS : REV_CNTR_THRPY_CAP_IND_1_CD

LENGTH : 1

CODE TABLE : REV_CNTR_THRPY_CAP_IND_CD_TB

267. Revenue Center Therapy CAP Indicator 2 Code
1 3851 3851 CHAR

Effective with Version 'K', the field used to
identify whether the claim line is subject to a therapy cap.

DB2 ALIAS : REV_THRPY_CAP_2_CD
SAS ALIAS : RTHRPY2
STANDARD ALIAS : REV_CNTR_THRPY_CAP_IND_2_CD

LENGTH : 1

CODE TABLE : REV_CNTR_THRPY_CAP_IND_CD_TB

268. Revenue Center Therapy CAP Indicator 3 Code
1 3852 3852 CHAR

Effective with Version 'K', the field used to
identify whether the claim line is subject to a therapy cap.

DB2 ALIAS : REV_THRPY_CAP_3_CD
SAS ALIAS : RTHRPY3

STANDARD ALIAS : REV_CNTR_THRPY_CAP_IND_3_CD

LENGTH : 1

CODE TABLE : REV_CNTR_THRPY_CAP_IND_CD_TB

269. Revenue Center Therapy CAP Indicator 4 Code
1 3853 3853 CHAR

Effective with Version 'K', the field used to
identify whether the claim line is subject to a therapy cap.

DB2 ALIAS : REV_THRPY_CAP_4_CD
SAS ALIAS : RTHRPY4
STANDARD ALIAS : REV_CNTR_THRPY_CAP_IND_4_CD

LENGTH : 1

CODE TABLE : REV_CNTR_THRPY_CAP_IND_CD_TB

270. Revenue Center Therapy CAP Indicator 5 Code
1 3854 3854 CHAR

Effective with Version 'K', the field used to
identify whether the claim line is subject to a therapy cap.

DB2 ALIAS : REV_THRPY_CAP_5_CD
SAS ALIAS : RTHRPY5
STANDARD ALIAS : REV_CNTR_THRPY_CAP_IND_5_CD

LENGTH : 1

CODE TABLE : REV_CNTR_THRPY_CAP_IND_CD_TB

271. Revenue Center FPS Model Number
2 3855 3856 CHAR

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

DB2 ALIAS : REV_FPS_MODEL_NUM
SAS ALIAS : RMODEL
STANDARD ALIAS : REV_CNTR_FPS_MODEL_NUM

LENGTH : 2

272. Revenue Center FPS Reason Code
3 3857 3859 CHAR

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

such as denial, reductions or increases in payment.

DB2 ALIAS : REV-FPS-RSN-CD
SAS ALIAS : RFPSRSN
STANDARD ALIAS : REV_CNTR_FPS_RSN_CD

LENGTH : 3

CODE TABLE : CLM_ADJ_RSN_TB

273. Revenue Center FPS Remark Code
5 3860 3864 CHAR

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

DB2 ALIAS : REV_FPS_RMRK_CD
SAS ALIAS : RFPSRMRK
STANDARD ALIAS : REV_CNTR_FPS_RMRK_CD

LENGTH : 5

CODE TABLE : CLM_RMTNC_ADVC_TB

274. Revenue Center FPS MSN 1 Code
5 3865 3869 CHAR

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

DB2 ALIAS : REV_FPS_MSN_1_CD
SAS ALIAS : RFPSMSN1
STANDARD ALIAS : REV_CNTR_FPS_MSN_1_CD

LENGTH : 5

CODE TABLE : CLM_FPS_MSN_CD_TB

275. Revenue Center FPS MSN 2 Code
5 3870 3874 CHAR

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

DB2 ALIAS : REV_FPS_MSN_2_CD
SAS ALIAS : RFPSMSN2
STANDARD ALIAS : REV_CNTR_FPS_MSN_2_CD

LENGTH : 5

CODE TABLE : CLM_FPS_MSN_CD_TB

276. Revenue Center Patient/Initial Visit Add-On Payment Amount
6 3875 3880 PACK

Effective with CR#9 (October 2014 release), this field represents a base rate increase factor of 1.3516 for new patient initial preventive physical examination (IPPE) and annual wellness visit.

NOTE: This field only applies to Outpatient claims.

DB2 ALIAS : REV_ADD_ON_AMT
SAS ALIAS : ADDONAMT
STANDARD ALIAS : REV_CNTR_PTNT_ADD_ON_PMT_AMT

LENGTH : 9.2 SIGNED : Y

277. Revenue Center Prior Authorization Indicator Code
4 3881 3884 CHAR

Effective with CR#9 (October 2014 release), this indicator is assigned by CMS for each prior authorization program to define the applicable line of busines (i.e. Part A, Part B, DME, Home Health and Hospice).

NOTE: This field applies to all institutional claim.

DB2 ALIAS : REV_AUTHRZTN_CD
SAS ALIAS : REVPRIOR
STANDARD ALIAS : REV_CNTR_PRIOR_AUTHRZTN_IND_CD

LENGTH : 4

CODE TABLE : REV_CNTR_PRIOR_AUTHRZTN_TB

278. Revenue Center Unique Tracking Number
14 3885 3898 CHAR

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

NOTE: This field applies to all institutional claims.

DB2 ALIAS : REV_UNIQ_TRKNG_NUM
SAS ALIAS : REVTRKNG
STANDARD ALIAS : REV_CNTR_UNIQ_TRKNG_NUM

LENGTH : 14

DERIVATIONS :
Position 1 - 2 = MAC Identifier (e.g. RR for Railroad, OF = Jurisdiction F, 05 = Jurisdiction 5, etc.)

Position 3 = Line of Business (e.g. A = Part A,
B = Part B, D = DME & H = Home Health
Hospice)
Position 4- 14 = a unique sequence number assigned by
the Shared System

279. Revenue Center Representative Payee (RP) Indicator Code
1 3899 3899 CHAR

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

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

DB2 ALIAS : REV_CNTR_RP_IND_CD
SAS ALIAS : RCRPIND
STANDARD ALIAS : REV_CNTR_RP_IND_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : RP_IND_TB

280. Revenue Center Transitional Drug Add-On Payment Amount
6 3900 3905 PACK

Effective with CR#13 (January 2018 release), the amount for the Transitional Drug Add-On Payment Adjustment (TDAPA) for ESRD claims (72X) with injectable, intraveneous, and oral calcimimetics when reported with an AX modifier. These services qualify for an add-on payment from the ESRD Pricer.

NOTE: This field only applies to Outpatient claims.

DB2 ALIAS : TRNSTNL_DRUG_AMT
SAS ALIAS : TDAPAAMT
STANDARD ALIAS : REV_CNTR_TRNSTNL_DRUG_AMT

LENGTH : 7.4 SIGNED : Y

SOURCE : CWF

EDIT RULES :
$$$$$$$cccc

281. Revenue Center Model Reimbursement Amount
6 3906 3911 PACK

Effective with CR#16, this line-level field will be used to identify the "Net Reimbursement Amount" of what

Medicare would have paid for the Global Budget Service reflected at the line level, from a hospital participating in the particular model.

Note: For the participating hospitals in the PA model all inpatient and outpatient services (Facility/Technical Services) are considered part of the Model/Global Budget Services. Basically, all of the services for a participating hospital would be global except for CAH Method II (85X) claim lines with revenue center codes 096X, 097X and 098X. The CAH Method II professional services (rev codes 096X, 097X and 098X) process as they do today, they have nothing to do with the model.

DB2 ALIAS : UNDEFINED
SAS ALIAS : RCMODELA
STANDARD ALIAS : REV_CNTR_MODEL_REIMBRSMT_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

282. Revenue Center Ordering Physician NPI Number
10 3912 3921 CHAR

Effective with Version L (January 2021 release), this line level field will be used to identify the ordering physicians National Provider Identifier (NPI).

NOTE: This data element will be reflected on all institutional claim types but only impacts Outpatient, Home Health and Hospice claims. No data will be sent in on Inpatient/ SNF claims. The field is reflected in the revenue center trailer on all claim types for consistency.

DB2 ALIAS : UNDEFINED
SAS ALIAS : ORDRGNPI
STANDARD ALIAS : REV_CNTR_ORDRG_PHYSN_NPI_NUM

LENGTH : 10

SOURCE : CWF

283. Revenue Center Voluntary Service Indicator Code
1 3922 3922 CHAR

Effective with Version L (January 2021 release), this line level field will be used to identify if the service (Procedure Code) was voluntary or required.

NOTE:

Data for this field will not start coming in until the July 2021
release (July 6, 2021).

Valid Values:
V = A Voluntary procedure code
Blank = A Required procedure code

DB2 ALIAS : UNDEFINED
SAS ALIAS : RCVLNTRY
STANDARD ALIAS : REV_CNTR_VLNTRY_SRVC_IND_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV_CNTR_VLNTRY_SRVC_IND_TB

284. Revenue Center Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) Amount

6 3923 3928 PACK

Effective with CR#17, this line level field will be used to
represent the ESRD PPS payment adjustment for new and inno-
vative equipment and supplies and is included in the full
ESRD PPS payment.

NOTE: This field will only come in on Outpatient claims.
We are adding it to all institutional claim types to keep
the revenue center trailer consistent.

DB2 ALIAS : UNDEFINED
SAS ALIAS : RCTPNIES
STANDARD ALIAS : REV_CNTR_TPNIES_AMT

LENGTH : 7.4 SIGNED : Y

EDIT RULES :
$$$$$$$CCCC

285.

326 3929 4254 CHAR

DB2 ALIAS : H_FILLER_9

LENGTH : 326

286. End of Record Code

3 30919 30921 CHAR

Effective with Version 'I', the code used
to identify the end of a record/segment or
the end of the claim.

DB2 ALIAS : END_REC_CD

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

LENGTH : 3

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

SOURCE : NCH

CODE TABLE : END_REC_TB

QUERY: RIFQQ11, RIFQQ21 ON DB2T
**********END OF MAIN REPORT FOR RECORD:
FI_HHA_CLM_REC**********

TABLE OF CODES APPENDIX FOR RECORD: FI_HHA_CLM_REC, STATUS: PROD, VERSION: 21104
PRINTED: 04/26/2021, USER: F43D, DATA SOURCE: CA REPOSITORY ON DB2T

BENE_CWF_LOC_TB Beneficiary Common Working File Location Table

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

BENE_IDENT_TB Beneficiary Identification Code (BIC) Table

Social Security Administration:

A = Primary claimant
B = Aged wife, age 62 or over (1st claimant)
B1 = Aged husband, age 62 or over (1st claimant)
B2 = Young wife, with a child in her care (1st claimant)
B3 = Aged wife (2nd claimant)
B4 = Aged husband (2nd claimant)
B5 = Young wife (2nd claimant)

B6 = Divorced wife, age 62 or over (1st claimant)
B7 = Young wife (3rd claimant)
B8 = Aged wife (3rd claimant)
B9 = Divorced wife (2nd claimant)
BA = Aged wife (4th claimant)
BD = Aged wife (5th claimant)
BG = Aged husband (3rd claimant)
BH = Aged husband (4th claimant)
BJ = Aged husband (5th claimant)
BK = Young wife (4th claimant)
BL = Young wife (5th claimant)
BN = Divorced wife (3rd claimant)
BP = Divorced wife (4th claimant)
BQ = Divorced wife (5th claimant)
BR = Divorced husband (1st claimant)
BT = Divorced husband (2nd claimant)
BW = Young husband (2nd claimant)
BY = Young husband (1st claimant)
C1-C9,CA-CZ = Child (includes minor, student or disabled child)
D = Aged widow, 60 or over (1st claimant)
D1 = Aged widower, age 60 or over (1st claimant)
D2 = Aged widow (2nd claimant)
D3 = Aged widower (2nd claimant)
D4 = Widow (remarried after attainment of age 60) (1st claimant)
D5 = Widower (remarried after attainment of age 60) (1st claimant)
D6 = Surviving divorced wife, age 60 or over (1st claimant)
D7 = Surviving divorced wife (2nd claimant)
D8 = Aged widow (3rd claimant)
D9 = Remarried widow (2nd claimant)
DA = Remarried widow (3rd claimant)
DD = Aged widow (4th claimant)
DG = Aged widow (5th claimant)
DH = Aged widower (3rd claimant)
DJ = Aged widower (4th claimant)
DK = Aged widower (5th claimant)
DL = Remarried widow (4th claimant)
DM = Surviving divorced husband (2nd claimant)
DN = Remarried widow (5th claimant)
DP = Remarried widower (2nd claimant)
DQ = Remarried widower (3rd claimant)
DR = Remarried widower (4th claimant)
DS = Surviving divorced husband (3rd claimant)
DT = Remarried widower (5th claimant)
DV = Surviving divorced wife (3rd claimant)
DW = Surviving divorced wife (4th claimant)
DX = Surviving divorced husband (4th

claimant)
DY = Surviving divorced wife (5th claimant)
DZ = Surviving divorced husband (5th claimant)
E = Mother (widow) (1st claimant)
E1 = Surviving divorced mother (1st claimant)
E2 = Mother (widow) (2nd claimant)
E3 = Surviving divorced mother (2nd claimant)
E4 = Father (widower) (1st claimant)
E5 = Surviving divorced father (widower) (1st claimant)
E6 = Father (widower) (2nd claimant)
E7 = Mother (widow) (3rd claimant)
E8 = Mother (widow) (4th claimant)
E9 = Surviving divorced father (widower) (2nd claimant)
EA = Mother (widow) (5th claimant)
EB = Surviving divorced mother (3rd claimant)
EC = Surviving divorced mother (4th claimant)
ED = Surviving divorced mother (5th claimant
EF = Father (widower) (3rd claimant)
EG = Father (widower) (4th claimant)
EH = Father (widower) (5th claimant)
EJ = Surviving divorced father (3rd claimant)
EK = Surviving divorced father (4th claimant)
EM = Surviving divorced father (5th claimant)
F1 = Father
F2 = Mother
F3 = Stepfather
F4 = Stepmother
F5 = Adopting father
F6 = Adopting mother
F7 = Second alleged father
F8 = Second alleged mother
J1 = Primary prouty entitled to HIB (less than 3 Q.C.) (general fund)
J2 = Primary prouty entitled to HIB (over 2 Q.C.) (RSI trust fund)
J3 = Primary prouty not entitled to HIB (less than 3 Q.C.) (general fund)
J4 = Primary prouty not entitled to HIB (over 2 Q.C.) (RSI trust fund)
K1 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)
K2 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)

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

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

Railroad Retirement Board:

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

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

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

BENE_MDCR_STUS_TB CWF Beneficiary Medicare Status Table

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

BENE_PRMRY_PYR_TB Beneficiary Primary Payer Table

A = Working aged bene/spouse with employer
group health plan (EGHP)
B = End stage renal disease (ESRD) beneficiary
in the 18 month coordination period with
an employer group health plan
C = Conditional payment by Medicare; future
reimbursement expected
D = Automobile no-fault (eff. 4/97; Prior
to 3/94, also included any liability
insurance)
E = Workers' compensation
F = Public Health Service or other federal
agency (other than Dept. of Veterans
Affairs)
G = Working disabled bene (under age 65

with LGHP)
H = Black Lung
I = Dept. of Veterans Affairs
J = Any liability insurance
(eff. 3/94 - 3/97)
L = Any liability insurance (eff. 4/97)
(eff. 12/90 for carrier claims and 10/93
for FI claims; obsoleted for all claim
types 7/1/96)

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

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

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

Prior to 12/90

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

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

BENE_RACE_TB Beneficiary Race Table

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

BENE_SEX_IDENT_TB Beneficiary Sex Identification Table

1 = Male

2 = Female
0 = Unknown

CLM_ADJ_RSN_TB Claim Adjustment Reason Code

1 = Deductible Amount
Start: 01/01/1995
2 = Coinsurance Amount
Start: 01/01/1995
3 = Co-payment Amount
Start: 01/01/1995
4 = The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
5 = The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
6 = The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
7 = The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
8 = The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
9 = The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
10 = The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF),

if present.
Start: 01/01/1995

11 = The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
Last Modified: 09/20/2009

12 = The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

13 = The date of death precedes the date of service.
Start: 01/01/1995

14 = The date of birth follows the date of service.
Start: 01/01/1995

15 = The authorization number is missing, invalid, or does not apply to the billed services or provider.
Start: 01/01/1995

16 = Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Start: 01/01/1995

17 = Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
Start: 01/01/1995
Stop: 07/01/2009

18 = Duplicate claim/service. This change effective 1/1/2013: Exact duplicate claim/ service (Use only with Group Code OA)
Start: 01/01/1995

19 = This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
Start: 01/01/1995

20 = This injury/illness is covered by the liability carrier.
Start: 01/01/1995

21 = This injury/illness is the liability of the no-fault carrier.
Start: 01/01/1995

22 = This care may be covered by another payer

per coordination of benefits.
Start: 01/01/1995

23 = The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
Start: 01/01/1995

24 = Charges are covered under a capitation agreement/managed care plan.
Start: 01/01/1995

25 = Payment denied. Your Stop loss deductible has not been met.
Start: 01/01/1995
Stop: 04/01/2008

26 = Expenses incurred prior to coverage.
Start: 01/01/1995

27 = Expenses incurred after coverage terminated
Start: 01/01/1995

28 = Coverage not in effect at the time the service was provided.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Redundant to codes 26&27.

29 = The time limit for filing has expired.
Start: 01/01/1995

30 = Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
Start: 01/01/1995
Stop: 02/01/2006

31 = Patient cannot be identified as our insured
Start: 01/01/1995

32 = Our records indicate that this dependent is not an eligible dependent as defined.
Start: 01/01/1995

33 = Insured has no dependent coverage.
Start: 01/01/1995

34 = Insured has no coverage for newborns.
Start: 01/01/1995

35 = Lifetime benefit maximum has been reached.
Start: 01/01/1995

36 = Balance does not exceed co-payment amount.
Start: 01/01/1995
Stop: 10/16/2003

37 = Balance does not exceed deductible.
Start: 01/01/1995
Stop: 10/16/2003

38 = Services not provided or authorized by designated (network/primary care) providers.
Start: 01/01/1995
Stop: 01/01/2013

39 = Services denied at the time authorization/ pre-certification was requested.
Start: 01/01/1995

40 = Charges do not meet qualifications for

emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

41 = Discount agreed to in Preferred Provider contract.
Start: 01/01/1995
Stop: 10/16/2003

42 = Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)
Start: 01/01/1995
Stop: 06/01/2007

43 = Gramm-Rudman reduction.
Start: 01/01/1995
Stop: 07/01/2006

44 = Prompt-pay discount.
Start: 01/01/1995

45 = Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)
Start: 01/01/1995

46 = This (these) service(s) is (are) not covered.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 96.

47 = This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
Start: 01/01/1995
Stop: 02/01/2006

48 = This (these) procedure(s) is (are) not covered.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 96.

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if

present.
Start: 01/01/1995

51 = These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe /order/perform the service billed.
Start: 01/01/1995
Stop: 02/01/2006

53 = Services by an immediate relative or a member of the same household are not covered.
Start: 01/01/1995

54 = Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

55 = Procedure/treatment is deemed experimental/ investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

56 = Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

57 = Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
Start: 01/01/1995
Stop: 06/30/2007
Notes: Split into codes 150, 151, 152, 153 and 154.

58 = Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

59 = Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent

anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

60 = Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.
Start: 01/01/1995

61 = Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

62 = Payment denied/reduced for absence of, or exceeded, pre-certification/ authorization.
Start: 01/01/1995
Stop: 04/01/2007

63 = Correction to a prior claim.
Start: 01/01/1995
Stop: 10/16/2003

64 = Denial reversed per Medical Review.
Start: 01/01/1995
Stop: 10/16/2003

65 = Procedure code was incorrect. This payment reflects the correct code.
Start: 01/01/1995
Stop: 10/16/2003

66 = Blood Deductible.
Start: 01/01/1995

67 = Lifetime reserve days. (Handled in QTY, QTY01=LA)
Start: 01/01/1995
Stop: 10/16/2003

68 = DRG weight. (Handled in CLP12)
Start: 01/01/1995
Stop: 10/16/2003

69 = Day outlier amount.
Start: 01/01/1995

70 = Cost outlier - Adjustment to compensate for additional costs.
Start: 01/01/1995

71 = Primary Payer amount.
Start: 01/01/1995
Stop: 06/30/2000
Notes: Use code 23.

72 = Coinsurance day. (Handled in QTY, QTY01=CD)
Start: 01/01/1995
Stop: 10/16/2003

73 = Administrative days.
Start: 01/01/1995
Stop: 10/16/2003

74 = Indirect Medical Education Adjustment.
Start: 01/01/1995
75 = Direct Medical Education Adjustment.
Start: 01/01/1995
76 = Disproportionate Share Adjustment.
Start: 01/01/1995
77 = Covered days. (Handled in QTY, QTY01=CA)
Start: 01/01/1995
Stop: 10/16/2003
78 = Non-Covered days/Room charge adjustment.
Start: 01/01/1995
79 = Cost Report days. (Handled in MIA15)
Start: 01/01/1995
Stop: 10/16/2003
80 = Outlier days. (Handled in QTY, QTY01=OU)
Start: 01/01/1995
Stop: 10/16/2003
81 = Discharges.
Start: 01/01/1995
Stop: 10/16/2003
82 = PIP days.
Start: 01/01/1995
Stop: 10/16/2003
83 = Total visits.
Start: 01/01/1995
Stop: 10/16/2003
84 = Capital Adjustment. (Handled in MIA)
Start: 01/01/1995
Stop: 10/16/2003
85 = Patient Interest Adjustment (Use Only Group code PR)
Start: 01/01/1995
Notes: Only use when the payment of interest is the responsibility of the patient.
86 = Statutory Adjustment.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Duplicative of code 45.
87 = Transfer amount.
Start: 01/01/1995
Stop: 01/01/2012
88 = Adjustment amount represents collection against receivable created in prior overpayment.
Start: 01/01/1995
Stop: 06/30/2007
89 = Professional fees removed from charges.
Start: 01/01/1995
90 = Ingredient cost adjustment. Note: To be used for pharmaceuticals only.
Start: 01/01/1995
91 = Dispensing fee adjustment.
Start: 01/01/1995

92 = Claim Paid in full.
Start: 01/01/1995
Stop: 10/16/2003
93 = No Claim level Adjustments.
Start: 01/01/1995
Stop: 10/16/2003
Notes: As of 004010, CAS at the claim level is optional.
94 = Processed in Excess of charges.
Start: 01/01/1995
95 = Plan procedures not followed.
Start: 01/01/1995
96 = Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
97 = The benefit for this service is included in the payment/allowance for another service/ procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
98 = The hospital must file the Medicare claim for this inpatient non-physician service.
Start: 01/01/1995
Stop: 10/16/2003
99 = Medicare Secondary Payer Adjustment Amount.
Start: 01/01/1995
Stop: 10/16/2003
100 = Payment made to patient/insured/responsible party/employer.
Start: 01/01/1995
101 = Predetermination: anticipated payment upon completion of services or claim adjudication.
Start: 01/01/1995
102 = Major Medical Adjustment.
Start: 01/01/1995
103 = Provider promotional discount (e.g., Senior citizen discount).
Start: 01/01/1995
104 = Managed care withholding.
Start: 01/01/1995
105 = Tax withholding.
Start: 01/01/1995
106 = Patient payment option/election not in effect.
Start: 01/01/1995

107 = The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
108 = Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
109 = Claim/service not covered by this payer/ contractor. You must send the claim/service to the correct payer/contractor.
Start: 01/01/1995
110 = Billing date predates service date.
Start: 01/01/1995
111 = Not covered unless the provider accepts assignment.
Start: 01/01/1995
112 = Service not furnished directly to the patient and/or not documented.
Start: 01/01/1995
113 = Payment denied because service/procedure was provided outside the United States or as a result of war.
Start: 01/01/1995
Stop: 06/30/2007
Notes: Use Codes 157, 158 or 159.
114 = Procedure/product not approved by the Food and Drug Administration.
Start: 01/01/1995
115 = Procedure postponed, canceled, or delayed.
Start: 01/01/1995
116 = The advance indemnification notice signed by the patient did not comply with requirements.
Start: 01/01/1995
117 = Transportation is only covered to the closest facility that can provide the necessary care.
Start: 01/01/1995
118 = ESRD network support adjustment.
Start: 01/01/1995
119 = Benefit maximum for this time period or occurrence has been reached.
Start: 01/01/1995
120 = Patient is covered by a managed care plan.
Start: 01/01/1995
Stop: 06/30/2007
Notes: Use code 24.
121 = Indemnification adjustment - compensation for outstanding member responsibility.
Start: 01/01/1995

122 = Psychiatric reduction.
Start: 01/01/1995
123 = Payer refund due to overpayment.
Start: 01/01/1995
Stop: 06/30/2007
Notes: Refer to implementation guide for proper handling of reversals.
124 = Payer refund amount - not our patient.
Start: 01/01/1995
Stop: 06/30/2007
Notes: Refer to implementation guide for proper handling of reversals.
125 = Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Start: 01/01/1995
126 = Deductible -- Major Medical
Start: 02/28/1997
Stop: 04/01/2008
Notes: Use Group Code PR and code 1.
127 = Coinsurance -- Major Medical
Start: 02/28/1997
Stop: 04/01/2008
Notes: Use Group Code PR and code 2.
128 = Newborn's services are covered in the mother's Allowance.
Start: 02/28/1997
129 = Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Start: 02/28/1997
130 = Claim submission fee.
Start: 02/28/1997
131 = Claim specific negotiated discount.
Start: 02/28/1997
132 = Prearranged demonstration project adjustment.
Start: 02/28/1997
133 = The disposition of the claim/service is pending further review. This change effective 1/1/2013: The disposition of the claim/service is pending further review. (Use only with Group Code OA)
Start: 02/28/1997
134 = Technical fees removed from charges.
Start: 10/31/1998
135 = Interim bills cannot be processed.
Start: 10/31/1998
136 = Failure to follow prior payer's coverage rules. (Use Group Code OA). This change

effective 7/1/2013: Failure to follow prior payer's coverage rules. (Use only with Group Code OA)
Start: 10/31/1998
137 = Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
Start: 02/28/1999
138 = Appeal procedures not followed or time limits not met.
Start: 06/30/1999
139 = Contracted funding agreement - Subscriber is employed by the provider of services.
Start: 06/30/1999
140 = Patient/Insured health identification number and name do not match.
Start: 06/30/1999
141 = Claim spans eligible and ineligible periods of coverage.
Start: 06/30/1999
Stop: 07/01/2012
142 = Monthly Medicaid patient liability amount.
Start: 06/30/2000
143 = Portion of payment deferred.
Start: 02/28/2001
144 = Incentive adjustment, e.g. preferred product/service.
Start: 06/30/2001
145 = Premium payment withholding
Start: 06/30/2002
Stop: 04/01/2008
Notes: Use Group Code CO and code 45.
146 = Diagnosis was invalid for the date(s) of service reported.
Start: 06/30/2002
147 = Provider contracted/negotiated rate expired or not on file.
Start: 06/30/2002
148 = Information from another provider was not provided or was insufficient/incomplete.
At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Start: 06/30/2002
149 = Lifetime benefit maximum has been reached for this service/benefit category.
Start: 10/31/2002
150 = Payer deems the information submitted does not support this level of service.
Start: 10/31/2002
151 = Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
Start: 10/31/2002

152 = Payer deems the information submitted does not support this length of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 10/31/2002
153 = Payer deems the information submitted does not support this dosage.
Start: 10/31/2002
154 = Payer deems the information submitted does not support this day's supply.
Start: 10/31/2002
155 = Patient refused the service/procedure.
Start: 06/30/2003
156 = Flexible spending account payments. Note: Use code 187.
Start: 09/30/2003
Stop: 10/01/2009
157 = Service/procedure was provided as a result of an act of war.
Start: 09/30/2003
158 = Service/procedure was provided outside of the United States.
Start: 09/30/2003
159 = Service/procedure was provided as a result of terrorism.
Start: 09/30/2003
160 = Injury/illness was the result of an activity that is a benefit exclusion.
Start: 09/30/2003
161 = Provider performance bonus
Start: 02/29/2004
162 = State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.
Start: 02/29/2004
163 = Attachment referenced on the claim was not received.
Start: 06/30/2004
164 = Attachment referenced on the claim was not received in a timely fashion.
Start: 06/30/2004
165 = Referral absent or exceeded.
Start: 10/31/2004
166 = These services were submitted after this payers responsibility for processing claims under this plan ended.
Start: 02/28/2005
167 = This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Payment Information REF), if present.
Start: 06/30/2005
168 = Service(s) have been considered under the

patient's medical plan. Benefits are not available under this dental plan.
Start: 06/30/2005
169 = Alternate benefit has been provided.
Start: 06/30/2005
170 = Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 06/30/2005
171 = Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 06/30/2005
172 = Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 06/30/2005
173 = Service was not prescribed by a physician. This change effective 7/1/2013: Service/ equipment was not prescribed by a physician.
Start: 06/30/2005
174 = Service was not prescribed prior to delivery.
Start: 06/30/2005
175 = Prescription is incomplete.
Start: 06/30/2005
176 = Prescription is not current.
Start: 06/30/2005
177 = Patient has not met the required eligibility requirements.
Start: 06/30/2005
178 = Patient has not met the required spend down requirements.
Start: 06/30/2005
179 = Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) , if present.
Start: 06/30/2005
180 = Patient has not met the required residency requirements.
Start: 06/30/2005
181 = Procedure code was invalid on the date of service.
Start: 06/30/2005

182 = Procedure modifier was invalid on the date of service.
Start: 06/30/2005
183 = The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 06/30/2005
184 = The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 06/30/2005
185 = The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 06/30/2005
Last Modified: 09/20/2009
186 = Level of care change adjustment.
Start: 06/30/2005
187 = Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)
Start: 06/30/2005
188 = This product/procedure is only covered when used according to FDA recommendations.
Start: 06/30/2005
189 = 'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service
Start: 06/30/2005
190 = Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.
Start: 10/31/2005
191 = Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service

Payment information REF)
Start: 10/31/2005
192 = Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.
Start: 10/31/2005
193 = Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
Start: 02/28/2006
194 = Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.
Start: 02/28/2006
195 = Refund issued to an erroneous priority payer for this claim/service.
Start: 02/28/2006
196 = Claim/service denied based on prior payer's coverage determination.
Start: 06/30/2006
Stop: 02/01/2007
Notes: Use code 136.
197 = Precertification/authorization/notification absent.
Start: 10/31/2006
198 = Precertification/authorization exceeded.
Start: 10/31/2006
199 = Revenue code and Procedure code do not match.
Start: 10/31/2006
200 = Expenses incurred during lapse in coverage
Start: 10/31/2006
201 = Workers' Compensation case settled. Patient is responsible for amount of this claim/ service through WC 'Medicare set aside arrangement' or other agreement. (Use group code PR). This change effective 7/1/2013: Workers Compensation case settled. Patient is responsible for amount of this claim/ service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR)
Start: 10/31/2006
202 = Non-covered personal comfort or convenience services.
Start: 02/28/2007
203 = Discontinued or reduced service.
Start: 02/28/2007

204 = This service/equipment/drug is not covered under the patient's current benefit plan
Start: 02/28/2007
205 = Pharmacy discount card processing fee
Start: 07/09/2007
206 = National Provider Identifier - missing.
Start: 07/09/2007
207 = National Provider identifier - Invalid format
Start: 07/09/2007
208 = National Provider Identifier - Not matched.
Start: 07/09/2007
209 = Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA) This change effective 7/1/2013: Per regulatory or other agreement. The provider. cannot collect this amount from the patient However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)
Start: 07/09/2007
210 = Payment adjusted because pre-certification/ authorization not received in a timely fashion
Start: 07/09/2007
211 = National Drug Codes (NDC) not eligible for rebate, are not covered.
Start: 07/09/2007
212 = Administrative surcharges are not covered
Start: 11/05/2007
213 = Non-compliance with the physician self referral prohibition legislation or payer policy.
Start: 01/27/2008
214 = Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only
Start: 01/27/2008
215 = Based on subrogation of a third party settlement
Start: 01/27/2008

216 = Based on the findings of a review organization
Start: 01/27/2008
217 = Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only)
Start: 01/27/2008
218 = Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) To be used for Workers' Compensation only
Start: 01/27/2008
219 = Based on extent of injury. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).
Start: 01/27/2008
220 = The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Property and Casualty only)
Start: 01/27/2008
221 = Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). This change

effective 7/1/2013: Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property & Casualty only)
Start: 01/27/2008

222 = Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 06/01/2008

223 = Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
Start: 06/01/2008

224 = Patient identification compromised by identity theft. Identity verification required for processing this and future claims.
Start: 06/01/2008

225 = Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)
Start: 06/01/2008

226 = Information requested from the Billing/ Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 7/1/2013: Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/ incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Start: 09/21/2008

227 = Information requested from the patient/ insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be

comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Start: 09/21/2008

228 = Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication
Start: 09/21/2008

229 = Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR. This change effective 7/1/2013: Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)
Start: 01/25/2009

230 = No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty.
Start: 01/25/2009

231 = Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 07/01/2009

232 = Institutional Transfer Amount. Note - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.
Start: 11/01/2009

233 = Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
Start: 01/24/2010

234 = This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Start: 01/24/2010

235 = Sales Tax
Start: 06/06/2010

236 = This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative. This change effective 7/1/2013: This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.
Start: 01/30/2011

237 = Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Start: 06/05/2011

238 = Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR). This change effective 7/1/2013: Claim spans eligible and ineligible periods of coverage , this is the reduction for the ineligible period. (Use only with Group Code PR)
Start: 03/01/2012

239 = Claim spans eligible and ineligible periods of coverage. Rebill separate claims.
Start: 03/01/2012

240 = The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 06/03/2012

241 = Low Income Subsidy (LIS) Co-payment Amount
Start: 06/03/2012

242 = Services not provided by network/primary care providers.
Start: 06/03/2012

243 = Services not authorized by network/primary care providers.
Start: 06/03/2012

244 = Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.
Start: 09/30/2012

245 = Provider performance program withhold.
Start: 09/30/2012

246 = This non-payable code is for required reporting only.

Start: 09/30/2012
247 = Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.
Start: 09/30/2012
Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).
248 = Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.
Start: 09/30/2012
Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).
249 = This claim has been identified as a readmission. (Use only with Group Code CO)
Start: 09/30/2012
250 = The attachment content received is inconsistent with the expected content.
Start: 09/30/2012
251 = The attachment content received did not contain the content required to process this claim or service.
Start: 09/30/2012
252 = An attachment is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
Start: 09/30/2012
A0 = Patient refund amount.
Start: 01/01/1995
A1 = Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Start: 01/01/1995
A2 = Contractual adjustment.
Start: 01/01/1995
Stop: 01/01/2008
Notes: Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code.
A3 = Medicare Secondary Payer liability met.
Start: 01/01/1995
Stop: 10/16/2003
A4 = Medicare Claim PPS Capital Day Outlier Amount.
Start: 01/01/1995
Stop: 04/01/2008
A5 = Medicare Claim PPS Capital Cost Outlier

Amount.
Start: 01/01/1995

A6 = Prior hospitalization or 30 day transfer requirement not met.
Start: 01/01/1995

A7 = Presumptive Payment Adjustment
Start: 01/01/1995

A8 = Ungroupable DRG.
Start: 01/01/1995

B1 = Non-covered visits.
Start: 01/01/1995

B2 = Covered visits.
Start: 01/01/1995
Stop: 10/16/2003

B3 = Covered charges.
Start: 01/01/1995
Stop: 10/16/2003

B4 = Late filing penalty.
Start: 01/01/1995

B5 = Coverage/program guidelines were not met or were exceeded.
Start: 01/01/1995

B6 = This payment is adjusted when performed/ billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.
Start: 01/01/1995
Stop: 02/01/2006

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

B8 = Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995

B9 = Patient is enrolled in a Hospice.
Start: 01/01/1995

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
Start: 01/01/1995

B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/ processor.
Start: 01/01/1995

B12 = Services not documented in patients' medical records.
Start: 01/01/1995
B13 = Previously paid. Payment for this claim/ service may have been provided in a previous payment.
Start: 01/01/1995
B14 = Only one visit or consultation per physician per day is covered.
Start: 01/01/1995
B15 = This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/ procedure has not been received/adjudicated . Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Start: 01/01/1995
B16 = 'New Patient' qualifications were not met.
Start: 01/01/1995
B17 = Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
Start: 01/01/1995
Stop: 02/01/2006
B18 = This procedure code and modifier were invalid on the date of service.
Start: 01/01/1995
Stop: 03/01/2009
B19 = Claim/service adjusted because of the finding of a Review Organization.
Start: 01/01/1995
Stop: 10/16/2003
B20 = Procedure/service was partially or fully furnished by another provider.
Start: 01/01/1995
B21 = The charges were reduced because the service/care was partially furnished by another physician.
Start: 01/01/1995
Stop: 10/16/2003
B22 = This payment is adjusted based on the diagnosis.
Start: 01/01/1995
B23 = Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.
Start: 01/01/1995
D1 = Claim/service denied. Level of subluxation is missing or inadequate.
Start: 01/01/1995
Stop: 10/16/2003

Notes: Use code 16 and remark codes if necessary.

D2 = Claim lacks the name, strength, or dosage of the drug furnished.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if necessary.

D3 = Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if necessary.

D4 = Claim/service does not indicate the period of time for which this will be needed.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if necessary.

D5 = Claim/service denied. Claim lacks individual lab codes included in the test.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if necessary.

D6 = Claim/service denied. Claim did not include patient's medical record for the service.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if necessary.

D7 = Claim/service denied. Claim lacks date of patient's most recent physician visit.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if necessary.

D8 = Claim/service denied. Claim lacks indicator that 'x-ray is available for review.'
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if necessary.

D9 = Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 16 and remark codes if

necessary.
D10 = Claim/service denied. Completed physician financial relationship form not on file.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 17.
D11 = Claim lacks completed pacemaker registration form.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 17.
D12 = Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 17.
D13 = Claim/service denied. Performed by a facility/supplier in which the ordering/ referring physician has a financial interest.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 17.
D14 = Claim lacks indication that plan of treatment is on file.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 17.
D15 = Claim lacks indication that service was supervised or evaluated by a physician.
Start: 01/01/1995
Stop: 10/16/2003
Notes: Use code 17.
D16 = Claim lacks prior payer payment information
Start: 01/01/1995
Stop: 06/30/2007
Notes: Use code 16 with appropriate claim payment remark code âN4ã.
D17 = Claim/Service has invalid non-covered days.
Start: 01/01/1995
Stop: 06/30/2007
Notes: Use code 16 with appropriate claim payment remark code.
D18 = Claim/Service has missing diagnosis information.
Start: 01/01/1995
Stop: 06/30/2007
Notes: Use code 16 with appropriate claim payment remark code.
D19 = Claim/Service lacks Physician/Operative or other supporting documentation
Start: 01/01/1995

Stop: 06/30/2007
Notes: Use code 16 with appropriate claim payment remark code.

D20 = Claim/Service missing service/product information.
Start: 01/01/1995
Stop: 06/30/2007
Notes: Use code 16 with appropriate claim payment remark code.

D21 = This (these) diagnosis(es) is (are) missing or are invalid
Start: 01/01/1995
Stop: 06/30/2007

D22 = Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for time frame only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code
Start: 01/27/2008
Stop: 01/01/2009

D23 = This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
Start: 11/01/2009
Stop: 01/01/2012

W1 = Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).
Start: 02/29/2000

W2 = Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider

should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.
Start: 10/17/2010

W3 = The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only.
Start: 09/30/2012

W4 = Workers' Compensation Medical Treatment Guideline Adjustment.
Start: 09/30/2012

Y1 = Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only.
Start: 09/30/2012

Y2 = Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only.
Start: 09/30/2012

Y3 = Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment.

Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only.
Start: 09/30/2012

CLM_BENE_ID_TYPE_TB Claim Beneficiary Identifier Type Table

M = MBI
H = HICN

CLM_BILL_TYPE_TB Claim Bill Type Table

11 = Hospital-inpatient (Part A)
12 = Hospital-inpatient or home health visits (Part B only)
13 = Hospital-outpatient (HHA-A also) (under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00)
14 = Hospital-Laboratory Services Provided to Non-patients
15 = Hospital-intermediate care - level I (obsolete)
16 = Hospital-intermediate care - level II (obsolete)
17 = Hospital-intermediate care - level III (obsolete)
18 = Hospital-swing beds
19 = Reserved for national assignment
21 = SNF-inpatient (including Part A)
22 = SNF-inpatient or home health visits (Part B only)
23 = SNF-outpatient (HHA-A also)
24 = SNF-other (Part B) - (obsolete)
25 = SNF-intermediate care - level I (obsolete)
26 = SNF-intermediate care - level II (obsolete)
27 = SNF-intermediate care - level III (obsolete)
28 = SNF-swing beds
29 = SNF-reserved for national assignment
31 = HHA-inpatient (including Part A) (obsolete)
32 = HHA-Home Health Services under a Plan of Treatment (name revised 10/2013)
33 = HHA-outpatient (plan of treatment under Part A, including DME under Part A) (term. 10/2013)
34 = HHA-other (for medical and surgical services not under a plan of treatment) (obsolete)
35 = HHA-intermediate care - level I (obsolete)
36 = HHA-intermediate care - level II (obsolete)

37 = HHA-intermediate care - level III (obsolete)
38 = HHA-swing beds (obsolete)
39 = HHA-reserved for national assignment
41 = Religious Nonmedical Health Care Institution (RNHCI)
hospital-inpatient (including Part A) (all references
to Christian Science (CS) is obsolete eff. 8/00 and
replaced with RNHCI)
42 = RNHCI hospital-inpatient or home health visits (Part B only)
43 = RNHCI hospital-outpatient (HHA-A also)
44 = RNHCI hospital-other (Part B) - (obsolete)
45 = RNHCI hospital-intermediate care - level I (obsolete)
46 = RNHCI hospital-intermediate care - level II (obsolete)
47 = RNHCI hospital-intermediate care - level III (obsolete)
48 = RNHCI hospital-swing beds (obsolete)
49 = RNHCI hospital-reserved for national assignment
51 = CS extended care-inpatient (including Part A) OBSOLETE
eff. 7/00 - implementation of Religious Nonmedical
Health Care Institutions (RNHCI)
52 = RNHCI extended care-inpatient or home health visits
(Part B only) (eff. 7/00) - OBSOLETE; prior to 7/00
Christian Science (CS)
53 = RNHCI extended care-outpatient (HHA-A also) (eff. 7/00);
OBSOLETE - prior to 7/00 referenced CS
54 = RNHCI extended care-other (Part B)(eff. 7/00)- OBSOLETE;
prior to 7/00 referenced CS
55 = RNHCI extended care-intermediate care - level I (eff. 7/00)
OBSOLETE - prior to 7/00 referenced CS
56 = RNHCI extended care-intermediate care - level II (eff. 7/00)
OBSOLETE - prior to 7/00 referenced CS
57 = RNHCI extended care-intermediate care - level III (eff. 7/00)
OBSOLETE - prior to 7/00 referenced CS
58 = RNHCI extended care-swing beds (eff. 7/00)- OBSOLETE
prior to 7/00 referenced CS
59 = RNHCI extended care-reserved for national assignment
(eff. 7/00) - OBSOLETE; prior to 7/00 referenced CS
61 = Intermediate care-inpatient (including Part A)
OBSOLETE
62 = Intermediate care-inpatient or home health visits (Part B only)
OBSOLETE
63 = Intermediate care-outpatient (HHA-A also) - OBSOLETE
64 = Intermediate care-other (Part B)- OBSOLETE
65 = Intermediate care-intermediate care - level I
66 = Intermediate care-intermediate care - level II
67 = Intermediate care-intermediate care - level III - OBSOLETE
68 = Intermediate care-swing beds - OBSOLETE
69 = Reserved for national assignment
71 = Clinic-rural health
72 = Clinic-hospital based or independent renal dialysis facility
73 = Clinic-Freestanding
74 = Clinic-ORF only (eff 4/97);
ORF and CMHC (10/91 - 3/97)
75 = Clinic-CORF
76 = Clinic-CMHC (eff 4/97)
77 = Clinic-Federally Qualified Health Center (FQHC)

eff. 4/2010
78 = Clinic-reserved for national assignment
79 = Clinic-other
81 = Hospice (non-hospital based)
82 = Hospice (hospital based)
83 = Ambulatory Aurgical Center
(Discontinued for Hospitals Subject to Outpatient PPS;
hospitals must use 13X for ASC claims submitted for OPPS
payment -- eff. 7/00)
84 = Freestanding Birthing Center
85 = Critical Access Hospital (eff. 10/94)
86 = Residential Facility (eff. 4/1/2010)
87 = Freestanding Non-residential Opioid Treatment
Programs (eff. 1/2021)
88 = Reserved for national assignment
89 = Special facility or ASC surgery-other
91 = Reserved for national assignment
92 = Reserved for national assignment
93 = Reserved for national assignment
94 = Reserved for national assignment
95 = Reserved for national assignment
96 = Reserved for national assignment
97 = Reserved for national assignment
98 = Reserved for national assignment
99 = Reserved for national assignment

CLM_CARE_IMPRVMT_MODEL_TB Claim Care Improvement Model Table

61 = CLAIM CARE IMPROVEMENT MODEL 1
62 = CLAIM CARE IMPROVEMENT MODEL 2
63 = CLAIM CARE IMPROVEMENT MODEL 3
64 = CLAIM CARE IMPROVEMENT MODEL 4

CLM_DGNS_VRSN_TB Claim Diagnosis Version Code Table

Valid Values:
9 = ICD-9
0 = ICD-10

CLM_DISP_TB Claim Disposition Table

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

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

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

CLM_EXCPTD_NEXCPTD_TRTMT_TB Claim Excepted/Nonexcepted Treatment Table

0 = No Entry
1 = Excepted
2 = Nonexcepted

CLM_FAC_TYPE_TB Claim Facility Type Table

1 = Hospital
2 = Skilled nursing facility (SNF)
3 = Home health agency (HHA)
4 = Religious Nonmedical (Hospital)
(eff. 8/1/00); prior to 8/00 referenced Christian Science (CS)
5 = Religious Nonmedical (Extended Care)
(eff. 8/1/00); prior to 8/00 referenced CS
(discontinued effective 10/1/05)
6 = Intermediate care
7 = Clinic or hospital-based renal dialysis facility
8 = Special facility or ASC surgery
9 = Reserved

CLM_FPS_MSN_CD_TB Claim FPS MSN Code Table

Section 1 Ambulance
1.1 = Payment for transportation is allowed only to the closest facility that can provide the necessary care.
1.10 = Air ambulance is not covered since you were not taken to the airport by ambulance.
1.11 = The information provided does not support the need for an air ambulance. The approved amount is based on ground ambulance.
1.2 = Payment is denied because the ambulance company is not approved by Medicare.
1.3 = Ambulance service to a funeral home is not covered.
1.4 = Transportation in a vehicle other than an ambulance is not covered.
1.5 = Transportation to a facility to be closer

to home or family is not covered.
1.6 = This service is included in the allowance for the ambulance transportation.
1.7 = Ambulance services to or from a doctor's office are not covered.
1.8 = This service is denied because you refused to be transported.
1.9 = Payment for ambulance services does not include mileage when you were not in the ambulance.

Section 10 Foot Care
10.1 = Shoes are only covered as part of a leg brace.

Section 11 Transfer of Claims or Parts of Claims
11.1 = Your claim has been forwarded to the correct Medicare contractor for processing. You will receive a notice from them.
11.10 = We have identified you as a Railroad Retirement Board (RRB) Medicare beneficiary. You must send your claim for these services for processing to the RRB carrier Palmetto GBA, at PO Box 10066, Augusta, GA 30999.
11.11 = This claim/service is not payable under our claims jurisdiction. We have notified your provider to send your claim for these services to the United Mine Workers of America for processing.
11.2 = This information is being sent to Medicaid. They will review it to see if additional benefits can be paid.
11.3 = Our records show that you are enrolled in a Medicare health plan. Your provider must bill this service to the plan.
11.4 = Our records show that you are enrolled in a Medicare health plan. Your claim was sent to the plan for processing.
11.5 = This claim will need to be submitted to (another carrier, a Durable Medical Equipment Medicare Administrative Contractor (DME MAC), or Medicaid agency)
11.6 = We have asked your provider to submit this claim to the proper Medicare Administrative Contractor (MAC). That MAC is (name and address).
NOTE: Due to different systems' capabilities, DMACs may omit the final sentence in this message, "That MAC is (name and address)," whenever this message is used. Part A and Part B MACs are expected to use the complete message.

This instruction also applies to the Spanish translation of the message.

11.7 = This claim/service is not payable under our claims jurisdiction area. We have notified your provider that they must forward the claim/service to the correct carrier for processing.

11.8 = This claim will need to be submitted to the Region B Durable Medical Equipment Regional Carrier.

11.9 = This claim/service is not payable under our claims jurisdiction. We have notified your provider to send your claim for these services to the Railroad Retirement Board Medicare carrier.

Section 12 Hearing Aids

12.1 = Hearing aids are not covered.

Section 13 Skilled Nursing Facility

13.1 = No qualifying hospital stay dates were shown for this skilled nursing facility stay.

13.10 = Medicare Part B doesn't pay for items or services provided by this type of healthcare provider since our records show that you were receiving Medicare Part A benefits in a skilled nursing facility on this date.

13.11 = You have ___ days(s) remaining of your total 100 days of skilled nursing facility benefits for this benefit period

13.12 = Medicare Part B doesn't pay separately for this item/service. Payment for this item/service should be included in another Medicare benefit. The hospital/ nursing facility must bill for this Medicare service.

13.2 = Skilled nursing facility benefits are only available after a hospital stay of at least 3 days.

13.3 = Information provided does not support the need for skilled nursing facility care.

13.4 = Information provided does not support the need for continued care in a skilled nursing facility.

13.5 = You were not admitted to the skilled nursing facility within 30 days of your hospital discharge.

13.6 = Rural primary care skilled nursing facility benefits are only available after a hospital stay of at least 2 days.

13.7 = Normally, care is not covered when provided in a bed that is not certified

by Medicare. However, since you received covered care, we have decided that you will not have to pay the facility for anything more than Medicare coinsurance and noncovered items.

13.8 = The skilled nursing facility should file a claim for Medicare benefits because you were an inpatient.

13.9 = Medicare Part B does not pay for this item or service since our records show that you were in a skilled nursing facility on this date.

Section 14 Laboratory

14.1 = The laboratory is not approved for this type of test.

14.10 = Medicare does not allow a separate payment for EKG readings.

14.11 = A travel allowance is paid only when a covered specimen collection fee is billed

14.12 = Payment for transportation can only be made if an X-ray or EKG is performed.

14.13 = The laboratory was not approved for this test on the date it was performed.

14.2 = Medicare approved less for this individual test because it can be done as part of a complete group of tests.

14.3 = Services or items not approved by the Food and Drug Administration are not covered.

14.4 = Payment denied because the claim did not show who performed the test and/or the amount charged.

14.5 = Payment denied because the claim did not show if the test was purchased by the physician or if the physician performed the test.

14.6 = This test must be billed by the laboratory that did the work.

14.7 = This service is paid at 100% of the Medicare approved amount.

14.8 = Payment cannot be made because the physician has a financial relationship with the laboratory.

14.9 = Medicare cannot pay for this service for the diagnosis shown on the claim.

Section Medical Necessity

15.1 = The information provided does not support the need for this many services or items.

15.10 = Medicare does not pay for more than one assistant surgeon for this procedure.

15.11 = Medicare does not pay for an assistant surgeon for this procedure/surgery.

15.12 = Medicare does not pay for two surgeons for this procedure.
15.13 = Medicare does not pay for team surgeons for this procedure.
15.14 = Medicare does not pay for acupuncture.
15.15 = Payment has been reduced because information provided does not support the need for this item as billed.
15.16 = Your claim was reviewed by our medical staff.
15.17 = We have approved this service at a reduced level.
15.18 = Medicare does not cover this service at home.
15.19 = Local Coverage Determinations (LCDs) help Medicare decide what is covered. An LCD was used for your claim. You can compare your case to the LCD, and send information from your doctor if you think it could change our decision. Call 1-800-MEDICARE (1-800-633-4227) for a copy of the LCD.
15.2 = The information provided does not support the need for this equipment.
15.20 = The following policies were used when we made this decision: _____
15.21 = The information provided does not support the need for this many services or items in this period of time but you do not have to pay this amount.
15.22 = The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service.
15.3 = The information provided does not support the need for the special features of this equipment.
15.4 = The information provided does not support the need for this service or item.
15.5 = The information provided does not support the need for similar services by more than one doctor during the same time period.
15.6 = The information provided does not support the need for this many services or items within this period of time.
15.7 = The information provided does not support the need for more than one visit a day.
15.8 = The information provided does not support the level of service as shown on the claim.
15.9 = The Quality Improvement Organization did not approve this service.
15.96 = Medicare does not pay for this

investigational device(s).
15.97 = Medicare cannot pay for this investigational device because the approved period for the investigational device in the FDA clinical trial has not begun.
15.98 = Medicare cannot pay for this investigational device because the approved period for the investigational device in the FDA clinical trial has expired.
15.99 = Medicare does not pay for this many services on the same day. You cannot be billed for this service.

Section 16 Miscellaneous
16.1 = The service cannot be approved because the date on the claim shows it was billed before it was provided.
16.10 = Medicare does not pay for this item or service.
16.11 = Payment was reduced for late filing. You cannot be billed for the reduction.
16.12 = Outpatient mental health services are paid at 50% of the approved charges.
16.13 = The code(s) your provider used is/are not valid for the date of service billed.
16.14 = The attached check replaces your previous check (#____) dated (_____).
16.15 = The attached check replaces your previous check.
16.16 = As requested, this is a duplicate copy of your Medicare Summary Notice. See "Message Expiration Date" and "Message Notes" columns ------->
16.17 = Medicare only pays for these services if you get them with total parenteral nutrition.
16.18 = Medicare won't pay for services provided before certified parenteral/enteral nutrition therapy started.
16.19 = The amount Medicare pays for a parenteral/enteral nutrition supply is based on the level of care you need (based on your diagnosis).
16.2 = This service cannot be paid when provided in this location/facility.
16.20 = The approved payment for calories/grams is the most Medicare may allow for the diagnosis stated.
16.21 = The procedure code was changed to reflect the actual service rendered.
16.22 = Medicare does not pay for services when no charge is indicated.

16.23 = This check is for the amount you overpaid
16.24 = Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, the service must be provided by a doctor licensed to practice in the United States.
16.25 = Medicare does not pay for this much equipment, or this many services or supplies.
16.26 = Medicare does not pay for services or items related to a procedure that has not been approved or billed.
16.27 = This service is not covered since our records show you were in the hospital at this time.
16.28 = Medicare does not pay for services or equipment that you have not received.
16.29 = Payment is included in another service you have received.
16.3 = The claim did not show that this service or item was prescribed by your doctor.
16.30 = Services billed separately on this claim have been combined under this procedure.
16.31 = You are responsible to pay the primary physician care the agreed monthly charge.
16.32 = Medicare does not pay separately for this service.
16.33 = Your payment includes interest because Medicare exceeded processing time limits.
16.34 = You should not be billed for this service . You are only responsible for any deductible and coinsurance amounts listed in the "You May Be Billed" column. This message should be revised to read "Maximum You May Be Billed" (in place of "You May Be Billed") when your MAC implements the new MSN design. See "Message Implementation Date" and "Message Notes."
16.35 = You do not have to pay this amount.
16.36 = If you have already paid it, you are entitled to a refund from this provider.
16.37 = Please see the back of this notice. See "Message Expiration Date" and "Message Notes" columns
16.38 = Charges are not incurred for leave of absence days.
16.39 = Only one provider can be paid for this service per calendar month. Payment has already been made to another provider for this service.
16.4 = This service requires prior approval by the Quality Improvement Organization.

16.40 = Only one inpatient service per day is allowed.
16.41 = Payment is being denied because you refused to request reimbursement under your Medicare benefits.
16.42 = The provider's determination of noncoverage is correct.
16.43 = This service cannot be approved without a treatment plan and supervision of a doctor.
16.44 = Routine care is not covered.
16.45 = You cannot be billed separately for this item or service. You do not have to pay this amount.
16.46 = Medicare payment limits do not affect a Native American's right to free care at Indian Health Institutions.
16.47 = When deductible is applied to outpatient psychiatric services, you may be billed for up to the approved amount. The "You May Be Billed" column will tell you the correct amount to pay your provider. This message should be revised to read "Maximum You May Be Billed" (in place of "You May Be Billed" when your MAC implements the new MSN design.
16.48 = Medicare does not pay for this item or service for this condition.
16.49 = This claim/service is not covered because alternative services were available, and should have been utilized.
16.5 = This service cannot be approved without a treatment plan by a physical or occupational therapist.
16.50 = The doctor or supplier may not bill more than the Medicare allowed amount.
16.51 = This service is not covered prior to July 1, 2001.
16.52 = This service was denied because coverage for this service is provided only after a documented failed trial of pelvic muscle exercise training.
16.53 = The amount Medicare paid the provider for this claim is ($_____).
16.54 = This service is not covered prior to January 1, 2002.
16.55 = The provider billed this charge as non-covered.
16.56 = Claim denied because information from the Social Security Administration indicates that you have been deported.
16.57 = Medicare Part B does not pay for this item or service since our records show that you were in a Medicare health plan

on this date. Your provider must bill this service to the Medicare health plan.
16.58 = The provider billed this charge as non-covered. You do not have to pay this amount.
16.59 = Medicare doesn't pay for missed appointments.
16.6 = This item or service cannot be paid unless the provider accepts assignment.
16.60 = Want to see your MSN right away? Access your Original Medicare claims directly at www.MyMedicare.gov, usually within 24 hours after Medicare processes the claim. You can also order duplicate MSNs, track your preventive services, and print an "On the Go" report to share with your provider.
16.61 = Outpatient mental health services are paid at 55% of the approved amount.
16.62 = Outpatient mental health services are paid at 60% of the approved amount
16.63 = Outpatient mental health services are paid at 65% of the approved amount.
16.64 = IMPORTANT: Starting in March 2010, Medicare will begin to mail Part A and Part B MSNs in the same envelope when possible.
16.66 = Medicare doesn't pay for DMEPOS items or services when provided by a hospital or physician if there is no matching date of discharge or date of service.
16.67 = Medicare doesn't pay for services or items when provided by a hospital when there is no matching date of discharge.
16.7 = Your provider must complete and submit your claim.
16.71 = Your provider must complete and submit your claim.
16.72 = This claim was denied because it was Submitted with a non-affirmative prior authorization request.
16.73 = This claim has received a payment reduction because it did not first go through the prior authorization process.
16.74 = This claim is denied because there is no record of a prior authorization request to support this record.
16.76 = This service/item was not covered because you have exceeded the lifetime limit for getting this service/item.
16.77 = This service/item was not covered because it was not provided as part of a qualifying trial/study.
16.8 = Payment is included in another service

received on the same day.
16.9 = This allowance has been reduced by the amount previously paid for a related procedure.
16.98 = The amount you paid to the provider for this claim was more than the required payment. You should be receiving a refund of $_____ from your provider, which is the difference between what you paid and what you should have paid.
16.99 = The amount owed you is $_____. Medicare no longer routinely issues payment under $1 This amount due will be included on a future check issued to you. If you want this money issued immediately , please contact us at the address and phone number shown at the bottom of this page.

Section 17 Non Physician Services
17.1 = Services performed by a private duty nurse are not covered.
17.10 = The allowance has been reduced because the anesthesiologist medically directed concurrent procedures.
17.11 = This item or service cannot be paid as billed.
17.12 = This service is not covered when provided by an independent therapist.
17.13 = Each year, Medicare pays for a limited amount of physical therapy and speech-language pathology services and a separate amount of occupational therapy services. Medically necessary therapy over these limits is covered when approved by Medicare.
17.14 = Charges for maintenance therapy are not covered.
17.15 = This service cannot be paid unless certified by your physician every (___) days.
17.16 = The hospital should file a claim for Medicare benefits because these services were performed in a hospital setting.
17.17 = Medicare already paid for an initial visit for this service with this physician, another physician in his group practice, or a provider. Your doctor or provider must use a different code to bill for subsequent visits.
17.18 = ($) has been applied during this calendar year (CCYY) towards the ($) limit on outpatient physical therapy and speech-language pathology benefits.

17.19 = ($) has been applied during this calendar year (CCYY) towards the ($) limit on outpatient occupational therapy benefits.
17.2 = This anesthesia service must be billed by a doctor.
17.21 = The items or service was denied because Medicare can't pay for services ordered by or referred by this provider at this time" for this message number.
17.25 = Medicare does not pay for services of a nurse practitioner/clinical nurse specialist for this place and/or date of service.
17.3 = This service was denied because you did not receive it under the direct supervision of a doctor.
17.33 = Medicare does not pay for services by a noncertified nonphysician practitioner.
17.4 = Services performed by an audiologist are not covered except for diagnostic procedures.
17.5 = Your provider's employer must file this claim and agree to accept assignment.
17.6 = Full payment was not made for this service(s) because the yearly limit has been met.
17.7 = This service must be performed by a licensed clinical social worker.
17.8 = Payment was denied because the maximum benefit allowance has been reached.
17.9 = Medicare (Part A/Part B) pays for this service. The provider must bill the correct Medicare contractor.

Section 18 Preventive Care
18.1 = Routine examinations and related services aren't covered.
18.10 = Expired
18.11 = Expired
18.12 = Screening mammograms are covered annually for women 40 years of age and older.
18.13 = This service isn't covered for people under 50 years old.
18.14 = Service is being denied because it has not been (12/24/48) months since your last (test/procedure) of this kind.
18.15 = Medicare only covers this procedure for people considered to be at high risk for colorectal cancer.
18.16 = This service is being denied because payment has already been made for a similar procedure within a set time frame
18.17 = Medicare pays for a screening Pap test and a screening pelvic examination once

every 2 years unless high risk factors are present.
18.18 = Medicare does not pay for this service separately since payment of it is included in our allowance for other services you received on the same day.
18.19 = This service isn't covered until after your 50th birthday.
18.2 = This immunization and/or preventive care is not covered.
18.20 = Expired
18.21 =
18.22 = This service was denied because Medicare only allows the Welcome to Medicare preventive visit within the first 12 months you have Part B coverage.
18.23 = You pay 25% of the Medicare-approved amount for this service.
18.24 = This service was denied. Medicare doesn't cover an Annual Wellness Visit within the first 12 months of your Medicare Part B coverage. Medicare does cover a one-time Welcome to Medicare preventive visit with in the first 12 months.
18.25 = Your Annual Wellness Visit has been approved. You will qualify for another Annual Wellness Visit 12 months after the date of this visit.
18.26 = This service was denied because it occurred too soon after your last covered Annual Wellness Visit. Medicare only covers one Annual Wellness Visit within a 12 month period.
18.27 = This service was denied because it occurred too soon after your Initial Preventive Physical Exam.
18.3 = Screening mammography is not covered for women under 35 years of age.
18.4 = This service is being denied because it has not been (__) months since your last examination of this kind.
18.5 = Medicare will pay for another screening mammogram in 12 months.
18.6 = A screening mammography is covered only once for women age 35 - 39.
18.7 = Screening pap tests are covered only once every 24 months unless high risk factors are present.
18.8 = Deleted during EOMB-MSN transition.
18.9 = Deleted during EOMB-MSN transition.
18.94 = Medicare pays for screening Pap smear and/or screening pelvic examination (including a clinical breast examination) only once every 2 years unless high risk

factors are present.

Section 19 Hospital Based Physician Services
19.1 = Services of a hospital-based specialist are not covered unless there is an agreement between the hospital and the specialist.
19.2 = Payment was reduced because this service was performed in a hospital outpatient setting rather than a provider's office.
19.3 = Only one hospital visit or consultation per provider is allowed per day.

Section 2 Blood
2.1 = The first three pints of blood used in each year are not covered.
2.2 = Charges for replaced blood are not covered

Section 20 Benefit Limits
20.1 = You have used all of your benefit days for this period.
20.10 = This service was denied because Medicare only pays up to 10 hours of diabetes education training during the initial 12-month period. Our records show you have already obtained 10 hours of training.
20.11 = This service was denied because Medicare pays for two hours of follow-up diabetes education training during a calendar year . Our records show you have already obtained two hours of training for this calendar year.
20.12 = This service was denied because Medicare only covers this service once a lifetime.
20.13 = This service was denied because Medicare only pays up to three hours of medical nutrition therapy during a calendar year. Our records show you have already received three hours of medical nutrition therapy.
20.14 = This service was denied because Medicare only pays two hours of follow-up for medical nutrition therapy during a calendar year. Our records show you have already received two hours of follow-up services for this calendar year.
20.2 = You have reached your limit of 190 days of psychiatric hospital services.
20.3 = You have reached your limit of 60 lifetime reserve days.
20.4 = (__) of the Benefit Days Used were charged to your Lifetime Reserve Day benefit.

20.5 = These services cannot be paid because your benefits are exhausted at this time.
20.6 = Days used has been reduced by the primary group insurer's payment.
20.7 = You have (___) day(s) remaining of your 190-day psychiatric limit.
20.8 = Days are being subtracted from your total inpatient hospital benefits for this benefit period.
20.9 = Services after (mm/dd/yy) cannot be paid because your benefits were exhausted.
20.91 = This service was denied. Medicare covers a one-time initial preventative physical exam (Welcome to Medicare physical exam) if you get it within the first 12 months of the effective date of your Medicare Part B coverage.

Section 21 Restrictions to Coverage
21.1 = Services performed by an immediate relative or a member of the same household are not covered.
21.10 = A surgical assistant is not covered for this place and/or date of service.
21.11 = This service was not covered by Medicare at the time you received it.
21.12 = This hospital service was not covered because the attending physician was not eligible to receive Medicare benefits at the time the service was performed.
21.13 = This surgery was not covered because the attending physician was not eligible to receive Medicare benefits at the time the service was performed.
21.14 = Medicare cannot pay for this investigational device because the FDA clinical trial period has not begun.
21.15 = Medicare cannot pay for this investigational device because the FDA clinical trial period has ended.
21.16 = Medicare does not pay for this investigational device.
21.17 = Your provider submitted noncovered charges. You are responsible for paying these charges.
21.18 = This item or service is not covered when performed or ordered by this provider.
21.19 = This provider decided to dropout of Medicare. No payment can be made for this service. You are responsible for this charge. Under Federal law, your doctor cannot charge you more than the limiting charge amount.
21.2 = The provider of this service is not

eligible to receive Medicare payments.
21.20 = This provider decided to dropout of Medicare. No payment can be made for this service. You are responsible for this charge.
21.21 = This service was denied because Medicare only covers this service under certain circumstances.
21.22 = Medicare does not pay for this service because it is considered investigational and/or experimental in these circumstances.
21.23 = Your claim is being denied because the physician noted on the claim has been deceased for more than 15 months.
21.24 = This service is not covered for patients over age 60.
21.25 = This service was denied because Medicare only covers this service in certain settings.
21.26 = Claim denied because services were provided by an Opt-Out physician or practitioner. No Medicare payment may be made.
21.27 = Services provided by a Medicare sanctioned/excluded provider. No Medicare payment may be made.
21.3 = This provider was not covered by Medicare when you received this service.
21.30 = The provider decided to drop out of Medicare. No payment can be made for this service. You are responsible for this charge.
21.31 = This service was not covered by Medicare at the time you recieved it.
21.32 = This service was denied because Medicare only covers this service under certain circumstances.
21.4 = Services provided outside the United States are not covered. See your Medicare Handbook for services received in Canada and Mexico.
21.5 = Services needed as a result of war are not covered.
21.6 = This item or service is not covered when performed, referred or ordered by this provider.
21.7 = This service should be included on your inpatient bill.
21.8 = Services performed using equipment that has not been approved by the Food and Drug Administration are not covered.
21.9 = Payment cannot be made for unauthorized service outside the managed care plan.

Section 22 Split Claims

22.1 = Your claim was separated for processing. The remaining services may appear on a separate notice.

Section 23 Surgery

23.1 = The cost of care before and after the surgery or procedure is included in the approved amount for that service.

23.10 = Payment has been reduced because this procedure was terminated before anesthesia was started.

23.11 = Payment cannot be made because the surgery was canceled or postponed.

23.12 = Payment has been reduced because the surgery was canceled after you were prepared for surgery.

23.13 = Because you were prepared for surgery and anesthesia was started, full payment is being made even though the surgery was canceled.

23.14 = The assistant surgeon must file a separate claim for this service.

23.15 = The approved amount is less because the payment is divided between two doctors.

23.16 = An additional amount is not allowed for this service when it is performed on both the left and right sides of the body.

23.17 = Medicare won't cover these services because they are not considered medically necessary.

23.2 = Cosmetic surgery and related services are not covered.

23.3 = Medicare does not pay for surgical supports except primary dressings for skin grafts.

23.4 = A separate charge is not allowed because this service is part of the major surgical procedure.

23.5 = Payment has been reduced because a different doctor took care of you before and/or after the surgery.

23.6 = This surgery was reduced because it was performed with another surgery on the same day.

23.7 = Payment cannot be made for an assistant surgeon in a teaching hospital unless a resident doctor was not available.

23.8 = This service is not payable because it is part of the total maternity care charge.

23.9 = Payment has been reduced because the charges billed did not include post-operative care.

Section 24 'Help Stop Fraud' messages
24.1 = Protect your Medicare number as you would
a credit card number.
24.10 = Always read the front and back of your
Medicare Summary Notice.
24.11 = Beware of Medicare scams, such as offers
of free milk or cheese for your Medicare
number.
24.12 = Read your Medicare Summary Notice
carefully for accuracy of dates, services
, and amounts billed to Medicare.
24.13 = Be sure you understand anything you are
asked to sign.
24.14 = Be sure any equipment or services you
received were ordered by your doctor.
24.15 = Review your Medicare Summary Notice and
report items and services that you did
not receive to Medicare's Fraud Hotline
at 1-866-417-2078.
FLORIDA - SPECIFIC MESSAGE
24.16 = Report items and services that you did
not receive to Medicare's Fraud Hotline
at 1-866-417-2078.
FLORIDA - SPECIFIC MESSAGE
24.19 = You may see some claims that have been
adjusted. For an explanation see the
General Information section
See Expiration Date and Message Notes
------->
24.2 = Beware of telemarketers or advertisements
offering free or discounted Medicare
items and services.
24.22 = You can make a difference! Last year,
tax-payers saved $4 billion-the largest
sum ever recovered in a single year-
thanks in large part to people who came
forward and reported suspicious activity.
See "Message Implementation Date" and
"Message Notes" columns. ---->
24.3 = Beware of door-to-door solicitors
offering free or discounted Medicare
items or services.
24.4 = Only your physician can order medical
equipment for you.
24.5 = Always review your Medicare Summary
Notice for correct information about the
items or services you received.
24.6 = Do not sell your Medicare number or
Medicare Summary Notice.
24.7 = Do not accept free medical equipment you
don't need.
24.8 = Beware of advertisements that read,
"This item is approved by Medicare", or

"No out-of-pocket expenses."
24.9 = Be informed - Read your Medicare Summary Notice.
See "Message Expiration Date" and "Message Notes" columns ----->

Section 25 Time Limit for filing
25.1 = This claim was denied because it was filed after the time limit.
25.2 = You can be billed only 20% of the charges that would have been approved.
25.3 = The time limit for filing your claim has expired, therefore appeal rights are not applicable for this claim.

Section 26 Vision
26.1 = Eye refractions are not covered.
26.2 = Eyeglasses or contact lenses are only covered after cataract surgery or if the natural lens of your eye is missing.
26.3 = Only one pair of eyeglasses or contact lenses is covered after cataract surgery with lens implant.
26.4 = This service is not covered when performed by this provider.
26.5 = This service is covered only in conjunction with cataract surgery.
26.6 = Payment was reduced because the service was terminated early.

Section 27 Hospice
27.1 = This service is not covered because you are enrolled in a hospice.
27.10 = The documentation indicates that the service level of continuous home care wasn't reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.
27.11 = The provider has billed in error for the routine home care items or services received.
27.12 = The documentation indicates that your respite level of care exceeded five consecutive days. Therefore, payment for every day beyond the 5th day will be paid at the routine home care rate.
27.13 = According to Medicare hospice requirements, this service is not covered because the service was provided by a non-attending physician.
27.2 = Medicare will not pay for inpatient respite care when it exceeds five consecutive days at a time.
27.3 = The physician certification requesting

hospice services was not received timely.
27.4 = The documentation received indicates that the general inpatient care level of services were not necessary for care related to the terminal illness. Therefore, payment will be adjusted to the routine home care rate.
27.5 = Payment for the day of discharge from the hospital will be made to the hospice agency at the routine home care rate.
27.6 = The documentation indicates the level of care was at the respite level not the general inpatient level of care. Therefore, payment will be adjusted to the routine home care rate.
27.7 = According to Medicare hospice requirements, the hospice election consent was not signed timely.
27.8 = The documentation submitted does not support that your illness is terminal.
27.9 = The documentation indicates your inpatient level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.
27.99 = Medicare allows your doctor to charge for developing a plan of treatment for your home health or hospice services.

Section 28 Mandatory
28.1 = Because you have Medicaid, your provider must agree to accept assignment.

Section 29 MSP
29.1 = Secondary payment cannot be made because the primary insurer information was either missing or incomplete.
29.10 = These services cannot be paid because you received them on or before you received a liability insurance payment for this injury or illness.
29.11 = Our records show that an automobile medical, liability, or no-fault insurance plan is primary for these services. Submit this claim to the primary payer.
29.12 = Our records show that these services may be covered under the Black Lung Program. Contact the U.S. Department of Labor, Federal Black Lung Program, P.O. Box 8302 , London, KY 40742-8302
29.13 = Medicare does not pay for these services because they are payable by another government agency. Submit this claim to that agency.

29.14 = Medicare's secondary payment is ($_____) . This is the difference between the primary insurer's approved amount of ($_____) and the primary insurer's paid amount of ($_____).

29.15 = Medicare's secondary payment is ($_____) . This is the difference between Medicare's approved amount of ($_____) and the primary insurer's paid amount of ($_____).

29.16 = Your primary insurer approved and paid ($_____) on this claim. Therefore, no secondary payment will be made by Medicare.

29.17 = Your provider agreed to accept ($_____) as payment in full on this (claim/service). Your primary insurer has already paid ($_____) so Medicare's payment is the difference between the two amounts.

29.18 = The amount listed in the "You May Be Billed" column assumes that your primary insurer paid the provider. If your primary insurer paid you, then you are responsible to pay the provider the amount your primary insurer paid to you plus the amount in the "You May Be Billed " column.
This message should be revised to read "If your primary insurer paid you for this claim, you are responsible to pay that amount to your provider plus the amount in the "Maximum You May Be Billed" column."
See "Message Implementation Date" and "Message Notes" columns.

29.19 = If your primary insurer paid your provider for this claim, you now only need to pay your provider the difference between the amount charged and the amount your primary insurer paid.

29.2 = No payment was made because your primary insurer's payment satisfied the provider's bill.

29.20 = If your primary insurer paid your provider for this claim, you only need to pay the difference between the amount your provider agreed to accept and the amount your primary insurer paid.

29.21 = If your primary insurer made payment on this claim, you may be billed the difference between the amount charged and your primary insurer's payment.

29.22 = If your primary insurer paid the provider , you need to pay the provider the

difference between the limiting charge amount and the amount the primary insurer paid your provider.

29.23 = No payment can be made because payment was already made by either worker's compensation or the Federal Black Lung Program.

29.24 = No payment can be made because payment was already made by another government entity.

29.25 = Medicare paid all covered services not paid by other insurer.

29.26 = The primary payer is _____.

29.27 = Your primary group's payment satisfied Medicare deductible and coinsurance.

29.28 = Your responsibility on this claim has been reduced by the amount paid by your primary insurer.

29.29 = Your provider is allowed to collect a total of ($_____) on this claim. Your primary insurer paid ($_____) and Medicare paid ($_____). You are responsible for the unpaid portion of ($_____).

29.3 = Medicare benefits are reduced because some of these expenses have been paid by your primary insurer.

29.30 = ($_____) of the money approved by your primary insurer has been credited to your Medicare Part B (A) deductible. You do not have to pay this amount.

29.31 = Resubmit this claim with the missing or correct information.

29.32 = Medicare's secondary payment is ($_____) . This is the difference between Medicare's limiting charge amount of ($_____) and the primary insurer's paid amount of ($_____).

29.33 = Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury(ies).

29.34 = The claim for this item/service was submitted by your complementary insurer on your behalf.

29.35 = Per statute, Medicare only accepts claims from your complementary insurer when Medicare is the primary payer.

29.71 = Medicare benefits are being paid on the condition that if you receive payment from liability insurance, an automobile medical insurance policy or plan, or any other no-fault insurance, you must repay

Medicare.

29.4 = In the future, if you send claims to Medicare for secondary payment, please send them to (carrier MSP address).

29.5 = Our records show that Medicare is your secondary payer. This claim must be sent to your primary insurer first.

29.6 = Our records show that Medicare is your secondary payer. Services provided outside your prepaid health plan are not covered. We will pay this time only since you were not previously notified.

29.7 = Medicare cannot pay for this service because it was furnished by a provider who is not a member of your employer prepaid health plan. Our records show that you were informed of this rule.

29.8 = This claim is denied because the service(s) may be covered by the worker's compensation plan. Ask your provider to submit a claim to that plan.

29.9 = Since your primary insurance benefits have been exhausted, Medicare will be primary on this accident related service.

Section 3 Chiropractic

3.1 = This service is covered only when recent x-rays support the need for the service.

3.7 = Medicare does not pay for this unless a sympton or sign of a problem is stated on the claim.

3.18 = This represents an adjustment of a previously processed claim. If an underpayment was made, the attached check pays the total claim allowed minus the amount originally paid. If an overpayment requiring a refund was made and a refund has not already been submitted, you will be contacted by letter from the Medicare claims office.

Section 30 Reasonable Charge and Fee Schedule

30.1 = The approved amount is based on a special payment method.

30.2 = The facility fee allowance is greater than the billed amount.

30.3 = Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than ($_____) . If you have already paid more than this amount, you are entitled to a refund from the provider.

30.4 = A change in payment methods has resulted in a reduced or zero payment for this

procedure.
30.41 = What Medicare pays for a service or item may be higher than the billed amount. This amount is correct. Medicare pays this provider less than the billed amount on other claims since payment rates are set in advance for certain services and averaged out over an entire year.
30.5 = This amount is the difference in billed amount and Medicare approved amount.

Section 31 Adjustments
31.1 = This is a adjustment to a previously processed claim and/or deductible record.
31.10 = This is an adjustment to a previously processed charge (s). This notice may not reflect the charges as they were originally submitted.
31.11 = The previous notice we sent stated that your doctor could not charge more than ($_____). This additional payment allows your doctor to bill you the full amount charged.
31.12 = The previous notice we sent stated the amount you could be charged for this service. This additional payment changed that amount. Your doctor cannot charge you more than ($_____).
31.13 = The Medicare paid amount has been reduced by ($_____) previously paid for this claim.
31.14 = This payment is the result of an Administrative Law Judge's decision.
31.15 = An adjustment was made based on a redetermination.
31.16 = An adjustment was made based on a reconsideration.
31.17 = This is an internal adjustment. No action is required on your part.
31.18 = This adjustment has resulted in an overpayment to your provide/supplier. Your provider/supplier has been requested to repay $_____ to Medicare. You do not have to pay this amount.
31.19 = If you do not agree with the Medicare approved amount(s), you may ask for a reconsideration. You must request a reconsideration within 180 days of the date of receipt of this notice. You may present any new evidence which could affect your decision. Call us at the number in the Customer Service block if you need more information about the reconsideration process.

This message should be revised to read, "If you disagree with the Medicare-approved amount, you may ask for a redetermination within 120 days of receipt of this notice. Call 1-800-MEDICARE if you need information on the redetermination process." when your MAC implements the new MSN design. See "Message Implementation Date" and "Message Notes" colums. ----->

31.2 = A payment adjustment was made based on a telephone review.

31.3 = This notice is being sent to you as the result of a reopening request.

31.4 = This notice is being sent to you as the result of a fair hearing request.

31.5 = If you do not agree with the Medicare approved amount(s) and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the limit you may combine amounts on other claims that have been reviewed. At the hearing, you may present any new evidence which could affect the decision. Call us at the number in the Customer Service block if you need more information about the hearing process.

31.6 = A payment adjustment was made based on a Quality Improvement Organization request.

31.7 = This claim was previously processed under an incorrect Medicare claim number or name. Our records have been corrected.

31.8 = This claim was adjusted to reflect the correct provider.

31.9 = This claim was adjusted because there was an error in billing.

31.95 = Per our telephone call, no payment can be made on your review request. The approved amount is the total allowance we can make for this service.

31.96 = Per our telephone call, no payment can be made on your review request. Medicare does not separately pay for these charges because the cost of related care before and after the surgery/procedure is part of the approved amount for the surgery/ procedure.

31.97 = Per our telephone call, no payment can be made on your review request. Medicare does not pay for this many services within this period of time.

31.98 = Per our telephone call, no payment can be

made on your review request. Medicare does not pay for routine foot care.

31.99 = As a result of the Hearing Officer's decision, no additional payment can be made.

Section Overpayments/Offsets

32.1 = ($_____) of this payment has been withheld to recover a previous overpayment.

32.2 = You should not be billed separately by your physician(s) for services provided during this inpatient stay.

32.3 = Medicare has paid $_____ for hospital and doctor services. You shouldn't be billed separately by your doctor(s) for services you got during this inpatient stay.

Section 33 Ambulatory Surgical Centers

33.1 = The ambulatory surgical center must bill for this service.

Section 34 Patient Paid/Split Payments

34.1 = Of the total ($_____) paid on this claim , we are paying you ($_____) because you paid your provider more than your 20% coinsurance on Medicare approved services. The remaining ($_____) was paid to the provider.

34.2 = The amount in the "You May Be Billed" column has been reduced by the amount you paid the provider at the time the services were rendered.
This message should be revised to read "Maximum You May Be Billed" (in place of "You May Be Billed") when your MAC implements the new MSN design.
See "Message Implementation Date" and "Message Notes" columns. ------>

34.3 = After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider.

34.4 = We are paying you ($_____) because the amount you paid the provider was more than you may be billed for Medicare approved charges.

34.5 = The amount owed you is ($_____). Medicare does not routinely issue checks for amounts under $1.00. This amount due will be included in your next check.
If you want this money issued immediately

, please contact us at the address or phone number in the Customer Service Information box.
The last sentence of this message should be revised to read, "If you want this money issued immediately, please call 1-800-MEDICARE (1-800-633-4227)." when your MAC implements the new MSN design. See "Message Implementation Date" and Message Notes" columns.

34.6 = Your check includes ($_____) which was withheld on a prior claim.

34.7 = This check includes an amount less than $1.00 that was withheld on a prior claim.

34.8 = The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of ($_____) from your provider, which is the difference between what you paid and what you should have paid.

34.9 = If you already paid the supplier/provider , the supplier/provider must refund any amount that exceeds the Medicare approved amount.

Section 35 Supplemental Coverage/Medigap

35.1 = This information is being sent to your private insurer(s). Send any questions regarding your benefits to them.

35.2 = We have sent your claim to your Medigap insurer. Send any questions regarding your benefits to them.

35.3 = A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer.

35.4 = A copy of this notice will not be forwarded to your Medigap insurer because your provider does not participate in the Medicare program. Please submit a copy of this notice to your Medigap insurer.

35.5 = We did not send this claim to your private insurer. They have indicated no additional payment can be made. Send any questions regarding your benefits to them

35.6 = Your supplemental policy is not a Medigap policy under Federal and State law or regulation. It is your responsibility to file a claim directly with your insurer.

35.7 = Please do not submit this notice to them (add-on to other messages as appropriate).

Section 36 Limitation of Liability

36.1 = Our records show that you were informed in writing, before receiving the service that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.

36.2 = You didn't know this service isn't covered so you don't have to pay. If you paid and do not receive a refund from your provider, you have 6 months to send a copy of this notice, your provider's bill, and proof that you paid to the address on the last page of this notice. Future services of this type won't be paid.

36.3 = Your provider was told that you're owed a refund for this service. If you don't get a refund within 30 days of getting this notice, send a copy of this notice to the address on the last page. Refunds may be delayed if your provider appeals this decision.

36.4 = You are getting a refund because your provider didn't tell you in writing that Medicare wouldn't pay for this service. In the future, you will have to pay for the service.

36.5 = You are getting a refund because your provider didn't tell you in writing that Medicare would approve a reduced level/ amount of services. In the future, you will have to pay for the service.

36.6 = Medicare is paying this claim, this time only, because it appears that neither you nor the provider knew that the service(s) would be denied. You will have to pay for future services of this type.

36.7 = This code is for informational/reporting purposes only. You should not be charged for this code. If there is a charge, you do not have to pay the amount.

Section 37 Deductible/Coinsurance

37.1 = This approved amount has been applied toward your deductible.

37.10 = You have now met ($_____) of your ($_____) Part A deductible for this benefit period.

37.11 = You have met the Part B deductible for (year).

37.12 = You have met the Part A deductible for this benefit period.

37.13 = You have met the blood deductible for

(year).
37.14 = You have met ($_____) pint(s) of your blood deductible for (year).
37.15 = After your deductible and coinsurance were applied, the amount Medicare paid was reduced due to Federal, State and local rules.
37.16 = You have now met $_____ of your $_____ Part B deductible for calendar year ____.
37.17 = The "Maximum You May Be Billed" column includes $_____ for your Part B deductible, $_____ for your Part B coinsurance, $_____ for your Part A deductible, and $_____ for your Part A coinsurance and/or lifetime reserve coinsurance.
*If your MAC will implement the new MSN design AFTER 07/01/13, use the following language for this message from 07/01/13 until your MAC DOES implement the new MSN design: The "You May Be Billed" column includes $_____ for your Part B deductible, $_____ for your Part B coinsurance, $_____ for your Part A deductible, and $_____ for your Part A coinsurance and/or lifetime reserve coinsurance.
37.2 = ($_____) of this approved amount has been applied toward your deductible.
37.3 = ($_____) was applied to your inpatient deductible.
37.4 = ($_____) was applied to your inpatient coinsurance.
37.5 = ($_____) was applied to your skilled nursing facility coinsurance.
37.6 = ($_____) was applied to your blood deductible.
37.7 = Part B cash deductible does not apply to these services.
37.8 = This coinsurance amount reflects the amount that you are required to pay for outpatient mental health treatment services under the Medicare program.
37.9 = You have now met ($_____) of your ($_____) Part B deductible for (year).

Section 38 General Information
38.1 = Discontinued 2002
38.10 = Compare the services you receive with those that appear on your Medicare Summary Notice. If you have questions, call your doctor or provider. If you feel further investigation is needed due to

possible fraud or abuse, call the phone number in the Customer Service Information Box.
The last sentence of this message should be revised to read, "If you feel further investigation is needed due to possible fraud or abuse, call 1-800-MEDICARE (1-800-633-4227)." when your MAC implements the new MSN design.
See "Message Implementation Date" and Message Notes" columns. ----->

38.11 = Preventive Messages:

January - Cervical Health

January is cervical health month. The Pap test is the most effective way to screen for cervical cancer. Medicare helps pay for screening Pap tests every two years. For more information on Pap tests, call your Medicare carrier.

January - National Glaucoma Awareness Month (Optional)
Glaucoma may cause blindness. Medicare helps pay for a yearly dilated eye exam for people at high risk for Glaucoma. African-Americans over 50 and people with diabetes or a family history of glaucoma are at higher risk. Talk to your doctor to learn if this exam is right for you.

February - General Preventive Services
Medicare helps pay for many preventive services including flu and pneumococcal shots, tests for cancer, diabetes monitoring supplies and others. Call 1-800-MEDICARE (1-800-633-4227) for more information.

March - National Colorectal Cancer Awareness Month
Colorectal cancer is the second leading cancer killer in the United States. Medicare helps pay for colorectal cancer screening tests. Talk to your doctor about screening options that are right for you.

April - General Preventive Services
Medicare helps pay for many preventive services including flu and pneumococcal shots, tests for cancer, diabetes monitoring supplies and others. Call

1-800-MEDICARE (1-800-633-4227) for more information.

May - National Osteoporosis Month
Do you know how strong your bones are? Medicare helps pay for bone mass measurement tests to measure the strength of bones for people at risk of osteoporosis. Talk to your doctor to learn if this test is right for you.

May - Breast Cancer Awareness (to coordinate with Mother's Day) - Optional
Early detection is the best protection from breast cancer. Get a mammogram. Not just once, but for a lifetime. Medicare helps pay for screening mammograms.

June - General Preventive Services Message:
Medicare helps pay for many preventive services including flu and pneumococcal shots, tests for cancer, diabetes monitoring supplies and others. Call 1-800-MEDICARE (1-800-633-4227) for more information.

July- Glaucoma Awareness
Glaucoma may cause blindness. Medicare helps pay for a yearly dilated eye exam for people at high risk for Glaucoma. African-American people over 50, and people with diabetes or a family history of glaucoma are at higher risk. Talk to your doctor to learn if this exam is right for you.

August - National Immunization Awareness Month (Contractors may elect to print this message during a different month of their choosing, but the message about the pneumococcal shot must be printed one month of each year.)
Get a pneumococcal shot. You may only need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment

September - Cold and Flu Campaign
During this flu season, get your flu shot . Contact your health care provider for the flu shot. Get the flu shot, not the

flu. You pay nothing if your health care provider accepts Medicare assignment.

September - Prostate Cancer Awareness Month - Optional
Prostate cancer is the second leading cause of cancer deaths in men. Medicare covers prostate screening tests once every 12 months for men with Medicare who are over age 50.

October - Breast Cancer Awareness Month
Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.

October - Continuation of Cold/Flu Campaign (optional)
If you have not received your flu shot, it is not too late. Please contact your health care provider about getting the flu shot.

November - American Diabetes Month
Medicare covers expanded benefits to help control diabetes

Section 38 General Information

38.12 = If you appeal this drug claim determination, send it to the Medicare contractor who processed your doctor's claim for giving you the drug.

38.13 = If you aren't due a payment check from Medicare, your Medicare Summary Notices (MSN) will now be mailed to you on a quarterly basis. You will no longer get a monthly statement in the mail for these types of MSNs. You will now get a statement every 90 days summarizing all of your Medicare claims. Your provider may send you a bill that you may need to pay before you get your MSN. When you get your MSN, look to see if you paid more than the MSN says is due. If you paid more, call your provider about a refund. If you have any questions about the bill from your provider, you should call your provider.

38.14 = Have limited income? Social Security can help with prescription drug costs. For more information on Extra Help with prescription drug costs and how to apply, visit www.socialsecurity.gov on the web

or call 1-800-772-1213. TTY users should call 1-800-325-0778.

38.15 = If the coinsurance amount you paid is more than the amount shown on your notice , you are entitled to a refund. Please contact your provider.

38.18 = ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2007. The limits are $1,740 in 2006 and $1780 in 2007 for PT and SLP combined and $1,740 in 2006 and $1780 in 2007 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE.
You have the right to request an itemized statement which details each Medicare item or service which you have received from your physician, hospital, or any other health supplier or health professional. Please contact them directly, in writing, if you would like an itemized statement.
Beneficiaries needing or receiving home health care may qualify for the new Home Health Independence Demonstration and have the freedom to leave home more often while remaining eligible for Medicare home health services. To qualify, you must meet several criteria, have a permanent disabling condition, and live in Colorado, Massachusetts, or Missouri. For more information, ask your home health agency about the "Home Health Independence Demonstration"; call 1(800) MEDICARE (1-800-633-4227); or visit our website at: www.cms.hhs.gov/researchers/demos/homehealthindependence.asp

38.18 = ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2007. The limits are $1,740 in 2006 and $1780 in 2007 for PT

and SLP combined and $1,740 in 2006 and $1780 in 2007 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE.

38.19 = Medicare Open Enrollment is from October 15 to December 7. This is when you can compare and change your health and drug plan coverage. If you're happy with your current plan, you don't have to do anything. Call 1-800-MEDICARE (1 800-633-4227) for more information.

38.2 = Discontinued

38.20 = You have the right to request an itemized statement which details each Medicare item or service you have received from a physician, hospital, or any other healthcare provider or supplier. Contact your provider to get an itemized statement.

38.22 = Planning to retire? Does your current insurance pay before Medicare pays? Call Medicare within the 6 months before you retire to update your records. Make sure your health care bills get paid correctly

38.23 = Save tax dollars by getting your "Medicare & You" handbook electronically. Visit www.mymedicare.gov to sign up.

38.24 = Please have your complete Medicare number with you when you call so your record can be located. To protect your privacy, this MSN doesn't include your entire number.

38.25 = This item or service is being denied. Medicare won't pay for a Medical Nutrition Therapy service and Diabetes Self Management Training item or service performed on the same date for the same person with Medicare.

38.26 = Your claims may have been adjusted since Medicare changed how it pays for certain services in 2010. You can compare claims that have been changed to previous statements you received in the past. Your provider may owe you a refund or you may have to pay more coinsurance. Call your provider or 1-800-MEDICARE.

38.27 = Get a pneumococcal shot. You may only

need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment

38.28 = Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.

38.3 = If you change your address, contact the Social Security Administration by calling 1-800-772-1213.

38.31 = To report a change of address, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

38.32 = Welcome to your new Medicare Summary Notice! It has clear language, larger print, and a personal summary of your claims and deductibles. This improved notice better explains how to get help with your questions, report fraud, or file an appeal. It also includes important information from Medicare!

38.4 = You're at high risk for complications from the flu and it's very important that you get vaccinated. Please contact your healthcare provider about getting the flu vaccine.

38.5 = If you haven't gotten your flu vaccine, it isn't too late. Please contact your health care provider about getting the vaccine.

38.6 = January is cervical cancer prevention month.

38.7 = The Pap test is the most effective way to screen for cervical cancer.

38.8 = Medicare helps pay for screening Pap tests once every two years.

38.9 = Colorectal cancer is the second leading cancer killer in the United States. Medicare helps pay for screening tests that can find polyps before they become cancerous and find cancer early when treatment may work best. Medicare helps pay for screening tests. Talk to your doctor about the screening options that are right for you.

Section 4 End-Stage Renal Disease (ESRD)

4.1 = This charge is more than Medicare pays for maintenance treatment of renal disease.

4.10 = No more than ($_____) can be paid for these supplies each month.

4.11 = The amount listed in the "You May Be

Billed" column is based on the Medicare approved amount. You are not responsible for the difference between the amount charged and the approved amount. This message should be revised to read "Maximum You May Be Billed" (in place of "You May Be Billed") when your MAC implements the new MSN design.

4.12 = This service has been denied/rejected since payment was made to your End Stage Renal Disease (ESRD) dialysis facility.

4.18 = Medicare cannot pay more than $_____ each month for these supplies. The provider cannot bill you for the supplies over this limit.

4.2 = This service is covered up to (insert appropriate number) months after transplant and release from the hospital.

4.3 = Prescriptions for immunosuppressive drugs are limited to a 30-day supply.

4.4 = Only one supplier per month may be paid for these supplies/services.

4.5 = Medicare pays the professional part of this charge to the hospital.

4.6 = Payment has been reduced by the number of days you were not in the usual place of treatment.

4.7 = Payment for all equipment and supplies is made through your dialysis center. They will bill Medicare for these services.

4.8 = This service cannot be paid because you did not choose an option for your dialysis equipment and supplies.

4.9 = Payment was reduced or denied because the monthly maximum allowance for this home dialysis equipment and supplies has been reached.

Section 41 Home Health Messages

41.1 = Medicare will only pay for this service when it is provided in addition to other services.

41.10 = Patients eligible to receive home health benefits from another government agency are not eligible to receive Medicare benefits for the same service.

41.11 = The doctor's orders for home health services were incomplete.

41.12 = According to the medical record, the provider has billed in error for these items/services.

41.13 = The provider has billed for services/

items not documented in your record.
41.14 = This service/item was billed incorrectly.
41.15 = The information provided indicates that you are able to perform personal care activities on your own.
41.16 = To receive Medicare payment, you must have a signed doctor's order before you receive the services.
41.2 = This service must be performed by a nurse who has the required psychiatric nurse credentials.
41.3 = The medical information did not support the need for continued services.
41.4 = Medicare considers this item to be inappropriate for home use.
41.5 = Medicare does not pay for comfort or convenience items.
41.6 = This item was not furnished under a plan of care established by your physician.
41.7 = This item is not considered by Medicare to be a prosthetic and/or orthotic device
41.8 = The information provided indicates that your illness or injury doesn't restrict your ability to leave your home, except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker).
41.9 = Services exceeded those ordered by your physician.

Section 42 Religious Nonmedical Health Care Institutions
42.1 = You received medical care at a facility other than a religious nonmedical health care institution but that care did not revoke your election to receive benefits for religious nonmedical health care.
42.2 = Since you received medical care at a facility other than a religious nonmedical health care institution, benefits for religious nonmedical health care services have been revoked for these services unless you file a new election.
42.3 = This service is not covered since you did not elect to receive religious nonmedical health care services instead of regular Medicare services.
42.4 = This service is not covered because you received medical health care services which revoked your election to religious nonmedical health care services.
42.5 = This service is not covered because you requested in writing that your election

to religious nonmedical health care services be revoked.

Section 5 Number/Name/Enrollment

5.1 = Our records show that you do not have Medicare entitlement under the number shown on this notice. If you do not agree, please contact your local Social Security office.

5.2 = The name or Medicare number was incorrect or missing. Please check your Medicare card. If the information on this notice is different from your card, contact your provider.

5.3 = Our records show that the date of death was before the date of service.

5.4 = If you cash the enclosed check, you are legally obligated to make payment for these services. If you do not wish to assume this obligation, please return this check.

5.5 = Our records show you did not have Part A (B) coverage when you received this service. If you disagree, please contact us at the customer service number shown on this notice.

5.6 = The name or Medicare number was incorrect or missing. Ask your provider to use the name or number shown on this notice for future claims.

5.7 = Medicare payment may not be made for the item or service because on the date of service you were not lawfully present in the United States.

Section 6 Drugs

6.1 = This drug is covered only when Medicare pays for the transplant.

6.2 = Drugs not specifically classified as effective by the Food and Drug Administration are not covered.

6.3 = Payment cannot be made for oral drugs that do not have the same active ingredients as they would have if given by injection.

6.4 = Medicare does not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours after administration of a Medicare covered chemotherapy drug.

6.5 = Medicare cannot pay for this injection because one or more requirements for coverage were not met.

Section 43 Demonstration Project Messages

60.1 = In partnership with physicians in your area, _____ is participating in a Medicare demonstration project that uses a simplified payment method to combine all hospital and physician care related to your hospital service.

2/18/13= Even though this service is being paid in accordance with the rules and guidelines under the Competitive Bidding Demonstration, future claims may be denied when this item is provided to this patient by a non-demonstration supplier. If you would like more information egarding this project, you may contact 1-888-289-0710.

60.11 = These services are covered by a demonstration project or payment model pilot. It will pay for all services related to this hospital stay. If you have already paid a provider for any of these services, you should receive a refund.

60.12 = Your co-payment under this demonstration is the lesser of 20% of the Medicare allowed amount or 20% of the allowed amount under your drug discount card.

60.13 = This claim is being processed under a demonstration project. Services cannot be covered because you do not reside in one of the demonstration areas.

60.14 = This claim is being processed under a demonstration project. Services cannot be covered because your doctor does not have a practice in one of the demonstration areas.

60.15 = Beginning April 1, 2005 through March 31, 2007, Medicare will cover additional chiropractic services. For more information, talk to your chiropractor, call 1-800-MEDICARE, or go to http://www.cms.hhs.gov/researchers/demos/eccs/default.asp.

60.16 = This claim is being processed under a demonstration or payment model pilot. All hospital and doctor services related to your hospital stay have been combined into a single payment. You may have to pay any unmet deductible and coinsurance amounts.

60.2 = The total Medicare approved amount for your hospital service is ($_____). ($_____) is the Part A Medicare amount for hospital services and ($_____) is

the Part B Medicare amount for physician services (of which Medicare pays 80 percent). You are responsible for any deductible and coinsurance amounts represented.

60.3 = Medicare has paid ($_____) for hospital and physician services. Your Part A deductible is ($_____). Your Part A coinsurance is ($_____) Your Part B coinsurance is ($_____).

60.4 = This claim is being processed under a demonstration project.

60.5 = This claim is being processed under a demonstration project. If you would like more information about this project, please contact 1-888-289-0710.

60.6 = A claim has been submitted on your behalf indicating that you are participating in the Medicare Coordinated Care Demonstration project. However, our records indicate that you are not currently enrolled or your enrollment has not yet been approved for the demonstration.

60.7 = A claim has been submitted on your behalf indicating that you are participating in the Medicare Coordinated Care Demonstration project. However, our records indicate that either you have terminated your election to participate in the demonstration project or the dates of service are outside the demonstration participation dates.

60.8 = The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.

60.9 = Our records indicate that this patient began using this service(s) prior to the current round of the DMEPOS Competitive Bidding Demonstration. Therefore, the approved amount is based on the allowance in effect prior to this round of bidding for this item.

Section 7 Duplicate Bills

7.1 = This is a duplicate of a charge already submitted.

7.15 = Medicare records show that payment for this service has already been made by another contractor.

7.2 = This is a duplicate of a claim processed by another contractor. You should receive a Medicare Summary Notice from them.

7.3 = This service/item is a duplicate of a previously processed service. You may only appeal the decision that this service/item is a duplicate. The appeals information on this notice only applies to the duplicate service issue.
7.4 = The claim for the billing fee was denied because it was submitted past the allowed time frame.
7.7 = Your physician has elected to participate in the Competitive Acquisition Program for these drugs. Claims for these drugs must be billed by the appropriate drug vendor instead of your physician.
7.8 = Your physician has elected to participate in the Competitive Acquisition Program (CAP) for Medicare Part B drugs. Medicare cannot pay for the administration of the drug(s) being billed because these drug(s) are not available from the CAP vendor.

Section 8 Durable Medical Equipment (DME)
8.1 = Your supplier is responsible for the servicing and repair of your rented equipment.
8.2 = To receive Medicare payment, you must have a doctor's prescription before you rent or purchase this equipment.
8.10 = Payment is included in the approved amount for other equipment.
8.11 = The purchase allowance has been reached. If you continue to rent this piece of equipment, the rental charges are your responsibility.
8.12 = The approved charge is based on the amount of oxygen prescribed by the doctor
8.13 = Monthly rental payments can be made for up to 15 months from the first paid rental month or until the equipment is no longer needed, whichever comes first.
8.14 = Your equipment supplier must furnish and service this item for as long as you continue to need it. Medicare will pay for maintenance and/or servicing for every 6 month period after the end of the 15th paid rental month.
8.15 = Maintenance and/or servicing of this item is not covered until 6 months after the end of the 15th paid rental month.
8.16 = Monthly allowance includes payment for oxygen and supplies.
8.17 = Payment for this item is included in the monthly rental payment amount.

8.18 = Payment is denied because the supplier did not have a written order from your doctor prior to delivery of this item.
8.19 = Sales tax is included in the approved amount for this item.
8.2 = To receive Medicare payment, you must have a doctor's prescription before you rent or purchase this equipment.
8.20 = Medicare does not pay for this equipment or item.
8.21 = Medicare won't cover this item without a new, revised or renewed certificate of medical necessity.
8.22 = No further payment can be made because the cost of repairs has added up to the purchase price of this item.
8.23 = No payment can be made because the item has reached the 15-month limit. Separate payments can be made for maintenance or servicing every 6 months.
8.24 = The claim doesn't show that you own the equipment requiring these parts or supplies.
8.25 = Payment cannot be made until you tell your supplier whether you want to rent or buy this equipment.
8.26 = Payment is reduced by 25% beginning the 4th month of rental.
8.27 = Payment is limited to 13 monthly rental payments because you have decided to purchase this equipment.
8.28 = Maintenance, servicing, replacement, or repair of this item is not covered.
8.29 = Payment is allowed only for the seat lift mechanism, not the entire chair.
8.3 = This equipment is not covered because its primary use is not for medical purposes.
8.30 = This item is not covered because the doctor did not complete the certificate of medical necessity.
8.31 = Payment is denied because blood gas tests cannot be performed by a durable medical equipment supplier.
8.32 = This item can only be rented for 2 months . If the item is still needed, it must be purchased.
8.33 = This is the next to last payment for this item.
8.34 = This is the last payment for this item.
8.35 = This item is not covered when oxygen is not being used.
8.36 = Payment is denied because the certificate of medical necessity on file was not in effect for this date of service.

8.37 = An oxygen recertification form was sent to the physician.
8.38 = This item must be rented for 2 months before purchasing it.
8.39 = This is the 10th month of rental payment. Your supplier should offer you the choice of changing the rental to a purchase agreement.
8.4 = Payment can't be made for equipment that's the same or similar to equipment already being used.
8.40 = We have previously paid for the purchase of this item.
8.41 = Payment for the amount of oxygen supplied has been reduced or denied because the monthly limit has been reached.
8.42 = Standby equipment is not covered.
8.43 = Payment has been denied because this equipment cannot deliver the liters per minute prescribed by your doctor.
8.44 = Payment is based on a standard item because information did not support the need for a deluxe or more expensive item.
8.45 = Payment for electric wheelchairs is allowed only if the purchase decision is made in the first or tenth month of rental.
8.46 = Payment is included in the allowance for another item or service provided at the same time.
8.47 = Supplies or accessories used with noncovered equipment are not covered.
8.48 = Payment for this drug is denied because the need for the equipment has not been established.
8.49 = This allowance has been reduced because part of this item was paid on another claim.
8.5 = Rented equipment that is no longer needed or used is not covered.
8.50 = Medicare can't pay for this drug/ equipment because our records show that your supplier isn't licensed to dispense prescription drugs, and, therefore, can't assure the safety and effectiveness of the drug/equipment.
8.51 = You are not liable for any additional charge as a result of receiving an upgraded item.
8.52 = You signed an Advanced Beneficiary Notice (ABN). You are responsible for the difference between the upgrade amount and the Medicare payment.
8.53 = This item or service was denied because

the upgrade information was invalid.

8.54 = If a supplier knew that Medicare wouldn't pay and you paid, you might get a refund unless you signed a notice in advance. Refunds may be delayed if the provider appeals. Call your supplier if you don't hear anything within 30 days.

8.55 = Medicare will process your first claim but, from now on, you must use a Medicare-enrolled supplier and put the supplier ID number on your claim. For a list of Medicare-enrolled suppliers call 1-800-MEDICARE or visit www.medicare.gov/supplier

8.56 = Medicare can't process this claim because you were already notified that you must use a supplier who has a Medicare supplier identification number, and this supplier doesn't have one.

8.57 = Your equipment supplier must furnish and service this item for as long as you continue to need it. Medicare will pay for maintenance and/or servicing for every 3-month period after the end of the 15th paid rental month.

8.58 = No payment can be made because the item has reached the 15-month limit. Separate payments can be made for maintenance or servicing every 3 months.

8.59 = Durable Medical Equipment Regional Carriers only pay for Epoetin Alfa and Darbepoetin Alfa for Method II End Stage Renal Disease home dialysis patients.

8.6 = A partial payment has been made because the purchase allowance has been reached. No further rental payments can be made.

8.60 = Payment is denied because there is no hospital stay/surgery on file for implantation of the Durable Medical Equipment (DME) or prosthetic device.

8.61 = This supplier isn't located in your competitive bidding area, but is required to accept the same price as a supplier in your area. This supplier may not charge you more than 20% of the bid price , plus any unmet deductibles.

8.62 = This supplier didn't win a contract for furnishing this item in the competitive bidding area where you received it. This supplier isn't allowed to charge you for this item unless you signed a written notice agreeing to pay before you got the item.

8.63 = This supplier isn't located in your

competitive bidding area, but is located in a different competitive bidding area. This supplier won a contract under national competitive bidding in their area. They must accept the bid price from your area as payment in full, and may not charge you more than 20% of the bid price for your area, plus any unmet deductibles.

8.64 = Monthly payments can be made for 13 months, or until the equipment is no longer needed, whichever comes first. After the 13th month, your supplier must transfer title of this equipment to you.

8.65 = Medicare will pay for medically necessary maintenance and/or servicing as needed after the end of the 13th paid rental month.

8.66 = Medicare has paid for 36 months of rental for your oxygen equipment. Your supplier must transfer title of this equipment to you. No further rental payments will be made. We will continue to pay for delivery of oxygen contents, as appropriate, and necessary maintenance of your equipment.

8.67 = Medicare has already paid for 36 months of rental for your oxygen equipment. The supplier should have transferred the title for the equipment to you. The supplier may not collect any more money from you for this equipment, and must provide you with a refund of any money you have already paid.

8.68 = Medicare will pay for you to rent oxygen for up to 36 months (or until you no longer need the equipment). After Medicare makes 36 payments, your supplier will transfer the title of the equipment to you, and you will own the equipment.

8.69 = Medicare will pay to maintain and service your oxygen equipment. This will start six months after the supplier transfers the title of the equipment to you.

8.7 = This equipment is covered only if rented.

8.70 = The Medicare-approved amount is based on the bid price for this item under the DMEPOS competitive bidding program.

8.71 = Our records show that you began using this item before the current round of competitive bidding and you decided to keep getting this item from your current supplier. The Medicare-approved amount is based on the bid price for this item.

8.72 = This item must be provided by a contract supplier under the DMEPOS competitive bidding program. You should not be billed for this item or service. You do not have to pay this amount. There are no Medicare appeal rights related to this item.
8.73 = The claim for this service was processed according to rules of the DMEPOS competitive bidding program.
8.74 = You signed an Advanced Beneficiary Notice (ABN) saying that you wanted to get this item from a non-winning supplier under the DMEPOS Competitive Bidding Program. Therefore, Medicare will not pay for this item. You must pay the supplier in full.
8.75 = Our records show that you began using this item before competitive bidding started for this item in your area. Because you decided to keep getting this item from your current supplier, this item will be paid at the standard payment amount and not at the bid price.
8.76 = This item or service is not covered because the claim shows that it was not given in a skilled nursing facility or a nursing facility. The claim for this item or service was processed according to the rules of the DMEPOS competitive bidding program.
8.78 = Medicare has paid for 36 months for your oxygen equipment. Your supplier is required to provide the oxygen equipment and related supplies, at no charge, for the remainder of the equipment's 5 year lifetime.
8.79 = Medicare has paid 36 months of rental for your oxygen equipment. The supplier may not collect any more money from you for this equipment, and must refund any money you have already paid.
8.8 = This equipment is covered only if purchased.
8.80 = Medicare will pay for rental of this equipment for 36 months (or until you no longer need the equipment). After 36 months, Medicare will continue to pay for delivery of liquid or gaseous contents, as long as it is still medically necessary.
8.81 = If the provider/supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment

, you may be entitled to a refund of any amounts you paid. However, if the provider/supplier requests a review of this claim within 30 days, a refund is not required until we complete our review . If you paid for this service and do not hear anything about a refund within the next 30 days, contact your provider/ supplier.

8.9 = Payment has been reduced by the amount already paid for the rental of this equipment.

8.90 = You live in a Competitive Bidding Area. This is a Competitive Bidding item. The Medicare approved amount is based on the bid price for this item under the DMEPOS competitive bidding program.

8.91 = Our records show that you began using this item before the DMEPOS Competitive Bidding program began and you decided to keep renting this item from your current supplier. The Medicare-approved amount is based on the bid price for this item for the area where you live.

8.92 = You live in a Competitive Bidding Area and this item must be provided by a Medicare-contract supplier under the DMEPOS competitive bidding program. Medicare won't pay for this item and you shouldn't be billed for this item or service. You don't have to pay this amount. Medicare appeal rights don't apply to this item.

8.93 = Medicare only pays 36 monthly payments for your oxygen. After 36 months, the supplier is still responsible for providing you with that equipment for 5 years. You shouldn't pay any more copayments.

8.95 = Our records show that you began using this item before the DMEPOS Competitive Bidding program started for this item in your area. Because you decided to keep renting this item from your current supplier, this item will be paid at the standard payment amount and not at the bid price.

8.96 = This item or service isn't covered because the claim shows that it wasn't provided in a skilled nursing facility or nursing facility. The claim for this item or service was processed according to the rules of the DMEPOS competitive bidding program.

8.97 = Starting January 1, 2011, you may have to use certain Medicare-contracted suppliers to get certain medical equipment and supplies. Visit www.medicare.gov or call 1-800-MEDICARE for details

Section 9 Failure to Furnish Information
9.1 = The information we requested was not received.
9.2 = This item or service was denied because information required to make payment was missing.
9.3 = Please ask your provider to submit a new, complete claim to us.
9.4 = This item or service was denied because information required to make payment was incorrect.
9.5 = Our records show your doctor did not order this supply or amount of supplies.
9.6 = Please ask your provider to resubmit this claim with a breakdown of the charges or services.
9.7 = We have asked your provider to resubmit the claim with the missing or correct information.
9.8 = The hospital has been asked to submit additional information, you should not be billed at this time.
9.9 = This service is not covered unless the supplier/provider files an electronic media claim (EMC).

Section 96 Jurisdiction-Specific
96.10 = Go paperless, go green! If you live in CT or NY you can stop getting paper Medicare Summary Notices (MSNs) in the mail, and get Electronic MSNs (eMSNs) online instead. To sign up, go to www.mymedicare.gov or call 1-800-MEDICARE (1-800-633-4227).
* See Message Notes ---------->

Section 97 FISS Part A
97.xx = The entire range of 97.xx messages have been blocked off for FISS/Part A usage.

Section 99 Florida-Specific
99.xx = The entire range of 99.xx messages have been blocked off for Florida usage.

CLM_FREQ_TB Claim Frequency Table

0 = Non-payment/zero claims
1 = Admit thru discharge claim
2 = Interim - first claim
3 = Interim - continuing claim (not valid for
PPS claims)
4 = Interim - last claim (not valid for PPS claims)
5 = Late charge(s) only claim
6 = Reserved for national assignment; Adjustment of prior claim.
Obsolete
7 = Replacement of prior claim;
eff 10/93, provider debit
8 = Void/cancel prior claim
eff 10/93, provider cancel
9 = Final claim -- used in an HH PPS
episode to indicate the claim
should be processed like debit/
credit adjustment to RAP (initial
claim) (eff. 10/00)
A = Admission election notice - used when hospice
or Religious Nonmedical Health Care Institution
is submitting the HCFA-1450 as an
admission notice - hospice NOE only
NOTE: This value is not present in the NCH
claims data because when they are used the
transaction does not represent a claim. This
frequency code is used on hospice notices of
election. Their purpose is to create a hospice
benefit period in CWF. No paymentor utilization
is reported on them.
B = Hospice/Medicare Coordinated Care Demonstration/
RNCHI - Termination/Revocation Notice - hospice
NOE only (eff 9/93)
NOTE: This value is not present in the NCH
claims data because when they are used the
transaction does not represent a claim. This
frequency code is used on hospice notices of
election. Their purpose is to create a hospice
benefit period in CWF. No paymentor utilization
is reported on them.
C = Hospice change of provider notice
- hospice NOE only (eff 9/93)
NOTE: This value is not present in the NCH
claims data because when they are used the
transaction does not represent a claim. This
frequency code is used on hospice notices of
election. Their purpose is to create a hospice
benefit period in CWF. No paymentor utilization
D = Hospice/Medicare Coordinated Care Demonstration/
RNHCI - void/cancel
- hospice NOE only (eff 9/93)
NOTE: This value is not present in the NCH
claims data because when they are used the
transaction does not represent a claim. This

frequency code is used on hospice notices of election. Their purpose is to create a hospice benefit period in CWF. No paymentor utilization

E = Hospice change of ownership - hospice NOE only (eff 1/97)
NOTE: This value is not present in the NCH claims data because when they are used the transaction does not represent a claim. This frequency code is used on hospice notices of election. Their purpose is to create a hospice benefit period in CWF. No paymentor utilization

F = Beneficiary initiated adjustment claim (eff 10/93)

G = CWF initiated adjustment claim (eff 10/93)

H = CMS initiated adjustment claim (eff 10/93)

I = Intermediary adjustment claim (other than PRO or provider) - used to identify a debit adjustment initiated by CMS or an intermediary (other than QIO or Provider) - eff 10/93, used to identify intermediary initiated adjustment only

J = Other adjustment request (eff 10/93)

K = OIG initiated adjustment (eff 10/93)

M = MSP initiated adjustment (eff 10/93)

N = Reserved for national assignment

O = Nonpayment/Zero claims

P = Adjustment required by Quality Improvement Organization (QIO) -- formerly Peer Review Organization (PRO)

Q = Claim Submitted for Reconsideration Outside of Timely Limits

X = Replacement of Prior Abbreviated Encounter Submission (used by Medicare Advantage contractor or other plan required to submit encounter data); Special adjustment processing - used for QA editing (eff 8/92) Obsolete

Z = New Abbreviated Encounter Submission (TOB '11Z') used for MCO enrollee hospital discharges 7/1/97 - 12/31/98; not stored in the NCH. Exception: Problem in startup months may have resulted in this abbreviated UB-92 being erroneously stored in the NCH.

CLM_HHA_LUPA_IND_TB Claim HHA Low Utilization Payment Adjustment (LUPA) Indicator Code Table

L = LUPA claim
BLANK = Not a LUPA claim

CLM_HHA_RFRL_TB Claim Home Health Referral Table

1 = Physician referral - The patient was admitted upon the recommendation of a personal physician.
2 = Clinic referral - The patient was admitted upon the recommendation of this facility's clinic physician.
3 = HMO referral - The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician.
4 = Transfer from hospital - The patient was admitted as an inpatient transfer from an acute care facility.
5 = Transfer from a skilled nursing facility (SNF) - The patient was admitted as an inpatient transfer from a SNF.
6 = Transfer from another health care facility - The patient was admitted as a transfer from a health care facility other than an acute care facility or SNF.
7 = Emergency room - The patient was admitted upon the recommendation of this facility's emergency room physician.
8 = Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative.
9 = Information not available - The means by which the patient was admitted is not known.
A = Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.
B = Transfer from another HHA - Beneficiaries are permitted to transfer from one HHA to another unrelated HHA under HH PPS. (eff. 10/00)
C = Readmission to same HHA - If a beneficiary is discharged from an HHA and then re-admitted within the original 60-day episode, the original episode must be closed early and a new one 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)

CLM_HIPPS_TB Claim SNF, HHA & IRF Health Insurance PPS Table

****
Please refer to the CMS website for the latest information
on the HIPPS Codes. The URL is
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/
ProspMedicareFeeSvcPmtGen/HIPPSCodes.html
(paste into browser address bar without any spaces)
****

CLM_MASS_ADJSTMT_IND_CD_TB Claim Mass Adjustment Indicator Code Table

I = Mass Adjustment (Incarcerated Beneficiary)
M = Mass Adjustment (MPFS)
O = Mass Adjustment (Other)

CLM_MCO_PD_TB Claim MCO Paid Switch Code Table

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

CLM_MDCD_INFO_TB Claim Medicaid Information Table

164 = Number of attachments submitted
166 = Abortion/sterilization code
167 = Child Health Assurance Program Referral Code
168 = Civilian Health and Medical Program of the
Uniformed Services Code

CLM_MDCR_NPMT_RSN_TB Claim Medicare Non-Payment Reason Table

Valid Values effective 1/2011 (2-byte values are replacing
the character values)
A = Covered worker's compensation (Obsolete)
B = Benefit exhausted
C = Custodial care - noncovered care
(includes all 'beneficiary at fault'
waiver cases) (Obsolete)
E = HMO out-of-plan services not emergency
or urgently needed (Obsolete)
E = MSP cost avoided - IRS/SSA/HCFA Data
Match (eff. 7/00)
F = MSP cost avoid HMO Rate Cell (eff. 7/00)
G = MSP cost avoided Litigation Settlement
(eff. 7/00)

H = MSP cost avoided Employer Voluntary
Reporting (eff. 7/00)
J = MSP cost avoid Insurer Voluntary
Reporting (eff. 7/00)
K = MSP cost avoid Initial Enrollment
Questionnaire (eff. 7/00)
N = All other reasons for nonpayment
P = Payment requested
Q = MSP cost avoided Voluntary Agreement
(eff. 7/00)
R = Benefits refused, or evidence not
submitted
T = MSP cost avoided - IEQ contractor
(eff. 9/76) (obsolete 6/30/00)
U = MSP cost avoided - HMO rate cell
adjustment (eff. 9/76) (Obsolete 6/30/00)
V = MSP cost avoided - litigation
settlement (eff. 9/76) (Obsolete 6/30/00)
W = Worker's compensation (Obsolete)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data
match project (obsolete 6/30/00)
Z = Zero reimbursement RAPs -- zero reimbursement
made due to medical review intervention or
where provider specific zero payment has been
determined. (effective with HHPPS - 10/00)
00 = MSP cost avoided - COB Contractor
12 = MSP cost avoided - BCBS Voluntary Agreements
13 = MSP cost avoided - Office of Personnel Management
14 = MSP cost avoided - Workman's Compensation (WC) Datamatch
15 = MSP cost avoided - Workman's Compensation Insurer Voluntary
Data Sharing Agreements (WC VDSA) (eff. 4/2006)
16 = MSP cost avoided - Liability Insurer VDSA (eff. 4/2006)
17 = MSP cost avoided - No-Fault Insurer VDSA (eff. 4/2006)
18 = MSP cost avoided - Pharmacy Benefit Manager Data
Sharing Agreement (eff. 4/2006)
19 = MSP cost avoided - Worker's Compensation Medicare Set-Aside
Arrangement
21 = MSP cost avoided - MIR Group Heqalth Plan (eff. 1/2009)
22 = MSP cost avoided - MIR non-Group Health Plan (eff. 1/2009)
25 = MSP cost avoided - Recovery Audit Contractor - California
(eff. 10/2005)
26 = MSP cost avoided - Recovery Audit Contractor - Florida
(eff. 10/2005)
39 = MSP cost avoided - GHP Recovery
41 = MSP cost avoided - NGHP Non-ORM
42 = MSP cost avoided - NGHP ORM Recovery
43 = MSP cost avoided - COBC/Medicare Part C/Medicare Advantage

Prior to 1/2011, the character values below were used to
represent the 2-byte values

NOTE: Effective 4/1/02, the Medicare nonpayment reason
code was expanded to a 2-byte field. The NCH instituted

a crosswalk from the 2-byte code to a 1-byte character code. Below are the character codes (found in NCH & NMUD). At some point, NMUD will carry the 2-byte code but NCH will continue to have the 1-byte character code.

! = MSP cost avoided - COB Contractor ('00' 2-byte code)
@ = MSP cost avoided - BC/BS Voluntary Agreements ('12' 2-byte code)
# = MSP cost avoided - Office of Personnel Management ('13' 2-byte code)
$ = MSP cost avoided - Workman's Compensation (WC) Datamatch ('14' 2-byte code)
* = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) ('15' 2-byte code) (eff. 4/2006)
(= MSP cost avoided - Liability Insurer VDSA ('16' 2-byte code) (eff. 4/2006)
) = MSP cost avoided - No-Fault Insurer VDSA ('17' 2-byte code) (eff. 4/2006)
+ = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement ('18' 2-byte code) (eff. 4/2006)
< = MSP cost avoided - MIR Group Health Plan ('21' 2-byte code) (eff. 1/2009)
> = MSP cost avoided - MIR non-Group Health Plan ('22' 2-byte code) (eff. 1/2009)
% = MSP cost avoided - Recovery Audit Contractor - - California ('25' 2-byte code) (eff. 10/2005)
& = MSP cost avoided - Recovery Audit Contractor - Florida ('26' 2-byte code) (eff. 10/2005)

CLM_OCRNC_SPAN_TB Claim Occurrence Span Table

70 = Qualifying Stay Dates for SNF Use Only - the from/through dates of at least a 3-day inpatient hospital stay that qualifies the resident for Medicare payment of SNF services billed. Code can only be used by SNF for billing.
71 = Hospital prior stay dates - the from/thru dates of any hospital stay that ended within 60 days of this hospital or SNF admission.
72 = First/last visit - the dates of the first and last visits occurring in this billing period if the dates are different from those in the statement covers period.
73 = Benefit eligibility period - the inclusive dates during which CHAMPUS medical benefits are available to a sponsor's bene as shown on the bene's ID card.

74 = Non-covered level of care - The from/
thru dates of a period at a noncovered
level of care in an otherwise
covered stay, excluding any period
reported with occurrence span code 76,
77, or 79.
75 = The from/thru dates of SNF level of care
during IP hospital stay. Shows PRO approval
of patient remaining in hospital
because SNF bed not available.
not applicable to swing bed
cases. PPS hospitals use in day
outlier cases only.
76 = Patient liability - From/thru
dates of period of noncovered care
for which hospital may charge
bene. The FI or PRO must have
approved such charges in advance.
patient must be notified in writing
3 days prior to noncovered period
77 = Provider liability (utilization charged) -
The from/thru dates of period of noncovered
care for which the provider is liable.
Eff 3/92, applies to provider liability
where bene is charged with utilization
and is liable for deductible/coinsurance
78 = SNF prior stay dates - The from/
thru dates of any SNF stay that
ended within 60 days of this hospital
or SNF admission.
79 = Provider Liability (non-utilization) (Payer code) -
Eff 3/92, from/thru dates of
period of noncovered care where
bene is not charged with utilization,
deductible, or coinsurance.
and provider is liable.
Eff 9/93, noncovered period of care
due to lack of medical necessity.
80 = Prior Same-SNF Stay Dates for Payment
Ban Purposes - the from/thru dates of a
prior same-SNF stay indicating a patient
resided in the SNF prior to, and if
applicable, during a payment ban period
up until their discharge to a hospital.
81 = Antepartum Days (CR7716) - eff. 7/2/12
82 - 99 = Reserved for state assignment
M0 = QIO/UR approved stay dates - Eff 10/93,
the first and last days that were
approved where not all of the stay was
approved.
M1 = Provider Liability-No Utilization -- from/
thru dates of a period of noncovered care
that is denied due to lack of medical
necessity or custodial care for which the

provider is liable. (eff. 10/01)
M2 = Dates of Inpatient Respite Care -- from/thru
dates of a period of inpatient respite care
for hospice patients. (eff. 10/00)
M3 = ICF Level of Care -- the from/through dates
of a period of intermediate level of care
during an inpatient hospital stay.
M4 = Residential Level of Care - The from/through
dates of a period of residential level of
care during an inpatient hospital stay.

CLM_PPS_IND_TB Claim PPS Indicator Table

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

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

Effective NCH weekly process date 6/5/98

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

CLM_PRCR_RTRN_TB Claim Pricer Return Code Table

*******Home Health Pricer Return Codes**********
*****TOB 32X or 33X, DOS 10/1/2000 and after******

Home Health Payment Return Codes:
00 = Final payment where no outlier applies
01 = Final payment where outlier applies
03 = Initial percentage payment, 0%
04 = Initial percentage payment, 50%
05 = Initial percentage payment, 60%
06 = LUPA payment only
07 = Final payment, SCIC
08 = Final payment, SCIC with outlier
09 = Final payment, PEP
11 = Final payment, PEP with outlier
12 = Final payment, SCIC within PEP
13 = FInal payment, SCIS within PEP with outlier

Home Health Error Return Codes:
10 = Invalid TOB

15 = Invalid PEP Days
16 = Invalid HRG Days, >60
20 = PEP indicator invalid
25 = Med review indicator invalid
30 = Invalid MSA code
35 = Invalid Initial Payment Indicator
40 = Dates < October 1, 2000 or invalid
70 = Invalid HRG Code
75 = No HRG present in 1st occurrence
80 = Invalid Revenue code
85 = No revenue code present on HH final claim/
adjustment

*********Hospice Pricer Return Codes**********
**********TOB 81X or 82X**********

Hospice Payment Return Codes:
00 = Home rate returned

Hospice Error Return Codes:
10 = Bad units
20 = Bad units2 < 8
30 = Bad MSA code
40 = Bad hospice wage index from MSA file
50 = Bad bene wage index from MSA file
51 = Bad provider number

**********SNF Pricer Return Codes*********
**********TOB 21X**********

SNF Payment return codes:
00 = RUG III group rate returned

SNF Error return codes:
20 = Bad RUG code
30 = Bad MSA code
40 = Thru date < July 1, 1998 or invalid
50 = Invalid Federal blend for that year
60 = Invalid Federal blend
61 = Federal blend = 0 and SNF thru date < January
1, 2000

****Inpatient Hospital Pricer Return Codes******
**********TOB 11X**********

Inpatient Hospital Payment return codes:
00 = Paid normal DRG payment
01 = Paid as a day outlier (Note: day outlier no longer
being paid as of 10/1/97)
02 = Paid as a cost outlier
03 = Transfer paid on a per diem basis up to and
including the ful DRG
05 = Transfer paid on a per diem basis up to and
including the full DRG which also qualified

for a cost outlier payment
06 = Provider refused cost outlier
10 = DRG is 209, 210, or 211 and post-acute transfer
12 = Post-acute transfer with specific DRGs. The following DRG's: 14, 113, 236, 263, 264, 429, 483
14 = Paid normal DRG payment with per diem days = or > GM ALOS
16 = Paid as a cost outlier with per diem days = or > GM ALOS

Inpatient Hospital Error return codes:
51 = No provider specific information found
52 = Invalid MSA# in provider file
53 = Waiver state - not calculated by PPS
54 = DRG < 001 or > 511, or = 214, 215, 221, 222, 438, 456, 457, 458
55 = Discharge date < provider effective start date or discharge date < MSA effective start date for PPS
56 = Invalid length of stay
57 = Review code invalid (Not 00, 03, 06, 07, 09)
58 = Total charges not numeric
61 = Lifetime reserve days not numeric or BILL-LTR-DAYS > 60
62 = Invalid number of covere days
65 = PAY-CODE not = A, B or C on provider specific file for capital
67 = Cost outlier with LOS > covered days

**********Outpatient PPS Pricer Return Codes******

Outpatient PPS Payment return codes:
01 = Line processed to payment
20 = Line processed but payment = 0 bene deductible = > adjusted payment

Outpatient PPS Error return codes:
30 = Missing, deleted or invalid APC
38 = Missing or invalid discount factor
40 = Invalid service indicator passed by the OCE
41 = Service indicator invalid for OPPS PRICER
42 = APC = '00000' or (packaging flag = 1 or 2)
43 = Payment indicator not = to 1 or 5 thru 9
44 = Service indicator = 'H' but payment indicator not = to 6
45 = Packaging flag not = to 0
46 = Line item denial/reject flag not = to 0 or line item denial/reject flag = to 1 and (APC not = 0033 or 0034 or 0322 or 0323 or 0324 or 0325 or 0373 or 0374)) or line item action flag not = to 1
47 = Line item action flag = 2 or 3
48 = Payment adjustment flag not valid
49 = Site of service flag not = to 0 or (APC 0033 is not

on the claim and service indicator = 'P' or APC = 0322, 0325, 0373, 0374)
50 = Wage index not located
51 = Wage index equals zero
52 = Provider specific file wage index reclassification code invalid or missing
53 = Service from date not numeric or < 20000801
54 = Service from date < provider effective date or service from date > provider termination date

Inpatient Rehab Facility (IRF) Pricer Return Codes

IRF Payment return codes:
00 = Paid normal CMG payment without outlier
01 = Paid normal CMG payment with outlier
02 = Transfer paid on a per diem basis without outlier
03 = Transfer paid on a per diem basis with outlier
04 = Blended CMG payment -- 2/3 Federal PPS rate + 1/3 provider specific rate -- without outlier
05 = Blended CMG payment -- 2/3 Federal PPS rate + 1/3 provider specific rate -- with outlier
06 = Blended transfer payment -- 2/3 Federal PPS transfer rate + 1/3 provider specific rate -- without outlier
07 = Blended transfer payment -- 2/3 Federal PPS transfer rate + 1/3 provider specific rate -- with outlier
10 = Paid normal CMG payment with penalty without outlier
11 = Paid normal CMG payment with penalty with outlier
12 = Transfer paid on a per diem basis with penalty without outlier
13 = Transfer paid on a per diem basis with penalty with outlier
14 = Blended CMG payment -- 2/3 Federal PPS rate + 1/3 provider specific rate -- with penalty without outlier
15 = Blended CMG payment -- 2/3 Federal PPS rate + 1/3 provider specific rate -- with penalty with outlier
16 = Blended transfer payment -- 2/3 Federal PPS transfer rate + 1/3 provider specific rate -- with penalty without outlier
17 = Blended transfer payment -- 2/3 Federal PPS transfer rate + 1/3 provider specific rate -- with penalty with outlier

IRF Error return codes:
50 = Provider specific rate not numeric
51 = Provider record terminated
52 = Invalid wage index
53 = Waiver state - not calculated by PPS
54 = CMG on claim not found in table

55 = Discharge date < provider effective start
date or discharge date < MSA effective start
date for PPS
56 = Invalid length of stay
57 = Provider specific rate zero when blended payment
requested
58 = Total covered charges not numeric
59 = Provider specific record not found
60 = MSA wage index record not found
61 = Lifetime reserve days not numeric or
BILL-LTR-DAYS > 60
62 = Invalid number of covered days
65 = Operating cost-to-charge ratio not numeric
67 = Cost outlier with LOS > covered days or cost
outlier threshold calculation
72 = Invalid blend indicator (not 3 or 4)
73 = Discharged before provider FY begin date
74 = Provider FY begin date not in 2002

Long Term Care Hospital (LTCH) Pricer Return Codes

LTCH Payment return codes:
00 = Normal DRG payment without outlier
01 = Normal DRG payment with outlier
02 = Short stay payment without outlier
03 = Short stay payment with outlier
04 = Blend year 1 - 80% facility rate plus 20%
normal DRG payment without outlier
05 = Blend year 1 - 80% facility rate plus 20%
normal DRG payment with outlier
06 = Blend year 1 - 80% facility rate plus 20%
short stay payment without outlier
07 = Blend year 1 - 80% facility rate plus 20%
short stay payment with outlier
08 = Blend year 2 - 60% facility rate plus 40%
normal DRG payment without outlier
09 = Blend year 2 - 60% facility rate plus 40%
normal DRG payment with outlier
10 = Blend year 2 - 60% facility rate plus 40%
short stay payment without outlier
11 = Blend year 2 - 60% facility rate plus 40%
short stay payment with outlier
12 = Blend year 3 - 40% facility rate plus 60%
normal DRG payment without outlier
13 = Blend year 3 - 40% facility rate plus 60%
normal DRG payment with outlier
14 = Blend year 3 - 40% facility rate plus 60%
short stay payment without outlier
15 = Blend year 3 - 40% facility rate plus 60%
short stay payment with outlier
16 = Blend year 4 - 20% facility rate plus 80%
normal DRG payment without outlier
17 = Blend year 4 - 20% facility rate plus 80%
normal DRG payment with outlier

18 = Blend year 4 - 20% facility rate plus 80%
short stay payment without outlier
19 = Blend year 4 - 20% facility rate plus 80%
short stay payment with outilier

LTCH Error return codes:
50 = Provider specific rate not numeric
51 = Provider record terminated
52 = Invalid wage index
53 = Waiver state - not calculated by PPS
54 = DRG on claim not found in table
55 = Discharge date < provider effective start date
or discharge date < MSA effective start date
for PPS
56 = Invalid length of stay
57 = Provider specific rate zero when blended payment
requested
58 = Total covered charges not numeric
59 = Provider specific record not found
60 = MSA wage index record not found
61 = Lifetime reserve days not numeric or BILL-LTR-DAYS
> 60
62 = Invalid number of covered days
65 = Operating cost-to-charge ratio not numeric
67 = Cost outlier with LOS > covered days or cost
outlier threshold calculation
72 = Invalid blend indicator (not 1 thru 5)
73 = Discharged before provider FY begin date
74 = Provider FY begin date not in 2002

End Stage Renal Disease (ESRD) Pricer Return Codes

ESRD Payment return codes:
00 = ESRD PPS payment calculated
01 = ESRD facility rate > zero

ESRD Error return codes:
50 = ESRD facility rate not numeric
52 = Provider type not = '40' or '41'
53 = Special payment indicator not = '1'
or blank
54 = Date of birth not numeric or = zero
55 = Patient weight not numeric or = zero
56 = Patient height not numeric or = zero
57 = Revenue center code not in range
58 = Condition code not = '73' or '74' or blank
60 = MSA wage adjusted rate record not found
98 = Claim through date before 4/1/2005 or not numeric

CLM_PRVDR_VLDTN_TB Claim Provider Validation Code Table

RP = Rendering Provider

OP = Operating Physician
CP = Ordering/Referring Physician
AP = Attending Physician
FA = Facility

CLM_PTNT_RLTNSHP_TB Claim Patient Relationship Table

01 = Spouse
04 = Grandparent
05 = Grandchild
07 = Niece/Nephew
10 = Foster child
15 = Ward of the court
17 = Step child
18 = Patient is insured
19 = Natural child/insured financial responsibility
20 = Employee
21 = Unknown
22 = Handicapped dependent
23 = Sponsored dependent
24 = Minor dependent of a minor dependent
32 = Mother
33 = Father
39 = Organ donor
40 = Cadaver donor
41 = Injured plaintiff
43 = Natural child/insured does not have financial responsibility

CLM_PWK_TB Claim Paperwork Code Table

P1 = one iteration is present
P2 = two iterations are present
P3 = three iterations are present
P4 = four iterations are present
P5 = five iterations are present
P6 = six iterations are present
P7 = seven iterations are present
P8 = eight iterations are present
P9 = nine iterations are present
P0 = ten iterations are present

CLM_QUERY_TB Claim Query Table

0 = Credit adjustment
1 = Interim bill
2 = Home Health Agency (HHA) benefits
exhausted (obsolete 7/98)

3 = Final bill
4 = Discharge notice (obsolete 7/98)
5 = Debit adjustment

CLM_RAC_ADJSTMT_TB Recovery Audit Contractor (RAC) Adjustment Indicator Table

R = RAC adjusted claim
Spaces

CLM_RLT_COND_TB Claim Related Condition Table

01 = Military service related - Medical condition incurred during military service.
02 = Employment related - Patient alleged that the medical condition causing this episode of care was due to environment/ events resulting from employment.
03 = Patient covered by insurance not reflected here - Indicates that patient or patient representative has stated that coverage may exist beyond that reflected on this bill.
04 = Information Only Bill - Health Maintenance Organization (HMO) enrollee - Medicare 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 30 months of entitlement covered by employer group health insurance - indicates Medicare may be secondary insurer. Eff 3/1/96, ESRD patient in 1st 30 months of entitlement covered by employer group health insurance.
07 = Treatment of nonterminal condition for hospice patient - The patient is a hospice enrollee, but the provider is not treating a terminal condition and is requesting Medicare reimbursement.
08 = Beneficiary would not provide information concerning other insurance coverage.
09 = Neither patient nor spouse is employed - Code indicates that in response to development questions, the patient and spouse have denied employment.
10 = Patient and/or spouse is employed but

no EGHP coverage exists or (eff 9/93) other employer sponsored/provided health insurance covering patient.

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

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

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

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

15 = Payer code - reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them. Prior to 3/07, clean claim (eff 10/92) OBSOLETE

16 = Payer code - reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them. Prior to 3/07. SNF transition exemption - An exemption from the post-hospital requirement applies for this SNF stay for the qualifying stay dates are more than 30 days prior to the admission date. OBSOLETE

17 = Patient is homeless (eff. 3/07). Prior to 3/07, code indicated Patient is over 100 years old - patient was over 100 years old at the date of admission.

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

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

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

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

22 = Patient on multiple drug regimen - A patient who is receiving multiple intravenous drugs while on home IV therapy
23 = Homecaregiver available - The patient has a caregiver available to assist him or her during self-administration of an intravenous drug
24 = Home IV patient also receiving HHA services - the patient is under care of HHA while receiving home IV drug therapy services
25 = Patient is Non-U.S. resident
26 = VA eligible patient chooses to receive services in Medicare certified facility rather than a VA facility (eff 3/92)
27 = Patient referred to a sole community hospital for a diagnostic laboratory test - (sole community hospital only). (eff 9/93)
28 = Patient and/or spouse's EGHP is secondary to Medicare - Qualifying EGHP for employers who have fewer than 20 employees. (eff 9/93)
29 = Disabled beneficiary and/or family member's LGHP is secondary to Medicare - Qualifying LGHP for employer having fewer than 100 full and part-time employees
30 = Qualifying Clinical Trials - Non-research services provided to all patients, in-cluding managed care enrollees, enrolled in a Qualified Clinical Trial.
31 = Patient is student (full time - day) - Patient declares that he or she is enrolled as a full time day student.
32 = Patient is student (cooperative/work study program)
33 = Patient is student (full time - night) - Patient declares that he or she is enrolled as a full time night student.
34 = Patient is student (part time) - Patient declares that he or she is enrolled as a part time student.
36 = General care patient in a special unit - Patient is temporarily placed in special care unit bed because no general care beds were available.
37 = Ward accommodation is patient's request - Patient is assigned to ward accommodations at patient's request.
38 = Semi-private room not available - Indicates that either private or ward

accommodations were assigned because semi-private accomodations were not available.
39 = Private room medically necessary - Patient needed a private room for medical reasons.
40 = Same day transfer - Patient transferred to another facility before midnight of the day of admission.
41 = Partial hospitalization - Eff 3/92, indicates claim is for partial hospitalization services. For OP services, this includes a variety of psych programs.
42 = Continuing Care Not Related to Inpatient Admission - continuing care not related to the condition or diagnosis for which the beneficiary received inpatient hospital services. (eff. 10/01)
43 = Continuing Care Not Provided Within Prescribed Postdischarge Window - continuing care was related to the inpatient admission but the prescribed care was not provided within the post-discharge window.(eff. 10/01)
44 = Inpatient Admission Changed to Outpatient - For use on outpatient claims only, when the physician ordered inpatient services, but upon internal review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria. (eff. 4/1/04)
45 = Ambiguous Gender Category - claim indicates patient has ambiguous gender characteristics (e.g. transgendered or hermaphordite).
46 = Nonavailability statement on file for CHAMPUS claim for nonemergency IP care for CHAMPUS bene residing within the catchment area (usually a 40 mile radius) of a uniform services hospital.
47 = Transfer from another Home Health Agency. (eff. 7/1/10)
48 = Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)
49 = Product Replacement within Product Lifecycle-replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly (eff. 4/2006)
50 = Product Replacement for Known Recall of a Product - Manufacturer or FDA has identified the product for recall and therefore replacement. (eff. 4/2006)
51 = Reserved for national assignment.

52 = Used to indicate a discharge due to the patient's unavailability/inability to receive hospice services from the hospice which has been responsible for the patient. (effective 7/2/12 - CR7677)
53 = Reserved for national assignment.
54 = No skilled HH visits in billing period (eff. 7/2016)
55 = SNF bed not available - The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56 = Medical appropriateness - Patient's SNF admission was delayed more than 30 days after hospital discharge because physical condition made it inappropriate to begin active care within that period
57 = SNF readmission - Patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
58 = Payment of SNF claims for beneficiaries disenrolling from terminating M+C plans plans who have not met the 3-day hospital stay requirement (eff. 10/1/00)
59 = Non-primary ESRD facility - code indicates that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.
60 = Operating cost day outlier - A hospital being paid under a prospective payment system (PPS) is reporting this stay as a day outlier.
61 = Operating cost cost outlier - A hospital is being paid under a prospective payment system (PPS) is requesting additional payment for this stay as a cost outlier.
62 = Payer Code - providers do not report this code. PIP bill - This bill is a periodic interim payment bill. Obsolete
63 = Payer Code - providers do not report this code. PRO denial received before batch clearance report - The HCSSACL receipt date is used on PRO adjustment if the PRO's notification is before orig bill's acceptance report. (Payer only code eff 9/93)
64 = Payer Code - providers do not report this code. Other than cleam claim - the claim is not a 'clean claim'. Obsolete
65 = Payer Code - Providers do not report this code. Non-PPS code - The bill is not a prospective payment system bill. Obsolete
66 = Outlier not claimed - Bill may meet the criteria for cost outlier, but the hospital did not claim the cost outlier

(PPS)
67 = Beneficiary elects not to use LTR days
68 = Beneficiary elects to use LTR days
69 = IME/DGME/N&AH Payment Only - providers request for supplemental IME/DGME/N&AH payment for each discharge of MCO enrollee, beginning 1/1/98, from teaching hospitals (facilities with approved medical residency training program); not stored in NCH. Exception: problem in startup year may have resulted in this special IME payment request being erroneously stored in NCH. If present, disregard claim as condition code '69' is not valid NCH claim.
70 = Self-administered EPO - Billing is for a home dialysis patient who self administers EPO.
71 = Full care in unit - Billing is for a patient who received staff assisted dialysis services in a hospital or renal dialysis facility.
72 = Self care in unit - Billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
73 = Self care training - Billing is for special dialysis services where the patient and helper (if necessary) were learning to perform dialysis.
74 = Home - Billing is for a patient who received dialysis services at home.
75 = Home 100% reimbursement - (not to be used for services after 4/15/90) The billing is for home dialsis patient using a dialysis machine that was purchased under the 100% program.
76 = Back-up facility - Billing is for a patient who received dialysis services 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 = Home Dialysis - Nursing Facility - Home dialysis furnished in a SNF or nursing

facility. (eff. 4/4/05)
81 - 99 = Reserved for state assignment.
85 = Delayed Recertification of Hospice Terminal Illness (eff. 1/2017)
89 = Opioid Treatment Program (OTP) - indicates claim is for opioid treatement services (eff. 1/2021)
90 = Service provided as part of an Expanded Access Approval (EA) to the IPPS Pricer. Code is for Inpatient and Outpatient claims that have reported Expanded Access (EA) services. Eff. 7/2021
91 = Service provided as part of an an Emergency Use Authorization (EUA) to the IPPS Pricer. Code is for Inpatient and Outpatient claims that have reported Emergency Use Authorization (EUA) services. Eff. 7/2021
A0 = TRICARE External Partnership Program - This code identifies TRICARE claims submitted under the External Partnership Program.
A0 = Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (eff. 9/01) Obsolete
A0 = CHAMPUS external partnership program special program indicator code. (eff 10/93) (obsolete)
A1 = EPSDT/CHAP - Early and periodic screening diagnosis and treatment special program indicator code. (eff 10/93)
A2 = Physically handicapped children's program - Services provided receive special funding through Title 8 of the Social Security Act or the CHAMPUS program for the handicapped. (eff 10/93)
A3 = Special federal funding - Designed for uniform use by state uniform billing committees.
Special program indicator code (eff 10/93)
A4 = Family planning - Designed for uniform use by state uniform billing committees.
Special program indicator code (eff 10/93)
A5 = Disability - Designed for uniform use by state uniform billing committees.
Special program indicator code (eff 10/93)
A6 = PPV/Medicare 100% Payment - Identifies that pneumococcal pneumonia 100% payment vaccine (PPV) services should be reimbursed under a special Medicare program provision.
Special program indicator code (eff 10/93)
A7 = Induced abortion to avoid danger to

woman's life. (terminated)
Special program indicator code (eff 10/93)
A7 = Hospital services provided in a mobile facility or with portable units (eff. 4/2020)
A8 = Induced abortion - Victim of rape/ incest.
Special program indicator code (eff 10/93)
A9 = Second opinion surgery - Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.
Special program indicator code (eff 10/93)
AA = Abortion Performed due to Rape (eff. 10/1/02)
AB = Abortion Performed due to Incest (eff. 10/1/02)
AC = Abortion Performed due to Serious Fetal Genetic Defect, Deformity or Abnormality (eff. 10/1/02)
AD = Abortion Performed due to a Life Endangering Physical Condition Caused by, arising from or exacerbated by the Pregnancy itself (eff. 10/1/02)
AE = Abortion Performed due to physical health of mother that is not life endangering (eff. 10/1/02)
AF = Abortion Performed due to emotional/ psychological health of mother (eff. 10/1/02)
AG = Abortion performed due to social economic reasons (eff. 10/1/02)
AH = Elective Abortion (eff. 10/1/02)
AI = Sterilization (eff. 10/1/02)
AJ = Payer Responsible for copayment (4/1/03)
AK = Air Ambulance Required - For ambulance claims. Time needed to transport poses a threat. (eff. 10/16/03)
AL = Specialized Treatment/bed Unavailable - For ambulance claims. Specialized treatment bed unavailable. Transported to alternate facility. (eff. 10/16/03)
AM = Non-emergency Medically Necessary Stretcher Transport Required - For ambulance claims. Non-emergency medically necessary stretcher transport required. (eff. 10/16/03)
AN = Preadmission Screening Not Required - person meets the criteria for an exemption from preadmission screening. (eff. 1/1/04)
B0 = Medicare Coordinated Care Demonstration Program - patient is a participant in a Medicare Coordinated Care Demonstration (eff. 10/01)
B1 = Beneficiary ineligible for demonstration program (eff. 10/01).
B2 = Critical Access Hospital Ambulance Attestation - Attestation by CAH that it meets the criteria for exemption from the Ambulance Fee Schedule

B3 = Pregnancy Indicator - Indicates the patient is pregnant. Required when mandated by law. (eff. 10/16/03)
B4 = Admission Unrelated to Discharge - Admission unrelated to discharge on same day. This code is for discharges starting on January 1, 2004.
B5 = Special program indicator
Reserved for national assignment.
B6 = Special program indicator
Reserved for national assignment.
B7 = Special program indicator
Reserved for national assignment.
B8 = Special program indicator
Reserved for national assignment.
B9 = Special program indicator
Reserved for national assignment.
BP = Gulf Oil Spill of 2010 - The code identifies claims where the provision of all services on the claim are related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico and/or circumstances related to such spill, including but not limited to subsequent clean-up activites.
C0 = Reserved for national assignment.
C1 = Approved as billed - The services provided for this billing period have been reviewed by the QIO/UR or intermediary and are fully approved including any day or cost outlier. (eff 10/93)
NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C2 = Automatic approval as billed based on focused review. (No longer used for Medicare)
QIO approval indicator services (eff 10/93)
NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C3 = Partial approval - The services provided for this billing period have been reviewed by the QIO/UR or intermediary and some portion has been denied (days or services). (eff 10/93)
NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C4 = Admission/services denied - Indicates that all of the services were denied by the QIO/UR.
QIO approval indicator services (eff 10/93)

NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C5 = Postpayment review applicable - QIO/UR review to take place after payment.
QIO approval indicator services (eff 10/93)
NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C6 = Admission preauthorization - The QIO/UR authorized this admission/ service but has not reviewed the services provided.
QIO approval indicator services (eff 10/93)
NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C7 = Extended authorization - the QIO has authorized these services for an extended length of time but has not reviewed the services provided.
QIO approval indicator services (eff 10/93)
NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C8 = Reserved for national assignment.
QIO approval indicator services (eff 10/93)
C9 = Reserved for national assignment.
QIO approval indicator services (eff 10/93)
D0 = Changes to service dates.
Change condition (eff 10/93)
D1 = Changes in charges.
Change condition (eff 10/93)
D2 = Changes in revenue codes/HCPCS/HIPPS Rate Code
Change condition (eff 10/93)
D3 = Second or subsequent interim PPS bill.
Change condition (eff 10/93)
D4 = Change in ICD-9-CM diagnosis and/or procedure code
Change condition (eff 10/93)
D5 = Cancel only to correct a beneficiary claim account number or provider identification number.
change condition (eff 10/93)
D6 = Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an OP bill containing services required to be included on the IP bill). Change condition eff 10/93.
D7 = Change to make Medicare the secondary payer.
Change condition (eff 10/93)

D8 = Change to make Medicare the primary
payer.
Change condition (eff 10/93)
D9 = Any other change.
Change condition (eff 10/93)
DR = Disaster Relief (eff. 10/2005) - Code used
to facilitate claims processing and track
services and items provided to victims of
Hurricane Katrina and any future disasters.
E0 = Change in patient status.
Change condition (eff 10/93)
EY = National Emphysema Treatment Trial (NETT)
or Lung Volume Reduction Surgery (LVRS)
clinical study (eff. 11/97) Obsolete
G0 = Multiple medical visits occur on the same
day in the same revenue center but visits
are distinct and constitute independent
visits (allows for payment under outpatient
PPS -- eff. 7/3/00).
H0 = Delayed Filing, Statement of Intent
Submitted -- statement of intent was sub-
mitted within the qualifying period to
specifically identify the existence of
another third party liability situation.
(eff. 9/01)
H2 = Discharge by a Hospice Provider for Cause
(eff. 1/1/09).
M0 = Reserved for national assignment.
M0 = All inclusive rate for outpatient services.
(payer only code). Obsolete
M1 = Reserved for national assignment.
M1 = Roster billed influenza virus vaccine.
(payer only code)
Eff 10/96, also includes pneumoccocal
pneumonia vaccine (PPV) Obsolete
M2 = Reserved for national assignment.
M2 = HH override code - home health total
reimbursement exceeds the $150,000 cap
or the number of total visits exceeds the
150 limitation. (eff 4/3/95) Obsolete
(payer only code)
M6 = Pennsylvania (PA) Rural Health Model (PARHM)
(payer only code)
MH = Acute Hospital Care at Home
(payer only code) eff. 7/2021
P1 = Do Not Resuscitate Order (DNR) - for
public health reporting only - code
indicates that a DNR order was written at
the time of or within the first 24 hours
of the patient's admission to the hospital
and is clearly documented in the patient's
medical record.
P7 = Direct Inpatient Admission from Emergency
Room - for public health reporting only

when required by state or federal law or regulations. Code indicates that patient was admitted directly from this facility's emergency room department. (eff. 7/1/10)

W0 = United Mine Workers of America (UMWA) SNF demonstration indicator (eff 1/97); but no claims transmitted until 2/98)

W2 = Duplicate of Original Bill - code indicates bill is exact duplicate of the original bill submitted. (eff. 10/1/08)

W3 = Level I Appeal - code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (I) is specified/ defined by the payer. (eff. 10/1/08)

W4 = Level II Appeal - Code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (II) is specified/ defined by the payer. (eff. 10/1/08)

W5 = Level III Appeal - Code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (III) is specified/ defined by the payer. (eff. 10/1/08)

XX = Transgender/Hermaphrodite Beneficiaries (eff. 1/2/07) Obsolete

ZA = Inpatient. Positive test result is not included in the patient's medical record. Eff. 7/2021 (payer only code)

ZB = Inpatient. Service provided as part of an Expanded Access Approval. Eff. 10/2020 (payer only code)

ZC = Inpatient. Clinical Trial of a different product. (payer only code). eff. 10/2020

ZD-ZZ = Reserved. Not currently in use by Medicare.

CLM_RLT_OCRNC_TB Claim Related Occurrence Table

01 = Auto accident - The date of an auto accident.

02 = No-fault insurance involved, including auto accident/other - The date of an accident where the state has applicable no-fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt).

03 = Accident/tort liability - The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.

04 = Accident/employment related - The

date of an accident relating to the patient's employment.
05 = Accident/No medical liability coverage - code indicating accident related injury for which there is no medical payment or third payrt liability coverage. Provide the date of accident/injury.
05 = Other accident - The date of an accident not described by the codes 01 thru 04. (obsolete)
06 = Crime victim - Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07 = Reserved for national assignment.
08 = Reserved for national assignment.
09 = Start of Infertility Treatment Cycle - code indicating the start date of infertility treatment cycle.
10 = Last Menstrual Period - code indicating the date of the last mentrual period; ONLY applies when patient is being treated for maternity related conditions.
11 = Onset of symptoms/illness - The date the patient first became aware of symptoms/illness.
12 = Date of onset for a chronically dependent individual - Code indicates the date the patient/bene became a chronically dependent individual.
13 = Reserved for national assignment.
14 = Reserved for national assignment.
15 = Reserved for national assignment.
16 = Date of Last Therapy - code denotes last day of therapy services (e.g., physical therapy, occupational therapy, speech therapy).
17 = Date outpatient occupational therapy plan established or last reviewed - Code indicating the date an occupational therapy plan was established or last reviewed (eff 3/93)
18 = Date of retirement (patient/bene) - Code indicates the date of retirement for the patient/bene.
19 = Date of retirement spouse - Code indicates the date of retirement for the patient's spouse.
20 = Guarantee of payment began - The date on which the provider began claiming Medicare payment under the guarantee of payment provision.
21 = UR notice received - Code indicating

the date of receipt by the hospital & SNF of the UR committee's finding that the admission or future stay was not medically necessary.

22 = Active care ended - The date on which a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.

23 = Cancellation of Hospice benefits - The date the RHHI cancelled the hospice benefit. (eff. 10/00). NOTE: this will be different than the revocation of the hospice benefit by beneficiaries.
Benefits exhausted - The last date for which benefits can be paid. (term 9/30/93; replaced by code A3)

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

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

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

27 = Date of Hospice Certification or Re-Certification -- code indicates the date of certification or recertification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods. (eff. 9/01)

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

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

29 = Date OPT plan established or last reviewed - the date a plan of treatment was established for outpatient physical

therapy.
Not used by hospital unless owner of facility
30 = Date speech pathology plan treatment established or last reviewed - The date a speech pathology plan of treatment was established or last reviewed.
Not used by hospital unless owner of facility
31 = Date bene notified of intent to bill (accommodations) - The date of the notice provided to the patient by the hospital stating that he no longer required a covered level of IP care.
32 = Date bene notified of intent to bill (procedures or treatment) - The date of the notice provided to the patient by the hospital stating requested care (diagnostic procedures or treatments) is not considered reasonable or necessary.
33 = First day of the Medicare coordination period for ESRD bene - During which Medicare benefits are secondary to benefits payable under an EGHP.
Required only for ESRD beneficiaries.
34 = Date of election of extended care facilities - The date the guest elected to receive extended care services (used by Religious Nonmedical Health Care Institutions only).
35 = Date treatment started for physical therapy - Code indicates the date services were initiated by the billing provider for physical therapy.
36 = Date of discharge for the IP hospital stay when patient received a transplant procedure - Hospital is billing for immunosuppressive drugs.
37 = The date of discharge for the IP hospital stay when patient received a noncovered transplant procedure - Hospital is billing for immunosuppresive drugs.
38 = Date treatment started for home IV therapy - Date the patient was first treated in his home for IV therapy.
39 = Date discharged on a continuous course of IV therapy - Date the patient was discharged from the hospital on a continuous course of IV therapy.
40 = Scheduled date of admission - The date on which a patient will be admitted as an inpatient to the hospital.
(This code may only be used on an outpatient claim.)

41 = Date of First Test for Pre-admission Testing - The date on which the first outpatient diagnostic test was performed as part of a pre-admission testing (PAT) program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s). (eff. 10/01)
42 = Date of discharge/termination of hospice care - for the final bill for hospice care. Eff 5/93, definition revised to apply only to date patient revoked hospice election.
43 = Scheduled Date of Canceled Surgery - date which ambulatory surgery was scheduled. (eff. 9/01)
44 = Date treatment started for occupational therapy - Code indicates the date services were initiated by the billing provider for occupational therapy.
45 = Date treatment started for speech therapy - Code indicates the date services were initiated by the billing provider for speech therapy.
46 = Date treatment started for cardiac rehabilitation - Code indicates the date services were initiated by the billing provider for cardiac rehabilitation.
47 = Date Cost Outlier Status Begins - code indicates that this is the first day the cost outlier threshold is reached. For Medicare purposes, a bene must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments. (eff. 9/01)
48 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.
49 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.
50 = Assessment Date - code indicating an assessment date as defined by the assessment instrument applicable to this provider type (e.g. Minimum Data Set (MDS) for skilled nursing). eff. 1/1/11
51 = Date of Last Kt/V Reading - for in-center hemodialysis patients, this is the date of the last reading taken during the

billing period. For peritoneal dialysis patients (and home hemodialysis patients), this date may be before the current billing period but should be within 4 months of the date of service. eff. 7/1/10

52 = Medical Certification/recertification date - the date of the most recent non-hospice medical certification or recertification of the patient. Use occurrence code 27 for Date of Hospice Certification or Recertification. eff. 1/1/11

54 = Physician Follow-up Date - Last date of a physician follow-up with the patient. eff. 1/1/11

55 = Used to report date of death. NOTE: The date of death will be present when the patient discharge status code is 20, 40, 41 or 42.

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

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

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

A4 = Split Bill Date - date patient became eligible due to medically needy spend down (sometimes referred to as "Split Bill Date").

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

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

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

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

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

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

M1 = X-ray not taken within the past 12 months or near enough to the start of treatment.
Start: 01/01/1997

M2 = Not paid separately when the patient is an inpatient.
Start: 01/01/1997

M3 = Equipment is the same or similar to equipment already being used.
Start: 01/01/1997

M4 = Alert: This is the last monthly installment payment for this durable medical equipment.
Start: 01/01/1997

M5 = Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.
Start: 01/01/1997

M6 = Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment.
Start: 01/01/1997

M7 = No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.
Start: 01/01/1997

M8 = We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.
Start: 01/01/1997

M9 = Alert: This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.
Start: 01/01/1997 |

M10 = Equipment purchases are limited to the first or the tenth month of medical necessity.
Start: 01/01/1997

M11 = DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's zip code.
Start: 01/01/1997

M12 = Diagnostic tests performed by a physician
must indicate whether purchased services are included on the claim.

Start: 01/01/1997
M13 = Only one initial visit is covered per specialty per medical group.
Start: 01/01/1997 |
M14 = No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.
Start: 01/01/1997
M15 = Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
Start: 01/01/1997
M16 = Alert: Please see our web site, mailings,
or bulletins for more details concerning this policy/procedure/decision.
Start: 01/01/1997 |
Notes: (Reactivated 4/1/04, Modified 11/18/05, 4/1/07)
M17 = Alert: Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.
Start: 01/01/1997
M18 = Certain services may be approved for home
use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home.
Start: 01/01/1997
M19 = Missing oxygen certification/ recertification.
Start: 01/01/1997
M20 = Missing/incomplete/invalid HCPCS.
Start: 01/01/1997
M21 = Missing/incomplete/invalid place of residence for this service/item provided in a home.
Start: 01/01/1997
M22 = Missing/incomplete/invalid number of miles traveled.
Start: 01/01/1997
M23 = Missing invoice.
Start: 01/01/1997
M24 = Missing/incomplete/invalid number of doses per vial.
Start: 01/01/1997 |
M25 = The information furnished does not

substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
Start: 01/01/1997 |
Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07, 11/1/10)

M26 = The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice.= The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.
Start: 01/01/1997 |
Notes: (Modified 10/1/02, 6/30/03, 8/1/05, 11/5/07. Also refer to N356)

M27 = Alert: The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were

not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.
Start: 01/01/1997 |
Notes: (Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07)

M28 = This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
Start: 01/01/1997

M29 = Missing operative note/report.
Start: 01/01/1997 |
Notes: (Modified 2/28/03, 7/1/2008)
Related to N233

M30 = Missing pathology report.
Start: 01/01/1997 |
Notes: (Modified 8/1/04, 2/28/03)
Related to N236

M31 = Missing radiology report.
Start: 01/01/1997 |
Notes: (Modified 8/1/04, 2/28/03) Related to N240

M32 = Alert: This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.
Start: 01/01/1997 |
Notes: (Modified 4/1/07)

M33 = Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.
Start: 01/01/1997 | Stop: 08/01/2004
Notes: Consider using M68

M34 = Claim lacks the CLIA certification number.
Start: 01/01/1997 |
Stop: 08/01/2004
Notes: Consider using MA120

M35 = Missing/incomplete/invalid pre-operative
photos or visual field results.
Start: 01/01/1997 | Stop: 02/05/2005
Notes: Consider using N178

M36 = This is the 11th rental month. We

cannot
pay for this until you indicate that the patient has been given the option of changing the rental to a purchase.
Start: 01/01/1997

M37 = Not covered when the patient is under age 35.
Start: 01/01/1997 |
Notes: (Modified 3/8/11)

M38 = The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
Start: 01/01/1997

M39 = The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.
Start: 01/01/1997 |
Notes: (Modified 2/1/04, 4/1/07, 11/1/09, 11/1/12) Related to N563

M40 = Claim must be assigned and must be filed
by the practitioner's employer.
Start: 01/01/1997

M41 = We do not pay for this as the patient has no legal obligation to pay for this.
Start: 01/01/1997

M42 = The medical necessity form must be personally signed by the attending physician.
Start: 01/01/1997

M43 = Payment for this service previously issued to you or another provider by another carrier/intermediary.
Start: 01/01/1997 |
Stop: 01/31/2004
Notes: Consider using Reason Code 23

M44 = Missing/incomplete/invalid condition code.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M45 = Missing/incomplete/invalid occurrence code(s).
Start: 01/01/1997 |
Notes: (Modified 12/2/04) Related to N299

M46 = Missing/incomplete/invalid occurrence span code(s).
Start: 01/01/1997 |
Notes: (Modified 12/2/04) Related to N300

M47 = Missing/incomplete/invalid internal or document control number.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M48 = Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.
Start: 01/01/1997 |
Stop: 01/31/2004
Notes: Consider using M97

M49 = Missing/incomplete/invalid value code(s)
or amount(s).
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M50 = Missing/incomplete/invalid revenue code(s).
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M51 = Missing/incomplete/invalid procedure code(s).
Start: 01/01/1997 |
Notes: (Modified 12/2/04) Related to N301

M52 = Missing/incomplete/invalid "from" date(s) of service.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M53 = Missing/incomplete/invalid days or units
of service.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M54 = Missing/incomplete/invalid total charges.
Start: 01/01/1997 |

M55 = We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.
Start: 01/01/1997

M56 = Missing/incomplete/invalid payer identifier.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M57 = Missing/incomplete/invalid provider identifier.
Start: 01/01/1997 |
Stop: 06/02/2005

M58 = Missing/incomplete/invalid claim information. Resubmit claim after corrections.

Start: 01/01/1997 | Stop: 02/05/2005

M59 = Missing/incomplete/invalid "to" date(s) of service.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M60 = Missing Certificate of Medical Necessity.
Start: 01/01/1997 |
Notes: (Modified 8/1/04, 6/30/03)
Related to N227

M61 = We cannot pay for this as the approval period for the FDA clinical trial has expired.
Start: 01/01/1997

M62 = Missing/incomplete/invalid treatment authorization code.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M63 = We do not pay for more than one of these
on the same day.
Start: 01/01/1997 |
Stop: 01/31/2004
Notes: Consider using M86

M64 = Missing/incomplete/invalid other diagnosis.
Start: 01/01/1997 |
Notes: (Modified 2/28/03)

M65 = One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated.
Please submit a separate claim for each interpreting physician.
Start: 01/01/1997

M66 = Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations.
Please submit the technical and professional components of this service as separate line items.
Start: 01/01/1997

M67 = Missing/incomplete/invalid other procedure code(s).
Start: 01/01/1997
Notes: (Modified 12/2/04) Related to N302

M68 = Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.
Start: 01/01/1997
Stop: 06/02/2005

M69 = Paid at the regular rate as you did not submit documentation to justify the modified procedure code.
Start: 01/01/1997 |
Notes: (Modified 2/1/04)

M70 = Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.
Start: 01/01/1997 |
Notes: (Modified 4/1/2007, 8/1/07)

M71 = Total payment reduced due to overlap of tests billed.
Start: 01/01/1997

M72 = Did not enter full 8-digit date (MM/DD/CCYY).
Start: 01/01/1997 |
Stop: 10/16/2003
Notes: Consider using MA52

M73 = The HPSA/Physician Scarcity bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components.
Start: 01/01/1997
Notes: (Modified 8/1/04)

M74 = This service does not qualify for a HPSA/Physician Scarcity bonus payment.
Start: 01/01/1997
Notes: (Modified 12/2/04)

M75 = Multiple automated multichannel tests performed on the same day combined for payment.
Start: 01/01/1997
Notes: (Modified 11/5/07)

M76 = Missing/incomplete/invalid diagnosis or condition.
Start: 01/01/1997
Notes: (Modified 2/28/03)

M77 = Missing/incomplete/invalid place of service.
Start: 01/01/1997
Last Modified: 02/28/2003
Notes: (Modified 2/28/03)

M78 = Missing/incomplete/invalid HCPCS modifier.
Start: 01/01/1997
Stop: 05/18/2006
Notes: (Modified 2/28/03,) Consider using Reason Code 4

M79 = Missing/incomplete/invalid charge.
Start: 01/01/1997
Notes: (Modified 2/28/03)

M80 = Not covered when performed during the same session/date as a previously processed service for the patient.
Start: 01/01/1997
Notes: (Modified 10/31/02)

M81 = You are required to code to the highest level of specificity.
Start: 01/01/1997
Notes: (Modified 2/1/04)

M82 = Service is not covered when patient is under age 50.
Start: 01/01/1997

M83 = Service is not covered unless the patient is classified as at high risk.
Start: 01/01/1997

M84 = Medical code sets used must be the codes
in effect at the time of service
Start: 01/01/1997
Notes: (Modified 2/1/04)

M85 = Subjected to review of physician evaluation and management services.
Start: 01/01/1997

M86 = Service denied because payment already made for same/similar procedure within set time frame.
Start: 01/01/1997

M87 = Claim/service(s) subjected to CFO-CAP prepayment review.
Start: 01/01/1997

M88 = We cannot pay for laboratory tests unless billed by the laboratory that did the work.
Start: 01/01/1997
Stop: 08/01/2004
Notes: Consider using Reason Code B20

M89 = Not covered more than once under age 40.
Start: 01/01/1997

M90 = Not covered more than once in a 12 month
period.
Start: 01/01/1997

M91 = Lab procedures with different CLIA certification numbers must be billed on separate claims.
Start: 01/01/1997

M92 = Services subjected to review under the Home Health Medical Review Initiative.
Start: 01/01/1997 | Stop: 08/01/2004

M93 = Information supplied supports a break in
therapy. A new capped rental period began with delivery of this equipment.

Start: 01/01/1997

M94 = Information supplied does not support a break in therapy. A new capped rental period will not begin.
Start: 01/01/1997

M95 = Services subjected to Home Health Initiative medical review/cost report audit.
Start: 01/01/1997

M96 = The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.
Start: 01/01/1997

M97 = Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
Start: 01/01/1997

M98 = Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.
Start: 01/01/1997
Stop: 01/31/2004
Notes: Consider using M99

M99 = Missing/incomplete/invalid Universal Product Number/Serial Number.
Start: 01/01/1997

M100 = We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
Start: 01/01/1997

M101 = Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.
Start: 01/01/1997
Stop: 01/31/2004
Notes: Consider using M78

M102 = Service not performed on equipment approved by the FDA for this purpose.
Start: 01/01/1997

M103 = Information supplied supports a break in therapy. However, the medical info-mation we have for this patient does not support the need for this item as billed. We have approved payment for

this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.
Start: 01/01/1997

M104 = Information supplied supports a break in therapy. a new capped rental period will begom wieth delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.
Start: 01/01/1997

M105 = Information supplied does not support a break in therapy. The medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.
Start: 01/01/1997

M106 = Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.
Start: 01/01/1997 |
Stop: 01/31/2004
Notes: Consider using MA 31

M107 = Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.
Start: 01/01/1997

M108 = Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.
Start: 01/01/1997 | Stop: 06/02/2005

M109 = We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring practitioner.
Start: 01/01/1997

M110 = Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.
Start: 01/01/1997 | Stop: 06/02/2005

M111 = We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.
Start: 01/01/1997

M112 = Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
Start: 01/01/1997

M113 = Our records indicate that this patient

began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program.
Start: 01/01/1997

M114 = This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these these projects, contact your local contractor.
Start: 01/01/1997

M115 = This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
Start: 01/01/1997

M116 = Processed under a demonstration project or program. Project or program is ending and additional services may not be paid under this project or program.
Start: 01/01/1997

M117 = Not covered unless submitted via electronic claim.
Start: 01/01/1997

M118 = Letter to follow containing further information.
Start: 01/01/1997
Stop: 01/01/2011

M119 = Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).
Start: 01/01/1997

M120 = Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.
Start: 01/01/1997
Stop: 06/02/2005

M121 = We pay for this service only when performed with a covered cryosurgical ablation.
Start: 01/01/1997

M122 = Missing/incomplete/invalid level of subluxation.
Start: 01/01/1997

M123 = Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
Start: 01/01/1997

M124 = Missing indication of whether the patient owns the equipment that requires the part or supply.
Start: 01/01/1997

Notes: Related to N230

M125 = Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
Start: 01/01/1997 |

M126 = Missing/incomplete/invalid individual lab codes included in the test.
Start: 01/01/1997 |

M127 = Missing patient medical record for this service.
Start: 01/01/1997 |
Notes: Related to N237

M128 = Missing/incomplete/invalid date of the patient's last physician visit.
Start: 01/01/1997 |
Stop: 06/02/2005

M129 = Missing/incomplete/invalid indicator of x-ray availability for review.
Start: 01/01/1997

M130 = Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
Start: 01/01/1997
Notes: Related to N231

M131 = Missing physician financial relationship form.
Start: 01/01/1997
Notes: Related to N239

M132 = Missing pacemaker registration form.
Start: 01/01/1997
Notes: Related to N235

M133 = Claim did not identify who performed the purchased diagnostic test or the amount you were charged for the test.
Start: 01/01/1997

M134 = Performed by a facility/supplier in which the provider has a financial interest.
Start: 01/01/1997

M135 = Missing/incomplete/invalid plan of treatment.
Start: 01/01/1997

M136 = Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.
Start: 01/01/1997

M137 = Part B coinsurance under a demonstration project or pilot program.
Start: 01/01/1997

M138 = Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the

time services were rendered. Coverage is limited to demonstration participants.
Start: 01/01/1997

M139 = Denied services exceed the coverage limit for the demonstration.
Start: 01/01/1997

M140 = Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday
Start: 01/01/1997
Stop: 1/30/2004
Notes: Consider using M82

M141 = Missing physician certified plan of care.
Start: 01/01/1997
Notes: Related to N238

M142 = Missing American Diabetes Association Certificate of Recognition.
Start: 01/01/1997
Last Modified: 02/28/2003
Notes: Related to N226

M143 = The provider must update license information with the payer.
Start: 01/01/1997 |

M144 = Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
Start: 01/01/1997

MA01 = Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
Start: 01/01/1997
8/1/05, 4/1/07)

MA02 = Alert: If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice.
Start: 01/01/1997

MA03 = If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. To meet the

$100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time.
Start: 01/01/1997
Stop: 10/01/2006
Last Modified: 11/18/2005
Notes: Consider using MA02 (Modified 10/31/02, 6/30/03, 8/1/05, 11/18/05)

MA04 = Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
Start: 01/01/1997

MA05 = Incorrect admission date patient status or type of bill entry on claim.
Start: 01/01/1997
Stop: 10/16/2003
Notes: Consider using MA30, MA40 or MA43

MA06 = Missing/incomplete/invalid beginning and/or ending date(s).
Start: 01/01/1997
Stop: 08/01/2004
Notes: Consider using MA31

MA07 = Alert: The claim information has also been forwarded to Medicaid for review.
Start: 01/01/1997

MA08 = Alert: Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.
Start: 01/01/1997

MA09 = Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.
Start: 01/01/1997

MA10 = Alert: The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.
Start: 01/01/1997

MA11 = Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.
Start: 01/01/1997
Stop: 01/31/2004

Notes: Consider using M32
MA12 = You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).
Start: 01/01/1997
MA13 = Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
Start: 01/01/1997
MA14 = Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.
Start: 01/01/1997
MA15 = Alert: Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
Start: 01/01/1997 |
MA16 = The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.
Start: 01/01/1997
MA17 = We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.
Start: 01/01/1997
MA18 = Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
Start: 01/01/1997
MA19 = Alert: Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.
Start: 01/01/1997
MA20 = Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of

incontinence.
Start: 01/01/1997
MA21 = SSA records indicate mismatch with name and sex.
Start: 01/01/1997
MA22 = Payment of less than $1.00 suppressed.
Start: 01/01/1997
MA23 = Demand bill approved as result of medical review.
Start: 01/01/1997
MA24 = Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period.
Start: 01/01/1997 |
MA25 = A patient may not elect to change a hospice provider more than once in a benefit period.
Start: 01/01/1997
MA26 = Alert: Our records indicate that you were previously informed of this rule.
Start: 01/01/1997 |
MA27 = Missing/incomplete/invalid entitlement number or name shown on the claim.
Start: 01/01/1997 |
MA28 = Alert: Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.
Start: 01/01/1997 |
MA29 = Missing/incomplete/invalid provider name, city, state, or zip code.
Start: 01/01/1997 |
Stop: 06/02/2005
MA30 = Missing/incomplete/invalid type of bill.
Start: 01/01/1997 |
MA31 = Missing/incomplete/invalid beginning and ending dates of the period billed.
Start: 01/01/1997 |
MA32 = Missing/incomplete/invalid number of covered days during the billing period.
Start: 01/01/1997 |
MA33 = Missing/incomplete/invalid noncovered days during the billing period.
Start: 01/01/1997 |
MA34 = Missing/incomplete/invalid number of coinsurance days during the billing period.

Start: 01/01/1997
MA35 = Missing/incomplete/invalid number of lifetime reserve days.
Start: 01/01/1997 |
MA36 = Missing/incomplete/invalid patient name.
Start: 01/01/1997 |
MA37 = Missing/incomplete/invalid patient's address.
Start: 01/01/1997 |
MA38 = Missing/incomplete/invalid birth date.
Start: 01/01/1997 |
Stop: 06/02/2005
MA39 = Missing/incomplete/invalid gender.
Start: 01/01/1997 |
MA40 = Missing/incomplete/invalid admission date.
Start: 01/01/1997 |
MA41 = Missing/incomplete/invalid admission type.
Start: 01/01/1997 |
MA42 = Missing/incomplete/invalid admission source.
Start: 01/01/1997 |
MA43 = Missing/incomplete/invalid patient status.
Start: 01/01/1997 |
MA44 = Alert: No appeal rights. Adjudicative decision based on law.
Start: 01/01/1997
MA45 = Alert: As previously advised, a portion or all of your payment is being held in a special account.
Start: 01/01/1997
MA46 = The new information was considered but additional payment will not be issued.
Start: 01/01/1997 |
MA47 = Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.
Start: 01/01/1997
MA48 = Missing/incomplete/invalid name or address of responsible party or primary payer.
Start: 01/01/1997
Last Modified: 02/28/2003
Notes: (Modified 2/28/03)
MA49 = Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight

services.
Start: 01/01/1997
Stop: 08/01/2004
Notes: Consider using MA76

MA50 = Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
Start: 01/01/1997 |

MA51 = Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
Start: 01/01/1997 |
Stop: 02/05/2005
Notes: Consider using MA120

MA52 = Missing/incomplete/invalid date.
Start: 01/01/1997 | Stop: 06/02/2005

MA53 = Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.
Start: 01/01/1997 |

MA54 = Physician certification or election consent for hospice care not received timely.
Start: 01/01/1997

MA55 = Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
Start: 01/01/1997

MA56 = Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
Start: 01/01/1997

MA57 = Patient submitted written request to revoke his/her election for religious non-medical health care services.
Start: 01/01/1997

MA58 = Missing/incomplete/invalid release of information indicator.
Start: 01/01/1997 |

MA59 = Alert: The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient

responsibility on this notice.
Start: 01/01/1997 |
MA60 = Missing/incomplete/invalid patient relationship to insured.
Start: 01/01/1997 |
MA61 = Missing/incomplete/invalid social security number or health insurance claim number.
Start: 01/01/1997 |
MA62 = Alert: This is a telephone review decision.
Start: 01/01/1997 |
MA63 = Missing/incomplete/invalid principal diagnosis.
Start: 01/01/1997 |
MA64 = Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
Start: 01/01/1997
MA65 = Missing/incomplete/invalid admitting diagnosis.
Start: 01/01/1997 |
MA66 = Missing/incomplete/invalid principal procedure code.
Start: 01/01/1997 |
Notes: Related to N303
MA67 = Correction to a prior claim.
Start: 01/01/1997
MA68 = Alert: We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim.
Start: 01/01/1997 |
MA69 = Missing/incomplete/invalid remarks.
Start: 01/01/1997
MA70 = Missing/incomplete/invalid provider representative signature.
Start: 01/01/1997 |
MA71 = Missing/incomplete/invalid provider representative signature date.
Start: 01/01/1997 |
MA72 = Alert: The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice.
Start: 01/01/1997 |
MA73 = Informational remittance associated

with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
Start: 01/01/1997

MA74 = This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
Start: 01/01/1997

MA75 = Missing/incomplete/invalid patient or authorized representative signature.
Start: 01/01/1997

MA76 = Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.
Start: 01/01/1997

MA77 = Alert: The patient overpaid you. You must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice.
Start: 01/01/1997

MA78 = The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.
Start: 01/01/1997
Stop: 01/31/2004
Notes: Consider using MA59

MA79 = Billed in excess of interim rate.
tart: 01/01/1997

MA80 = Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
Start: 01/01/1997

MA81 = Missing/incomplete/invalid provider/supplier signature.
Start: 01/01/1997 |

MA82 = Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.
Start: 01/01/1997 |
Stop: 06/02/2005

MA83 = Did not indicate whether we are the primary or secondary payer.

Start: 01/01/1997 |
MA84 = Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.
Start: 01/01/1997
MA85 = Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.
Start: 01/01/1997 |
Stop: 08/01/2004
Notes: Consider using MA92
MA86 = Missing/incomplete/invalid group or policy number of the insured for the primary coverage.
Start: 01/01/1997 |
Stop: 08/01/2004
Notes: Consider using MA92
MA87 = Missing/incomplete/invalid insured's name for the primary payer.
Start: 01/01/1997 |
Stop: 08/01/2004
Notes: Consider using MA92
MA88 = Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.
Start: 01/01/1997 |
MA89 = Missing/incomplete/invalid patient's relationship to the insured for the primary payer.
Start: 01/01/1997 |
MA90 = Missing/incomplete/invalid employment status code for the primary insured.
Start: 01/01/1997
MA91 = This determination is the result of the appeal you filed.
Start: 01/01/1997
MA92 = Missing plan information for other insurance.
Start: 01/01/1997
Notes: Related to N245
N245
MA93 = Non-PIP (Periodic Interim Payment) claim.
Start: 01/01/1997
MA94 = Did not enter the statement "Attending

physician not hospice employee" on the claim form to certify that the rendering physician is not an employee of the hospice.
Start: 01/01/1997
Notes: (Reactivated 4/1/04, Modified 8/1/05)

MA95 = A not otherwise classified or unlisted procedure code(s) was billed but a narrative description of the procedure was not entered on the claim. Refer to item 19 on the HCFA-1500.
Start: 01/01/1997
Stop: 01/01/2004
Notes: (Deactivated 2/28/2003) (Erroneous description corrected 9/2/2008) Consider using M51

MA96 = Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
Start: 01/01/1997

MA97 = Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.
Start: 01/01/1997 |

MA98 = Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.
Start: 01/01/1997 |
Stop: 10/16/2003
Notes: Consider using MA97

MA99 = Missing/incomplete/invalid Medigap information.
Start: 01/01/1997 |

MA100 = Missing/incomplete/invalid date of current illness or symptoms
Start: 01/01/1997 |

MA101 = A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.
Start: 01/01/1997
Stop: 01/01/2011
Notes: Consider using N538

MA102 = Missing/incomplete/invalid name or provider identifier for the rendering/referring/ ordering/ supervising provider.
Start: 01/01/1997
Stop: 08/01/2004
Notes: Consider using M68

MA103 = Hemophilia Add On.
Start: 01/01/1997
MA104 = Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.
Start: 01/01/1997
Stop: 01/31/2004
Notes: Consider using M128 or M57
MA105 = Missing/incomplete/invalid provider number for this place of service.
Start: 01/01/1997
Stop: 06/02/2005
MA106 = PIP (Periodic Interim Payment) claim.
Start: 01/01/1997
MA107 = Paper claim contains more than three separate data items in field 19.
Start: 01/01/1997
MA108 = Paper claim contains more than one data item in field 23.
Start: 01/01/1997
MA109 = Claim processed in accordance with ambulatory surgical guidelines.
Start: 01/01/1997
MA110 = Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.
Start: 01/01/1997
MA111 = Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.
Start: 01/01/1997
MA112 = Missing/incomplete/invalid group practice information.
Start: 01/01/1997
MA113 = Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.
Start: 01/01/1997
MA114 = Missing/incomplete/invalid information on where the services were furnished.
Start: 01/01/1997
MA115 = Missing/incomplete/invalid physical location (name and address, or PIN)

where the service(s) were rendered in a Health Professional Shortage Area (HPSA).
Start: 01/01/1997

MA116 = Did not complete the statement 'Homebound' on the claim to validate whether laboratory services were performed at home or in an institution.
Start: 01/01/1997
Notes: (Reactivated 4/1/04)

MA117 = This claim has been assessed a $1.00 user fee.
Start: 01/01/1997

MA118 = Coinsurance and/or deductible amounts apply to a claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. No Medicare payment issued.
Start: 01/01/1997

MA119 = Provider level adjustment for late claim filing applies to this claim.
Start: 01/01/1997
Stop: 05/01/2008
Notes: Consider using Reason Code B4

MA120 = Missing/incomplete/invalid CLIA certification number.
Start: 01/01/1997

MA121 = Missing/incomplete/invalid x-ray date.
Start: 01/01/1997

MA122 = Missing/incomplete/invalid initial treatment date.
Start: 01/01/1997

MA123 = Your center was not selected to participate in this study, therefore, we cannot pay for these services.
Start: 01/01/1997

MA124 = Processed for IME only.
Start: 01/01/1997
Stop: 01/31/2004
Notes: Consider using Reason Code 74

MA125 = Per legislation governing this program, payment constitutes payment in full.
Start: 01/01/1997

MA126 = Pancreas transplant not covered unless kidney transplant performed.
Start: 10/12/2001

MA127 = Reserved for future use.
Start: 10/12/2001
Stop: 06/02/2005

MA128 = Missing/incomplete/invalid FDA approval number.
Start: 10/12/2001

MA129 = This provider was not certified for

this procedure on this date of service.
Start: 10/12/2001
Stop: 01/31/2004
Notes: Consider using MA120 and Reason Code B7

MA130 = Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
Start: 10/12/2001

MA131 = Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.
Start: 10/12/2001

MA132 = Adjustment to the pre-demonstration rate.
Start: 10/12/2001

MA133 = Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
Start: 10/12/2001

MA134 = Missing/incomplete/invalid provider number of the facility where the patient resides.
Start: 10/12/2001

N1 = Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
Start: 01/01/2000

N2 = This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.
Start: 01/01/2000

N3 = Missing consent form.
Start: 01/01/2000
Notes: Related to N228

N4 = Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.
Start: 01/01/2000

N5 = EOB received from previous payer. Claim not on file.
Start: 01/01/2000

N6 = Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in

Medicare Part A and/or Medicare Part B.
Start: 01/01/2000
N7 = Processing of this claim/service has included consideration under Major Medical provisions.
Start: 01/01/2000
N8 = Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.
Start: 01/01/2000
N9 = Adjustment represents the estimated amount a previous payer may pay.
Start: 01/01/2000
N10 = Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Start: 01/01/2000
N11 = Denial reversed because of medical review.
Start: 01/01/2000
N12 = Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.
Start: 01/01/2000 |
N13 = Payment based on professional/technical component modifier(s).
Start: 01/01/2000
N14 = Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
Start: 01/01/2000 |
Stop: 10/01/2007
Notes: Consider using Reason Code 45
N15 = Services for a newborn must be billed separately.
Start: 01/01/2000
N16 = Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.
Start: 01/01/2000
N17 = Per admission deductible.
Start: 01/01/2000
Stop: 08/01/2004
Notes: Consider using Reason Code 1
N18 = Payment based on the Medicare allowed amount.
Start: 01/01/2000

Stop: 01/31/2004
Notes: Consider using N14
N19 = Procedure code incidental to primary procedure.
Start: 01/01/2000
N20 = Service not payable with other service rendered on the same date.
Start: 01/01/2000
N21 = Alert: Your line item has been separated into multiple lines to expedite handling.
Start: 01/01/2000
N22 = This procedure code was added/changed because it more accurately describes the services rendered.
Start: 01/01/2000
N23 = Alert: Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.
Start: 01/01/2000
N24 = Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.
Start: 01/01/2000
N25 = This company has been contracted by your benefit plan to provide administrative claims payment services only. This company does not assume financial risk or obligation with respect to claims processed on behalf of your benefit plan.
Start: 01/01/2000
N26 = Missing itemized bill/statement.
Start: 01/01/2000
Related to N232
N27 = Missing/incomplete/invalid treatment number.
Start: 01/01/2000
Last Modified: 02/28/2003
Notes: (Modified 2/28/03)
N28 = Consent form requirements not fulfilled.
Start: 01/01/2000
N29 = Missing documentation/orders/ notes/summary/report/chart.
Start: 01/01/2000
Notes: Related to N225
N30 = Patient ineligible for this service.
Start: 01/01/2000 | Last Modified: 06/30/2003
N31 = Missing/incomplete/invalid prescribing provider identifier.
Start: 01/01/2000
N32 = Claim must be submitted by the provider

who rendered the service.
Start: 01/01/2000
N33 = No record of health check prior to initiation of treatment.
Start: 01/01/2000
N34 = Incorrect claim form/format for this service.
Start: 01/01/2000
N35 = Program integrity/utilization review decision.
Start: 01/01/2000
N36 = Claim must meet primary payer's processing requirements before we can consider payment.
Start: 01/01/2000
N37 = Missing/incomplete/invalid tooth number/letter.
Start: 01/01/2000
N38 = Missing/incomplete/invalid place of service.
Start: 01/01/2000
Stop: 02/05/2005
Notes: Consider using M77
N39 = Procedure code is not compatible with tooth number/letter.
Start: 01/01/2000
N40 = Missing radiology film(s)/image(s).
Start: 01/01/2000
Notes: Related to N242
N41 = Authorization request denied.
Start: 01/01/2000 |
Stop: 10/16/2003
Notes: Consider using Reason Code 39
N42 = No record of mental health assessment.
Start: 01/01/2000
N43 = Bed hold or leave days exceeded.
Start: 01/01/2000
N44 = Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority.
Start: 01/01/2000 |
Stop: 10/16/2003
Notes: Consider using Reason Code 137
N45 = Payment based on authorized amount.
Start: 01/01/2000
N46 = Missing/incomplete/invalid admission hour.
Start: 01/01/2000
N47 = Claim conflicts with another inpatient stay.
Start: 01/01/2000
N48 = Claim information does not agree with information received from other

insurance carrier.
Start: 01/01/2000
N49 = Court ordered coverage information needs validation.
Start: 01/01/2000
N50 = Missing/incomplete/invalid discharge information.
Start: 01/01/2000
N51 = Electronic interchange agreement not on file for provider/submitter.
Start: 01/01/2000
N52 = Patient not enrolled in the billing provider's managed care plan on the date of service.
Start: 01/01/2000
N53 = Missing/incomplete/invalid point of pick-up address.
Start: 01/01/2000
Notes: (Modified 2/28/03)
N54 = Claim information is inconsistent with pre-certified/authorized services.
Start: 01/01/2000
N55 = Procedures for billing with group/referring/performing providers were not followed.
Start: 01/01/2000
N56 = Procedure code billed is not correct/valid for the services billed or the date of service billed.
Start: 01/01/2000
N57 = Missing/incomplete/invalid prescribing date.
Start: 01/01/2000
Notes: Related to N304
N58 = Missing/incomplete/invalid patient liability amount.
Start: 01/01/2000
N59 = Please refer to your provider manual for additional program and provider information.
Start: 01/01/2000
N60 = A valid NDC is required for payment of drug claims effective October 02.
Start: 01/01/2000
Stop: 01/31/2004
Notes: Consider using M119
N61 = Rebill services on separate claims.
Start: 01/01/2000
N62 = Dates of service span multiple rate periods. Resubmit separate claims.
Start: 01/01/2000
N63 = Rebill services on separate claim lines.
Start: 01/01/2000

N64 = The "from" and "to" dates must be different.
Start: 01/01/2000
N65 = Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
Start: 01/01/2000
N66 = Missing/incomplete/invalid documentation.
Start: 01/01/2000
Stop: 02/05/2005
Notes: Consider using N29 or N225.
N67 = Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient's admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.
Start: 01/01/2000
N68 = Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for your payment. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days.
Start: 01/01/2000
N69 = PPS (Prospective Payment System) code changed by claims processing system.
Start: 01/01/2000
N70 = Consolidated billing and payment applies.
Start: 01/01/2000
N71 = Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of

claims.
Start: 01/01/2000
N72 = PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records.
Start: 01/01/2000
N73 = A Skilled Nursing Facility is responsible for payment of outside providers who furnish these services/ supplies under arrangement to its residents.
Start: 01/01/2000
Stop: 01/31/2004
Notes: Consider using MA101 or N200
N74 = Resubmit with multiple claims, each claim covering services provided in only one calendar month.
Start: 01/01/2000
N75 = Missing/incomplete/invalid tooth surface information.
Start: 01/01/2000
N76 = Missing/incomplete/invalid number of riders.
Start: 01/01/2000
N77 = Missing/incomplete/invalid designated provider number.
Start: 01/01/2000
N78 = The necessary components of the child and teen checkup (EPSDT) were not completed.
Start: 01/01/2000
N79 = Service billed is not compatible with patient location information.
Start: 01/01/2000
N80 = Missing/incomplete/invalid prenatal screening information.
Start: 01/01/2000 |
N81 = Procedure billed is not compatible with tooth surface code.
Start: 01/01/2000
N82 = Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.
Start: 01/01/2000
N83 = No appeal rights. Adjudicative decision based on the provisions of a demonstration project.
Start: 01/01/2000
N84 = Alert: Further installment payments are forthcoming.
Start: 01/01/2000 |
N85 = Alert: This is the final installment payment.

Start: 01/01/2000 | Last Modified: 04/01/2007
Notes: (Modified 4/1/07, 8/1/07)

N86 = A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered.
Start: 01/01/2000

N87 = Home use of biofeedback therapy is not covered.
Start: 01/01/2000

N88 = Alert: This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care.
Start: 01/01/2000

N89 = Alert: Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
Start: 01/01/2000

N90 = Covered only when performed by the attending physician.
Start: 01/01/2000

N91 = Services not included in the appeal review.
Start: 01/01/2000

N92 = This facility is not certified for digital mammography.
Start: 01/01/2000

N93 = A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.
Start: 01/01/2000

N94 = Claim/Service denied because a more specific taxonomy code is required for adjudication.
Start: 01/01/2000

N95 = This provider type/provider specialty may not bill this service.
Start: 07/31/2001

N96 = Patient must be refractory to conventional therapy (documented

behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.
Start: 08/24/2001

N97 = Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.
Start: 08/24/2001

N98 = Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. Improvement is measured through voiding diaries.
Start: 08/24/2001

N99 = Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.
Start: 08/24/2001

N100 = PPS (Prospect Payment System) code corrected during adjudication.
Start: 09/14/2001

N101 = Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters 'HSP' and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.
Start: 10/31/2001
Stop: 01/31/2004
Notes: Consider uisng MA105

N102 = This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.
Start: 10/31/2001

N103 = Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does

not cover items and services furnished to an individual while he or she is in a Federal facility, or while he or she is in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.
Start: 10/31/2001

N104 = This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.
Start: 01/29/2002

N105 = This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.
Start: 01/29/2002

N106 = Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.
Start: 01/31/2002

N107 = Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.
Start: 01/31/2002

N108 = Missing/incomplete/invalid upgrade information.
Start: 01/31/2002 |
Last Modified: 02/28/2003
Notes: (Modified 2/28/03)

N109 = This claim/service was chosen for complex review and was denied after reviewing the medical records.
Start: 02/28/2002
Last Modified: 03/01/2009
Notes: (Modified 3/1/2009)

N110 = This facility is not certified for film mammography.
Start: 02/28/2002

N111 = No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
Start: 02/28/2002

N112 = This claim is excluded from your electronic remittance advice.
Start: 02/28/2002

N113 = Only one initial visit is covered per physician, group practice or provider.
Start: 04/16/2002

N114 = During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.
Start: 05/30/2002

N115 = This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.
Start: 05/30/2002

N116 = This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.
Start: 06/30/2002

N117 = This service is paid only once in a patient's lifetime.
Start: 07/30/2002

N118 = This service is not paid if billed more than once every 28 days.
Start: 07/30/2002

N119 = This service is not paid if billed once every 28 days, and the patient has

spent 5 or more consecutive days in any inpatient or Skilled /nursing Facility (SNF) within those 28 days.
Start: 07/30/2002

N120 = Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.
Start: 08/09/2002

N121 = Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered Skilled Nursing Facility (SNF) stay.
Start: 09/09/2002

N122 = Add-on code cannot be billed by itself.
Start: 09/12/2002

N123 = This is a split service and represents a portion of the units from the originally submitted service.
Start: 09/24/2002

N124 = Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.
Start: 09/26/2002
"Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice.
The requirements for a refund are in Ì1834(a)(18) of the Social Security Act (and in ÌÌ1834(j)(4) and 1879(h) by cross-reference to Ì1834(a)(18)).
Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office."

Start: 09/26/2002
N126 = Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.
Start: 10/17/2002
N127 = This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them.
Start: 10/31/2007
N128 = This amount represents the prior to coverage portion of the allowance.
Start: 10/31/2002
N129 = Not eligible due to the patient's age.
Start: 10/31/2002
N130 = Consult plan benefit documents/guidelines for information about restrictions for this service.
Start: 10/31/2002
N131 = Total payments under multiple contracts cannot exceed the allowance for this service.
Start: 10/31/2002
N132 = Alert: Payments will cease for services rendered by this US Government debarred or excluded provider after the 30 day grace period as previously notified.
Start: 10/31/2002
N133 = Alert: Services for predetermination and services requesting payment are being processed separately.
Start: 10/31/2002
N134 = Alert: This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service.
Start: 10/31/2002
N135 = Record fees are the patient's responsibility and limited to the specified co-payment.
Start: 10/31/2002
N136 = Alert: To obtain information on the process to file an appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.
Start: 10/31/2002
N137 = Alert: The provider acting on the Member's behalf, may file an appeal with the Payer. The provider, acting on the Member's behalf, may file a complaint with the State Insurance Regulatory

Authority without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The address may be obtained from the State Insurance Regulatory Authority.
Start: 10/31/2002

N138 = Alert: In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.
Start: 10/31/2002

N139 = Alert: Under the Code of Federal Regulations, Chapter 32, Section 199.13 a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
Start: 10/31/2002

N140 = Alert: You have not been designated as an authorized OCONUS provider therefore are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
Start: 10/31/2002

N141 = The patient was not residing in a long-term care facility during all or part of the service dates billed.
Start: 10/31/2002

N142 = The original claim was denied. Resubmit a new claim, not a replacement claim.
Start: 10/31/2002

N143 = The patient was not in a hospice program
during all or part of the service dates billed.
Start: 10/31/2002
N144 = The rate changed during the dates of service billed.
Start: 10/31/2002
N145 = Missing/incomplete/invalid provider identifier for this place of service.
Start: 10/31/2002
Stop: 06/02/2005
N146 = Missing screening document.
Start: 10/31/2002
Notes: Related to N243
N147 = Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete or invalid on the assignment request.
Start: 10/31/2002
N148 = Missing/incomplete/invalid date of last menstrual period.
Start: 10/31/2002
N149 = Rebill all applicable services on a single claim.
Start: 10/31/2002
N150 = Missing/incomplete/invalid model number.
Start: 10/31/2002
N151 = Telephone contact services will not be paid until the face-to-face contact requirement has been met.
Start: 10/31/2002
N152 = Missing/incomplete/invalid replacement claim information.
Start: 10/31/2002
N153 = Missing/incomplete/invalid room and board rate.
Start: 10/31/2002
N154 = Alert: This payment was delayed for correction of provider's mailing address.
Start: 10/31/2002
N155 = Alert: Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.
Start: 10/31/2002
N156 = Alert: The patient is responsible for the difference between the approved treatment and the elective treatment.
Start: 10/31/2002
N157 = Transportation to/from this destination is not covered.

Start: 02/28/2003
N158 = Transportation in a vehicle other than an ambulance is not covered.
Start: 02/28/2003
N159 = Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
Start: 02/28/2003
N160 = The patient must choose an option before a payment can be made for this procedure/ equipment/ supply/ service.
Start: 02/28/2003
N161 = This drug/service/supply is covered only when the associated service is covered.
Start: 02/28/2003
N162 = Alert: Although your claim was paid, you have billed for a test/specialty not included in your laboratory Certification. Your failure to correct the laboratory certification information will result in a denial of payment in the near future.
Start: 02/28/2003|
N163 = Medical record does not support code billed per the code definition.
Start: 02/28/2003
N164 = Transportation to/from this destination is not covered.
Start: 02/28/2003
Stop: 01/31/2004
Notes: Consider using N157
N165 = Transportation in a vehicle other than an ambulance is not covered.
Start: 02/28/2003
Stop: 01/31/2004
Notes: Consider using N158)
N166 = Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
Start: 02/28/2003
Stop: 01/31/2004
Notes: Consider using N159
N167 = Charges exceed the post-transplant coverage limit.
Start: 02/28/2003
N168 = The patient must choose an option before
a payment can be made for this procedure/ equipment/ supply/ service.
Start: 02/28/2003
Stop: 01/31/2004
Notes: Consider using N160
N169 = This drug/service/supply is covered

only when the associated service is covered.
Start: 02/28/2003
Stop: 01/31/2004
Notes: Consider using N161

N170 = A new/revised/renewed certificate of medical necessity is needed.
Start: 02/28/2003

N171 = Payment for repair or replacement is not covered or has exceeded the purchase price.
Start: 02/28/2003

N172 = The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.
Start: 02/28/2003

N173 = No qualifying hospital stay dates were provided for this episode of care.
Start: 02/28/2003

N174 = This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.
Start: 02/28/2003

N175 = Missing review organization approval.
Start: 02/28/2003
Notes: Related to N241

N176 = Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.
Start: 02/28/2003

N177 = Alert: We did not send this claim to patient's other insurer. They have indicated no additional payment can be made.
Start: 02/28/2003

N178 = Missing pre-operative photos or visual field results.
Start: 02/28/2003
Notes: Related to N244

N179 = Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
Start: 02/28/2003

N180 = This item or service does not meet the criteria for the category under which it was billed.
Start: 02/28/2003

N181 = Additional information is required from

another provider involved in this service.
Start: 02/28/2003
Last Modified: 12/01/2006
Notes: (Modified 12/1/06)

N182 = This claim/service must be billed according to the schedule for this plan.
Start: 02/28/2003

N183 = Alert: This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits.
Start: 02/28/2003

N184 = Rebill technical and professional components separately.
Start: 02/28/2003

N185 = Alert: Do not resubmit this claim/service.
Start: 02/28/2003

N186 = Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.
Start: 02/28/2003

N187 = Alert: You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
Start: 02/28/2003

N188 = The approved level of care does not match the procedure code submitted.
Start: 02/28/2003

N189 = Alert: This service has been paid as a one-time exception to the plan's benefit restrictions.
Start: 02/28/2003

N190 = Missing contract indicator.
Start: 02/28/2003
Notes: Related to N229

N191 = The provider must update insurance information directly with payer.
Start: 02/28/2003

N192 = Patient is a Medicaid/Qualified Medicare Beneficiary
Start: 02/28/2003

N193 = Specific federal/state/local program may cover this service through another payer.
Start: 02/28/2003

N194 = Technical component not paid if provider does not own the equipment used.
Start: 02/25/2003

N195 = The technical component must be billed separately.
Start: 02/25/2003
N196 = Alert: Patient eligible to apply for other coverage which may be primary.
Start: 02/25/2003
N197 = The subscriber must update insurance information directly with payer.
Start: 02/25/2003
N198 = Rendering provider must be affiliated with the pay-to provider.
Start: 02/25/2003
N199 = Additional payment/recoupment approved based on payer-initiated review/audit.
Start: 02/25/2003
N200 = The professional component must be billed separately.
Start: 02/25/2003
N201 = A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.
Start: 02/25/2003
Stop: 01/01/2011
Notes: Consider using N538
N202 = Additional information/explanation will be sent separately
Start: 06/30/2003
N203 = Missing/incomplete/invalid anesthesia time/units
Start: 06/30/2003
N204 = Services under review for possible pre-existing condition. Send medical records for prior 12 months
Start: 06/30/2003
N205 = Information provided was illegible
Start: 06/30/2003
N206 = The supporting documentation does not match the information sent on the claim.
Start: 06/30/2003
Notes: (Modified 3/6/12)
N207 = Missing/incomplete/invalid weight.
Start: 06/30/2003
N208 = Missing/incomplete/invalid DRG code
Start: 06/30/2003
N209 = Missing/incomplete/invalid taxpayer identification number (TIN).
Start: 06/30/2003
N210 = Alert: You may appeal this decision
Start: 06/30/2003
N211 = Alert: You may not appeal this decision
Start: 06/30/2003
N212 = Charges processed under a Point of Service benefit
Start: 02/01/2004

N213 = Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information
Start: 04/01/2004
N214 = Missing/incomplete/invalid history of the related initial surgical procedure(s)
Start: 04/01/2004
N215 = Alert: A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own claims determination.
Start: 04/01/2004
N216 = We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package
Start: 04/01/2004
N217 = We pay only one site of service per provider per claim
Start: 08/01/2004
N218 = You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for the time period specified in the contract or coverage manual.
Start: 08/01/2004
N219 = Payment based on previous payer's allowed amount.
Start: 08/01/2004
N220 = Alert: See the payer's web site or contact the payer's Customer Service department to obtain forms and instructions for filing a provider dispute.
Start: 08/01/2004
N221 = Missing Admitting History and Physical report.
Start: 08/01/2004
N222 = Incomplete/invalid Admitting History and Physical report.
Start: 08/01/2004
N223 = Missing documentation of benefit to the patient during initial treatment period.
N224 = Incomplete/invalid documentation of benefit to the patient during initial treatment period.
Start: 08/01/2004
N225 = Incomplete/invalid documentation/orders/notes/summary/report/chart.
Start: 08/01/2004
N226 = Incomplete/invalid American Diabetes

Association Certificate of Recognition.
Start: 08/01/2004
N227 = Incomplete/invalid Certificate of Medical Necessity.
Start: 08/01/2004
N228 = Incomplete/invalid consent form.
Start: 08/01/2004
N229 = Incomplete/invalid contract indicator.
Start: 08/01/2004
N230 = Incomplete/invalid indication of whether the patient owns the equipment equipment that requires the part or or supply.
Start: 08/01/2004
N231 = Incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
Start: 08/01/2004
N232 = Incomplete/invalid itemized bill/statement.
Start: 08/01/2004
N233 = Incomplete/invalid operative note/report.
Start: 08/01/2004
N234 = Incomplete/invalid oxygen certification/re-certification.
Start: 08/01/2004
N235 = Incomplete/invalid pacemaker registration form.
Start: 08/01/2004
N236 = Incomplete/invalid pathology report.
Start: 08/01/2004
N237 = Incomplete/invalid patient medical record for this service.
Start: 08/01/2004
N238 = Incomplete/invalid physician certified plan of care
Start: 08/01/2004
N239 = Incomplete/invalid physician financial relationship form.
Start: 08/01/2004
N240 = Incomplete/invalid radiology report.
Start: 08/01/2004
N241 = Incomplete/invalid review organization approval.
Start: 08/01/2004
N242 = Incomplete/invalid radiology film(s) /image(s).
Start: 08/01/2004
N243 = Incomplete/invalid/not approved screening document.
Start: 08/01/2004
N244 = Incomplete/invalid pre-operative

photos/visual field results.
Start: 08/01/2004
N245 = Incomplete/invalid plan information for other insurance
Start: 08/01/2004
N246 = State regulated patient payment limitations apply to this service.
Start: 12/02/2004
N247 = Missing/incomplete/invalid assistant surgeon taxonomy.
Start: 12/02/2004
N248 = Missing/incomplete/invalid assistant surgeon name.
Start: 12/02/2004
N249 = Missing/incomplete/invalid assistant surgeon primary identifier.
Start: 12/02/2004
N250 = Missing/incomplete/invalid assistant surgeon secondary identifier.
Start: 12/02/2004
N251 = Missing/incomplete/invalid attending provider taxonomy.
Start: 12/02/2004
N252 = Missing/incomplete/invalid attending provider name.
Start: 12/02/2004
N253 = Missing/incomplete/invalid attending provider primary identifier.
Start: 12/02/2004
N254 = Missing/incomplete/invalid attending provider secondary identifier.
Start: 12/02/2004
N255 = Missing/incomplete/invalid billing provider taxonomy.
Start: 12/02/2004
N256 = Missing/incomplete/invalid billing provider/supplier name.
Start: 12/02/2004
N257 = Missing/incomplete/invalid billing provider/supplier primary identifier.
Start: 12/02/2004
N258 = Missing/incomplete/invalid billing provider/supplier address.
Start: 12/02/2004
N259 = Missing/incomplete/invalid billing provider/supplier secondary identifier.
Start: 12/02/2004
N260 = Missing/incomplete/invalid billing provider/supplier contact information.
Start: 12/02/2004
N261 = Missing/incomplete/invalid operating provider name.
Start: 12/02/2004
N262 = Missing/incomplete/invalid operating

provider primary identifier.
Start: 12/02/2004
N263 = Missing/incomplete/invalid operating provider secondary identifier.
Start: 12/02/2004
N264 = Missing/incomplete/invalid ordering provider name.
Start: 12/02/2004
N265 = Missing/incomplete/invalid ordering provider primary identifier.
Start: 12/02/2004
N266 = Missing/incomplete/invalid ordering provider address.
Start: 12/02/2004
N267 = Missing/incomplete/invalid ordering provider secondary identifier.
Start: 12/02/2004
N268 = Missing/incomplete/invalid ordering provider contact information.
Start: 12/02/2004
N269 = Missing/incomplete/invalid other provider name.
Start: 12/02/2004
N270 = Missing/incomplete/invalid other provider primary identifier.
Start: 12/02/2004
N271 = Missing/incomplete/invalid other provider secondary identifier.
Start: 12/02/2004
N272 = Missing/incomplete/invalid other payer attending provider identifier.
Start: 12/02/2004
N273 = Missing/incomplete/invalid other payer operating provider identifier.
Start: 12/02/2004
N274 = Missing/incomplete/invalid other payer other provider identifier.
Start: 12/02/2004
N275 = Missing/incomplete/invalid other payer purchased service provider identifier.
Start: 12/02/2004
N276 = Missing/incomplete/invalid other payer referring provider identifier.
Start: 12/02/2004
N277 = Missing/incomplete/invalid other payer rendering provider identifier.
Start: 12/02/2004
N278 = Missing/incomplete/invalid other payer service facility provider identifier.
Start: 12/02/2004
N279 = Missing/incomplete/invalid pay-to provider name.
Start: 12/02/2004
N280 = Missing/incomplete/invalid pay-to

provider primary identifier.
Start: 12/02/2004
N281 = Missing/incomplete/invalid pay-to provider address.
Start: 12/02/2004
N282 = Missing/incomplete/invalid pay-to provider secondary identifier.
Start: 12/02/2004
N283 = Missing/incomplete/invalid purchased service provider identifier.
Start: 12/02/2004
N284 = Missing/incomplete/invalid referring provider taxonomy.
Start: 12/02/2004
N285 = Missing/incomplete/invalid referring provider name.
Start: 12/02/2004
N286 = Missing/incomplete/invalid referring provider primary identifier.
Start: 12/02/2004
N287 = Missing/incomplete/invalid referring provider secondary identifier.
Start: 12/02/2004
N288 = Missing/incomplete/invalid rendering provider taxonomy.
Start: 12/02/2004
N289 = Missing/incomplete/invalid rendering provider name.
Start: 12/02/2004
N290 = Missing/incomplete/invalid rendering provider primary identifier.
Start: 12/02/2004
N291 = Missing/incomplete/invalid rendering provider secondary identifier.
Start: 12/02/2004
N292 = Missing/incomplete/invalid service facility name.
Start: 12/02/2004
N293 = Missing/incomplete/invalid service facility primary identifier.
Start: 12/02/2004
N294 = Missing/incomplete/invalid service facility primary address.
Start: 12/02/2004
N295 = Missing/incomplete/invalid service facility secondary identifier.
Start: 12/02/2004
N296 = Missing/incomplete/invalid supervising provider name.
Start: 12/02/2004
N297 = Missing/incomplete/invalid supervising provider primary identifier.
Start: 12/02/2004
N298 = Missing/incomplete/invalid supervising

provider secondary identifier.
Start: 12/02/2004
N299 = Missing/incomplete/invalid occurrence date(s).
Start: 12/02/2004
N300 = Missing/incomplete/invalid occurrence span date(s).
Start: 12/02/2004
N301 = Missing/incomplete/invalid procedure date(s).
Start: 12/02/2004
N302 = Missing/incomplete/invalid other procedure date(s).
Start: 12/02/2004
N303 = Missing/incomplete/invalid principal procedure date.
Start: 12/02/2004
N304 = Missing/incomplete/invalid dispensed date.
Start: 12/02/2004
N305 = Missing/incomplete/invalid accident date.
Start: 12/02/2004
N306 = Missing/incomplete/invalid acute manifestation date.
Start: 12/02/2004
N307 = Missing/incomplete/invalid adjudication or payment date.
Start: 12/02/2004
N308 = Missing/incomplete/invalid appliance placement date.
Start: 12/02/2004
N309 = Missing/incomplete/invalid assessment date.
Start: 12/02/2004
N310 = Missing/incomplete/invalid assumed or relinquished care date.
Start: 12/02/2004
N311 = Missing/incomplete/invalid authorized to return to work date.
Start: 12/02/2004
N312 = Missing/incomplete/invalid begin therapy date.
Start: 12/02/2004
N313 = Missing/incomplete/invalid certification revision date.
Start: 12/02/2004
N314 = Missing/incomplete/invalid diagnosis date.
Start: 12/02/2004
N315 = Missing/incomplete/invalid disability from date.
Start: 12/02/2004
N316 = Missing/incomplete/invalid disability

to date.
Start: 12/02/2004
N317 = Missing/incomplete/invalid discharge hour.
Start: 12/02/2004
N318 = Missing/incomplete/invalid discharge or end of care date.
Start: 12/02/2004
N319 = Missing/incomplete/invalid hearing or vision prescription date.
Start: 12/02/2004
N320 = Missing/incomplete/invalid Home Health Certification Period.
Start: 12/02/2004
N321 = Missing/incomplete/invalid last admission period.
Start: 12/02/2004
N322 = Missing/incomplete/invalid last certification date.
Start: 12/02/2004
N323 = Missing/incomplete/invalid last contact date.
Start: 12/02/2004
N324 = Missing/incomplete/invalid last seen/visit date.
Start: 12/02/2004
N325 = Missing/incomplete/invalid last worked date.
Start: 12/02/2004
N326 = Missing/incomplete/invalid last x-ray date.
Start: 12/02/2004
N327 = Missing/incomplete/invalid other insured birth date.
Start: 12/02/2004
N328 = Missing/incomplete/invalid Oxygen Saturation Test date.
Start: 12/02/2004
N329 = Missing/incomplete/invalid patient birth date
Start: 12/02/2004
N330 = Missing/incomplete/invalid patient death date.
Start: 12/02/2004
N331 = Missing/incomplete/invalid physician order date.
Start: 12/02/2004
N332 = Missing/incomplete/invalid prior hospital discharge date.
Start: 12/02/2004
N333 = Missing/incomplete/invalid prior placement date.
Start: 12/02/2004
N334 = Missing/incomplete/invalid re- evaluation

date
Start: 12/02/2004
N335 = Missing/incomplete/invalid referral date.
Start: 12/02/2004
N336 = Missing/incomplete/invalid replacement date.
Start: 12/02/2004
N337 = Missing/incomplete/invalid secondary diagnosis date.
Start: 12/02/2004
N338 = Missing/incomplete/invalid shipped date.
Start: 12/02/2004
N339 = Missing/incomplete/invalid similar illness or symptom date.
Start: 12/02/2004
N340 = Missing/incomplete/invalid subscriber birth date.
Start: 12/02/2004
N341 = Missing/incomplete/invalid surgery date.
Start: 12/02/2004
N342 = Missing/incomplete/invalid test performed date.
Start: 12/02/2004
N343 = Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial start date.
Start: 12/02/2004
N344 = Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial end date.
Start: 12/02/2004
N345 = Date range not valid with units submitted.
Start: 03/30/2005
N346 = Missing/incomplete/invalid oral cavity designation code.
Start: 03/30/2005
N347 = Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.
Start: 03/30/2005
N348 = You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.
Start: 08/01/2005
N349 = The administration method and drug must be reported to adjudicate this service.
Start: 08/01/2005
N350 = Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report

procedure.
Start: 08/01/2005
N351 = Service date outside of the approved treatment plan service dates.
Start: 08/01/2005
N352 = Alert: There are no scheduled payments for this service. Submit a claim for each patient visit.
Start: 08/01/2005
N353 = Alert: Benefits have been estimated, when the actual services have been rendered, additional payment will be considered based on the submitted claim.
Start: 08/01/2005
N354 = Incomplete/invalid invoice
Start: 08/01/2005
"Alert: The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.
If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request appeal of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position.
If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.
The law also permits you to request an appeal at any time within 120 days of the date you receive this notice. However, an appeal request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless

of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.
The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days"
Start: 08/01/2005

N356 = Not covered when performed with, or subsequent to, a non-covered service.
Start: 08/01/2005

N357 = Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.
Start: 11/18/2005

N358 = Alert: This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted.
Start: 11/18/2005

N359 = Missing/incomplete/invalid height.
Start: 11/18/2005

N360 = Alert: Coordination of benefits has not been calculated when estimating benefits for this pre-determination. Submit payment information from the primary payer with the secondary claim.
Start: 11/18/2005

N361 = Payment adjusted based on multiple diagnostic imaging procedure rules
Start: 11/18/2005
Stop: 10/01/2007
Notes: (Modified 12/1/06)
Consider using Reason Code 59

N362 = The number of Days or Units of Service exceeds our acceptable maximum.
Start: 11/18/2005

N363 = Alert: in the near future we are implementing new policies/procedures that would affect this determination.
Start: 11/18/2005

N364 = Alert: According to our agreement, you must waive the deductible and/or coinsurance amounts.
Start: 11/18/2005

N365 = This procedure code is not payable. It is for reporting/information purposes

only.
Start: 04/01/2006
N366 = Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.
Start: 04/01/2006
N367 = Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account.
Start: 04/01/2006
Last Modified: 07/01/2008
N368 = You must appeal the determination of the previously adjudicated claim.
Start: 04/01/2006
N369 = Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.
Start: 04/01/2006
N370 = Billing exceeds the rental months covered/approved by the payer.
Start: 08/01/2006
N371 = Alert: title of this equipment must be transferred to the patient.
Start: 08/01/2006
N372 = Only reasonable and necessary maintenance/service charges are covered.
Start: 08/01/2006
N373 = It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf.
Start: 12/01/2006
N374 = Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required.
Start: 12/01/2006
N375 = Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.
Start: 12/01/2006
N376 = Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE.
Start: 12/01/2006
N377 = Payment based on a processed replacement claim.
Start: 12/01/2006
N378 = Missing/incomplete/invalid prescription quantity.

Start: 12/01/2006
N379 = Claim level information does not match line level information.
Start: 12/01/2006
N380 = The original claim has been processed, submit a corrected claim.
Start: 04/01/2007
N381 = Consult our contractual agreement for restrictions/billing/payment information related to these charges.
Start: 04/01/2007
N382 = Missing/incomplete/invalid patient identifier.
Start: 04/01/2007
N383 = Not covered when deemed cosmetic.
Start: 04/01/2007
Last Modified: 03/08/2011
Notes: (Modified 3/8/11)
N384 = Records indicate that the referenced body part/tooth has been removed in a previous procedure.
Start: 04/01/2007
N385 = Notification of admission was not timely
according to published plan procedures.
Start: 04/01/2007
N386 = This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
Start: 04/01/2007
N387 = Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.
Start: 04/01/2007
N388 = Missing/incomplete/invalid prescription number.
Start: 08/01/2007
N389 = Duplicate prescription number submitted.
Start: 08/01/2007
N390 = This service/report cannot be billed separately.
Start: 08/01/2007
N391 = Missing emergency department records.
Start: 08/01/2007
N392 = Incomplete/invalid emergency department records.

Start: 08/01/2007
N393 = Missing progress notes/report.
Start: 08/01/2007
N394 = Incomplete/invalid progress notes/report.
Start: 08/01/2007
N395 = Missing laboratory report.
Start: 08/01/2007
N396 = Incomplete/invalid laboratory report.
Start: 08/01/2007
N397 = Benefits are not available for incomplete service(s)/undelivered item(s).
Start: 08/01/2007
N398 = Missing elective consent form.
Start: 08/01/2007
N399 = Incomplete/invalid elective consent form.
Start: 08/01/2007
N400 = Alert: Electronically enabled providers should submit claims electronically.
Start: 08/01/2007
N401 = Missing periodontal charting.
Start: 08/01/2007
N402 = Incomplete/invalid periodontal charting.
Start: 08/01/2007
N403 = Missing facility certification.
Start: 08/01/2007
N404 = Incomplete/invalid facility certification.
Start: 08/01/2007
N405 = This service is only covered when the donor's insurer(s) do not provide coverage for the service.
Start: 08/01/2007
N406 = This service is only covered when the recipient's insurer(s) do not provide coverage for the service.
Start: 08/01/2007
N407 = You are not an approved submitter for this transmission format.
Start: 08/01/2007
N408 = This payer does not cover deductibles assessed by a previous payer.
Start: 08/01/2007
N409 = This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident.
Start: 08/01/2007
N410 = Not covered unless the prescription changes.
Start: 08/01/2007

N411 = This service is allowed one time in a 6-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)
Start: 08/01/2007
Stop: 02/01/2009

N412 = This service is allowed 2 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)
Start: 08/01/2007
Stop: 02/01/2009

N413 = This service is allowed 2 times in a benefit year. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)
Start: 08/01/2007
Stop: 02/01/2009

N414 = This service is allowed 4 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)
Start: 08/01/2007
Stop: 02/01/2009

N415 = This service is allowed 1 time in an 18-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)
Start: 08/01/2007
Stop: 02/01/2009

N416 = This service is allowed 1 time in a 3-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)
Start: 08/01/2007
Stop: 02/01/2009

N417 = This service is allowed 1 time in a 5-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)
Start: 08/01/2007
Stop: 02/01/2009

N418 = Misrouted claim. See the payer's claim submission instructions.
Start: 08/01/2007

N419 = Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change.
Start: 08/01/2007

N420 = Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery.
Start: 08/01/2007

N421 = Claim payment was the result of a payer's retroactive adjustment due to a review organization decision.
Start: 08/01/2007
N422 = Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program.
Start: 08/01/2007
N423 = Claim payment was the result of a payer's retroactive adjustment due to a non standard program.
Start: 08/01/2007
N424 = Patient does not reside in the geographic area required for this type of payment.
Start: 08/01/2007
N425 = Statutorily excluded service(s).
Start: 08/01/2007
N426 = No coverage when self-administered.
Start: 08/01/2007
N427 = Payment for eyeglasses or contact lenses can be made only after cataract surgery.
Start: 08/01/2007
N428 = Not covered when performed in this place of surgery.
Start: 08/01/2007
N429 = Not covered when considered routine.
Start: 08/01/2007
N430 = Procedure code is inconsistent with the units billed.
Start: 11/05/2007
N431 = Not covered with this procedure.
Start: 11/05/2007
N432 = Adjustment based on a Recovery Audit.
Start: 11/05/2007
N433 = Resubmit this claim using only your National Provider Identifier (NPI)
Start: 02/29/2008
N434 = Missing/Incomplete/Invalid Present on Admission indicator.
Start: 07/01/2008
N435 = Exceeds number/frequency approved /allowed within time period without support documentation.
Start: 07/01/2008
N436 = The injury claim has not been accepted and a mandatory medical reimbursement has been made.
Start: 07/01/2008
N437 = Alert: If the injury claim is accepted, these charges will be reconsidered.
Start: 07/01/2008
N438 = This jurisdiction only accepts paper

claims
Start: 07/01/2008
N439 = Missing anesthesia physical status report/indicators.
Start: 07/01/2008
N440 = Incomplete/invalid anesthesia physical status report/indicators.
Start: 07/01/2008
N441 = This missed appointment is not covered.
Start: 07/01/2008
N442 = Payment based on an alternate fee schedule.
Start: 07/01/2008
N443 = Missing/incomplete/invalid total time or begin/end time.
Start: 07/01/2008
N444 = Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation.
Start: 07/01/2008
N445 = Missing document for actual cost or paid amount.
Start: 07/01/2008
N446 = Incomplete/invalid document for actual cost or paid amount.
Start: 07/01/2008
N447 = Payment is based on a generic equivalent
as required documentation was not provided.
Start: 07/01/2008
N448 = This drug/service/supply is not included
in the fee schedule or
contracted/legislated fee arrangement
Start: 07/01/2008
N449 = Payment based on a comparable drug/service/supply.
Start: 07/01/2008
N450 = Covered only when performed by the primary treating physician or the designee.
Start: 07/01/2008
N451 = Missing Admission Summary Report.
Start: 07/01/2008
N452 = Incomplete/invalid Admission Summary Report.
Start: 07/01/2008
N453 = Missing Consultation Report.
Start: 07/01/2008
N454 = Incomplete/invalid Consultation Report.
Start: 07/01/2008
N455 = Missing Physician Order.
Start: 07/01/2008

N456 = Incomplete/invalid Physician Order.
Start: 07/01/2008
N457 = Missing Diagnostic Report.
Start: 07/01/2008
N458 = Incomplete/invalid Diagnostic Report.
Start: 07/01/2008
N459 = Missing Discharge Summary.
Start: 07/01/2008
N460 = Incomplete/invalid Discharge Summary.
Start: 07/01/2008
N461 = Missing Nursing Notes.
Start: 07/01/2008
N462 = Incomplete/invalid Nursing Notes.
Start: 07/01/2008
N463 = Missing support data for claim.
Start: 07/01/2008
N464 = Incomplete/invalid support data for claim.
Start: 07/01/2008
N465 = Missing Physical Therapy Notes/Report.
Start: 07/01/2008
N466 = Incomplete/invalid Physical Therapy Notes/Report.
Start: 07/01/2008
N467 = Missing Report of Tests and Analysis Report.
Start: 07/01/2008
N468 = Incomplete/invalid Report of Tests and Analysis Report.
Start: 07/01/2008
N469 = Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).
Start: 07/01/2008
N470 = This payment will complete the mandatory
medical reimbursement limit.
Start: 07/01/2008
N471 = Missing/incomplete/invalid HIPPS Rate Code.
Start: 07/01/2008
N472 = Payment for this service has been issued
to another provider.
Start: 07/01/2008
N473 = Missing certification.
Start: 07/01/2008
N474 = Incomplete/invalid certification
Start: 07/01/2008
N475 = Missing completed referral form.
Start: 07/01/2008
N476 = Incomplete/invalid completed referral form

Start: 07/01/2008
N477 = Missing Dental Models.
Start: 07/01/2008
N478 = Incomplete/invalid Dental Models
Start: 07/01/2008
N479 = Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
Start: 07/01/2008
N480 = Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
Start: 07/01/2008
N481 = Missing Models.
Start: 07/01/2008
N482 = Incomplete/invalid Models
Start: 07/01/2008
N483 = Missing Periodontal Charts.
Start: 07/01/2008
N484 = Incomplete/invalid Periodontal Charts
Start: 07/01/2008
N485 = Missing Physical Therapy Certification.
Start: 07/01/2008
N486 = Incomplete/invalid Physical Therapy Certification.
Start: 07/01/2008
N487 = Missing Prosthetics or Orthotics Certification.
Start: 07/01/2008
N488 = Incomplete/invalid Prosthetics or Orthotics Certification
Start: 07/01/2008
N489 = Missing referral form.
Start: 07/01/2008
N490 = Incomplete/invalid referral form
Start: 07/01/2008
N491 = Missing/Incomplete/Invalid Exclusionary Rider Condition.
Start: 07/01/2008
N492 = Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge.
Start: 07/01/2008
N493 = Missing Doctor First Report of Injury.
Start: 07/01/2008
N494 = Incomplete/invalid Doctor First Report of Injury.
Start: 07/01/2008
N495 = Missing Supplemental Medical Report.
Start: 07/01/2008
N496 = Incomplete/invalid Supplemental Medical

Report.
Start: 07/01/2008
N497 = Missing Medical Permanent Impairment or Disability Report.
Start: 07/01/2008
N498 = Incomplete/invalid Medical Permanent Impairment or Disability Report.
Start: 07/01/2008
N499 = Missing Medical Legal Report.
Start: 07/01/2008
N500 = Incomplete/invalid Medical Legal Report.
Start: 07/01/2008
N501 = Missing Vocational Report.
Start: 07/01/2008
N502 = Incomplete/invalid Vocational Report.
Start: 07/01/2008
N503 = Missing Work Status Report.
Start: 07/01/2008
N504 = Incomplete/invalid Work Status Report.
Start: 07/01/2008
N505 = Alert: This response includes only services that could be estimated in real time. No estimate will be provided for the services that could not be estimated in real time.
Start: 11/01/2008
N506 = Alert: This is an estimate of the member's liability based on the information available at the time the estimate was processed. Actual coverage and member liability amounts will be determined when the claim is processed. This is not a pre-authorization or a guarantee of payment.
Start: 11/01/2008
N507 = Plan distance requirements have not been met.
Start: 11/01/2008
N508 = Alert: This real time claim adjudication response represents the the member responsibility to the provider for services reported. The member will receive an Explanation of Benefits electronically or in the mail. Contact the insurer if there are any questions.
Start: 11/01/2008
N509 = Alert: A current inquiry shows the member's Consumer Spending Account contains sufficient funds to cover the member liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the

availability of funds and determination of eligible services at the time of payment processing.
Start: 11/01/2008

N510 = Alert: A current inquiry shows the members Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.
Start: 11/01/2008

N511 = Alert: Information on the availability of Consumer Spending Account funds to cover the member liability on this claim/service is not available at this time.
Start: 11/01/2008

N512 = Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.
Start: 11/01/2008

N513 = Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.
Start: 11/01/2008

N514 = Consult plan benefit documents/guidelines for information about restrictions for this service.
Start: 11/01/2008
Stop: 01/01/2011
Notes: Consider using N130

N515 = Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. (use N387 instead)
Start: 11/01/2008
Stop: 10/1/2009

N516 = Records indicate a mismatch between the submitted NPI and EIN.
Start: 03/01/2009

N517 = Resubmit a new claim with the requested information.
Start: 03/01/2009

N518 = No separate payment for accessories when furnished for use with oxygen equipment.
Start: 03/01/2009

N519 = Invalid combination of HCPCS modifiers.

Start: 07/01/2009
N520 = Alert: Payment made from a Consumer Spending Account.
Start: 07/01/2009
N521 = Mismatch between the submitted provider information and the provider information stored in our system.
Start: 11/01/2009
N522 = Duplicate of a claim processed, or to be processed, as a crossover claim.
Start: 11/01/2009
N523 = The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid.
Start: 03/01/2010
N524 = Based on policy this payment constitutes payment in full.
Start: 03/01/2010
N525 = These services are not covered when performed within the global period of another service.
Start: 03/01/2010
N526 = Not qualified for recovery based on employer size.
Start: 03/01/2010
N527 = We processed this claim as the primary payer prior to receiving the recovery demand.
Start: 03/01/2010
N528 = Patient is entitled to benefits for Institutional Services only.
Start: 03/01/2010
N529 = Patient is entitled to benefits for Professional Services only.
Start: 03/01/2010
N530 = Not Qualified for Recovery based on enrollment information.
Start: 03/01/2010 |
N531 = Not qualified for recovery based on direct payment of premium.
Start: 03/01/2010
N532 = Not qualified for recovery based on disability and working status.
Start: 03/01/2010
N533 = Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan.
Start: 07/01/2010
N534 = This is an individual policy, the employer does not participate in plan sponsorship.
Start: 07/01/2010

N535 = Payment is adjusted when procedure is performed in this place of service based on the submitted procedure code and place of service.
Start: 07/01/2010
N536 = We are not changing the prior payer's determination of patient responsibility, which you may collect, as this service is not covered by us.
Start: 07/01/2010
N537 = We have examined claims history and no records of the services have been found.
Start: 07/01/2010
N538 = A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.
Start: 07/01/2010
N539 = Alert: We processed appeals/waiver requests on your behalf and that request has been denied.
Start: 07/01/2010
N540 = Payment adjusted based on the interrupted stay policy.
Start: 11/01/2010
N541 = Mismatch between the submitted insurance type code and the information stored in our system.
Start: 11/01/2010
N542 = Missing income verification.
Start: 03/08/2011
N543 = Incomplete/invalid income verification
Start: 03/08/2011
N544 = Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future.
Start: 07/01/2011
N545 = Payment reduced based on status as an unsuccessful eprescriber per the Electronic Prescribing (eRx) Incentive Program.
Start: 07/01/2011
N546 = Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.
Start: 07/01/2011
N547 = A refund request (Frequency Type Code 8) was processed previously.
Start: 03/06/2012
N548 = Alert: Patient's calendar year deductible has been met.
Start: 03/06/2012

N549 = Alert: Patient's calendar year out-of-pocket maximum has been met.
Start: 03/06/2012
N550 = Alert: You have not responded to requests to revalidate your provider/supplier enrollment information. Your failure to revalidate your enrollment information will result in a payment hold in the near future.
Start: 03/06/2012
N551 = Payment adjusted based on the Ambulatory
Surgical Center (ASC) Quality Reporting Program.
Start: 03/06/2012
N552 = Payment adjusted to reverse a previous withhold/bonus amount.
Start: 03/06/2012
N553 = Payment adjusted based on a Low Income Subsidy (LIS) retroactive coverage or status change.
Start: 03/06/2012
Stop: 11/1/2012
N554 = Missing/Incomplete/Invalid Family Planning Indicator
Start: 07/01/2012
N555 = Missing medication list.
Start: 07/01/2012
N556 = Incomplete/invalid medication list.
Start: 07/01/2012
N557 = This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the specimen was collected.
Start: 07/01/2012
N558 = This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the equipment was received.
Start: 07/01/2012
N559 = This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the Ordering Physician is located.
Start: 07/01/2012
N560 = The pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim was not received.
Start: 11/01/2012
N561 = The bundled claim originally submitted for this episode of care includes related readmissions. You may resubmit the original claim to receive a corrected payment based on this

readmission.
Start: 11/01/2012

N562 = The provider number of your incoming claim does not match the provider number on the processed Notice of Admission (NOA) for this bundled payment.
Start: 11/01/2012

N563 = Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.
Start: 11/01/2012
Notes: Related to M39

N564 = Patient did not meet the inclusion criteria for the demonstration project or pilot program.
Start: 11/01/2012

N565 = Alert: This procedure code requires a modifier. Future claims containing this procedure code must include an appropriate modifier for the claim to be processed.
Start: 11/01/2012

N566 = Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed.
Start: 11/01/2012

CLM_RRB_EXCLSN_IND_TB Claim RRB Exclusion Indicator Table

Y = Exclude RRB beneficiary services from the prior authorization program

Blank = Subject RRB beneficiary services to prior authorization

CLM_SRVC_CLSFCTN_TYPE_TB Claim Service Classification Type Table

For facility type code 1 thru 6, and 9

1 = Inpatient (including Part A)

2 = Hospital based or Inpatient (Part B only) or home health visits under Part B

3 = Outpatient (HHA-A also)

4 = Other (Part B) -- (Includes HHA medical and other health services not under a plan of treatment, hospital or SNF for diagnostic clinical laboratory services for "nonpatients," and referenced diagnostic services. For HHAs

under PPS, indicates an osteoporosis claim.)
5 = Intermediate care - level I
6 = Intermediate care - level II
7 = Subacute Inpatient (revenue code 019X required)
(formerly Intermediate care - level III)
NOTE: 17X & 27X are discontinued effective 10/1/05.
8 = Swing beds (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)
9 = Reserved for national assignment

For facility type code 7

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

For facility type code 8

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

CLM_TRANS_TB Claim Transaction Table

0 = Religious NonMedical Health Care Institutions (RNHCI) bill (prior to 8/00, Christian Science bill), SNF bill, or state buy-in
1 = Psychiatric hospital facility bill or dummy psychiatric
2 = Tuberculosis hospital facility bill
3 = General care hospital facility bill or dummy LRD
4 = Regular SNF bill
5 = Home health agency bill (HHA)
6 = Outpatient hospital bill

C = CORF bill - type of OP bill in the HHA bill format
(obsoleted 7/98)
H = Hospice bill

CLM_VAL_TB Claim Value Table

01 = Most Common Semi-Private Rate - to provide for the recording of hospital's most common semi-private rate.
02 = Hospital Has No Semi-Private Rooms - Entering this code requires $0.00 amount.
03 = Reserved for national assignment.
04 = Inpatient professional component charges which are combined billed - For use only by some all inclusive rate hospitals. (Eff 9/93)
05 = Professional component included in charges and also billed separately to carrier - For use on Medicare and Medicaid bills if the state requests this information.
06 = Medicare blood deductible - Total cash blood deductible (Part A blood deductible).
07 = Medicare cash deductible (term 9/30/93) Reserved for national assignment.
08 = Medicare Part A lifetime reserve amount in first calendar year - Lifetime reserve amount charged in the year of admission. (not stored in NCH until 2/93)
09 = Medicare Part A coinsurance amount in the first calendar year - Coinsurance amount charged in the year of admission. (not stored in NCH until 2/93)
10 = Medicare Part A lifetime reserve amount in the second calendar year - Lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.
(in NCH until 2/93)
11 = Medicare Part A coinsurance amount in the second calendar year - Coinsurance amount charged in the year of discharge where the bill spans two calendar years (not stored in NCH until 2/93)
12 = Amount is that portion of higher priority EGHP insurance payment made on behalf of aged bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider

claimed conditional Medicare payment.
13 = Amount is that portion of higher priority EGHP insurance payment made on behalf of ESRD bene provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
14 = That portion of payment from higher priority no fault auto/other liability insurance made on behalf of bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional payment
15 = That portion of a payment from a higher priority WC plan made on behalf of a bene that the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
16 = That portion of a payment from higher priority PHS or other federal agency made on behalf of a bene the provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.
17 = Operating Outlier amount - Providers do not report this. For payer internal use only. Indicates the amount of day or cost outlier payment to be made. (Do not include any PPS capital outlier payment in this entry). Obsolete
18 = Operating Disproportionate share amount - Providers do not report this. For payer internal use only. Indicates the disproportionate share amount applicable to the bill. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry). Obsolete
19 = Operating Indirect medical education amount - Providers do not report this. For payer internal use only. Indicates the indirect medical education amount applicable to the bill. (Do not include PPS capital IME adjustment in this entry). Obsolete
20 = Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount. (used 10/1/91 - 3/1/92 for provider reporting. Payer only code eff 9/93.)

Obsolete
21 = Catastrophic - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
22 = Surplus - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
23 = Recurring monthly income - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
24 = Medicaid rate code - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
25 = Offset to the Patient Payment Amount (Prescription Drugs) - Prescription drugs paid for out of a long-term care facility resident/patient's fund in the billing period submitted (Statement Covers Period).
26 - Prescription Drugs Offset to Patient (Payment Amount - Hearing and Ear Services) Hearing and ear services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement covers period).
27 = Offset to the Patient (Payment Amount - Vision and Eye Services) - Vision and eye services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
28 = Offset to the Patient (Payment Amount - Dental Services) - Dental services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
29 = Offset to the Patient (Payment Amount - Chiropractic Services) - Chiropratic services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
30 = Preadmission Testing - the code used to reflect the charges for preadmission outpatient diagnostic services in preparation for a previously scheduled admission.
31 = Patient liability amount - Amount shown is that which you or the PRO approved to charge the bene for noncovered accommodations, diagnostic procedures or treatments.
32 = Multiple patient ambulance transport - The number of patients transported during one ambulance ride to the same destination.

(eff. 4/1/2003)
33 = Offset to the Patient Payment Amount (Podiatric Services) -- Podiatric services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
34 = Offset to the Patient Payment Amount (Medical Services) -- Other medical services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
35 = Offset to the Patient Payment Amount (Health Insurance Premiums) -- Other medical services paid out of a long-term care facility resident/ patient's funds in the billing period submitted.
37 = Pints of blood furnished - Total number of pints of whole blood or units of packed red cells furnished to the patient. (eff 10/93)
38 = Blood deductible pints - The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. (eff 10/93)
39 = Pints of blood replaced - The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient. (eff 10/93)
40 = New coverage not implemented by HMO - amount shown is for inpatient charges covered by HMO (eff 3/92). (use this code when the bill includes inpatient charges for newly covered services which are not paid by HMO.)
41 = Amount is that portion of a payment from higher priority Black Lung federal program made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
42 = Amount is that portion of a payment from higher priority VA made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
43 = Disabled bene under age 65 with LGHP - Amount is that portion of a payment from a higher priority LGHP made on behalf of a disabled Medicare bene the provider applied to Medicare covered services on this bill.

44 = Amount provider agreed to accept from
primary payer when amount less than charges
but more than payment received -
When a lesser amount is received and the
received amount is less than charges, a
Medicare secondary payment is due.
45 = Accident Hour - The hour the accident occurred
that necessitated medical treatment.
46 = Number of grace days - Following the
date of the PRO/UR determination, this
is the number of days determined by the
PRO/UR to be necessary to arrange for
the patient's post-discharge care.
(eff 10/93)
47 = Any liability insurance - Amount
is that portion from a higher priority
liability insurance made on behalf of
Medicare bene the provider
is applying to Medicare covered
services on this bill. (Eff 9/93)
48 = Hemoglobin reading - The patient's most
recent hemoglobin reading taken before
the start of the billing period (eff.
1/3/2006). Prior to 1/3/2006 defined as
the latest hemoglobin reading taken during
the billing cycle.
49 = Hematocrit reading - The patient's most
recent hematocrit reading taken before the
start of the billing period (eff. 1/3/2006).
Prior to 1/3/2006 defined as hematocrit
reading taken during the billing cycle.
50 = Physical therapy visits - Indicates
the number of physical therapy
visits from onset (at billing provider)
through this billing period.
51 = Occupational therapy visits - Indicates
the number of occupational therapy
visits from onset (at the billing
provider) through this billing period.
52 = Speech therapy visits - Indicates
the number of speech therapy
visits from onset (at billing provider)
through this billing period.
53 = Cardiac rehabilitation - Indicates
the number of cardiac rehabilitation
visits from onset (at billing
provider) through this billing period.
54 = New birth weight in grams - Actual birth
weight or weight at time of admission for
an extramural birth. Required on all claims
with type of admission of '4' and on other
claims as required by law.
55 = Eligibility Threshold for Charity Care - code
identifies the corresponding value amount at

which a health care facility determines the eligibility threshold of charity care.

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

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

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

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

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

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

NOTE: HHA claims with a thru date on or before 12/31/05, the value code amount field reflects the MSA code (followed by zeroes to fill the field). HHA claims with a thru date after 12/31/05, the value code amount field reflects the CBSA code.

62 = Number of Part A home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

63 = Number of Part B home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

64 = Amount of home health payments attributed to the Part A trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

65 = Amount of home health payments attributed to the Part B trust fund in a period of continuous care - necessitated by the

change in payment basis under HH PPS
(eff. 10/00)
66 = Medicare Spend-down Amount -- The dollar
amount that was used to meet th4e recipient's
spend-down liability for this claim.
67 = Peritoneal dialysis - The number of
hours of peritoneal dialysis provided
during the billing period (only the
hours spent in the home).
(eff. 10/97)
68 = EPO drug - Number of units of EPO
administered relating to the billing
period.
69 = State Charity Care Percent - code
indicates the percentage of charity
care eligibility for the patient.
70 = Interest amount - (Providers do not
report this.) Report the amount
applied to this bill.
71 = Funding of ESRD networks - (Providers
do not report this.) Report the
amount the Medicare payment was
reduced to help fund the ESRD networks.
72 = Flat rate surgery charge - Code
indicates the amount of the charge for
outpatient surgery where the hospital
has such a charging structure.
73 = Drug deductible - (For internal use by
third party payers only). Report the
amount of the drug deductible to be
applied to the claim.
74 = Drug coinsurance - (For internal use
by third party payers only). Report
the amount of drug coinsurance to be
applied to the claim.
75 = Gramm/Rudman/Hollings - (Providers do
not report this.) Report the amount of
the sequestration applied to this bill.
76 = Report provider's percentage of
billed charges interim rate during
billing period. Applies to OP
hospital, SNF and HHA claims
where interim rate is applicable.
Report to left of dollar/cents delimiter.
(TP payers internal use only)
77 = New Technology Add-on Payment Amount -
Amount of payments made for discharges
involving approved new technologies. If
the total covered costs of the discharge
exceed the DRG payment for the case
(including adjustments for IME and
disporportionate share hospitals (DSH) but
excluding outlier payments) an add-on
amount is made indicating a new technology

was used in the treatment of the beneficiary.
(eff. 4/1/03, under Inpatient PPS)
78 = Payer code - This codes is set aside for payer use only. Providers do not report these codes.
79 = Payer code - This code is set aside for payer use only. Providers do not report these codes.
80 = Covered days - the number of days covered by the primary payer as qualified by the payer.
81 = Non-covered Days - days of care not covered by the primary payer.
82 = Co-insurance Days - The inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/Swing bed days occurring after the 20th and before the 101st day in a single spell of illness.
83 = Lifetime Reserve Days - Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.
84 = Medicare Lifetime Reserve Amount in the third or greater calendar years'. Eff. 1/7/2013
85 = Medicare Coinsurance Amount in the third or greater calendar years'. Eff. 1/7/2013
86 = Invoice Cost (term. 3/2020)
87 = Gene Therapy Invoice Cost (eff. 4/2020)
88 = Allogeneic Stem Cell Transplant - Number of Related Donors Evaluation (eff. 7/2020)
89 = Allogeneic Stem Cell Transplant - Total All-inclusive Donor Charges (eff. 7/2020)
90 = Cell Therapy Invoice Cost (eff. 4/2020)
91 - 99 = Reserved for national assignment.
A0 = Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (eff. 9/01)
A1 = Deductible Payer A - The amount assumed by the provider to be applied to the patient's deductible amount to the invovling the indicated payer. (eff. 10/93)
- Prior value 07
A2 = Coinsurance Payer A - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)
A3 = Estimated Responsibility Payer A - The amount estimated by the provider to be paid by the indicated payer.
A4 = Self-administered drugs administered in an emergency situation - Ordinarily the only noncovered self-administered drug paid for under Medicare in an emergency

situation is insulin administered to a patient in a diabetic coma. (eff 7/97)

A5 = Covered self-administered drugs -- The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administered in the form and situation in which it was furnished to the patient.

A6 = Covered self-administered drugs -Diagnostic study and Other --- the amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons. For use with Revenue Center 0637.

A7 = Copayment A -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.

A8 = Patient Weight -- Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight.

A9 = Patient Height - Height of patient in centimeters Report this data only when the health plan has a predefined change in reimbursement that is affected by height.

AA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer A) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).

AB = Other Assessments or Allowances (Payer A) -- The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).

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

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

B3 = Estimated Responsibility Payer B - The amount estimated by the provider to be paid by the indicated payer.

B7 = Copayment B -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.

BA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer B) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).

BB = Other Assessments or Allowances (Payer B) --

The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).

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

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

C3 = Estimated Responsibility Payer C - The

C7 = Copayment C -- The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.

CA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer C) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).

CB = Other Assessments or Allowances (Payer C) -- The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).

D3 = Estimated Responsibility Patient - The amount estimated by the provider to be paid by the indicated patient.

D4 = Clinical Trial Number Assigned by NLM/NIH - Eight digit numeric National Library of Medicine/National Institute of Health clinical trial registry number or a default number of '99999999' if the trial does not have an 8-digit registry number. (Eff. 10/1/07)

D5 = Last Kt/V Reading - result of last Kt/V reading. For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within 4 months of the date of service. (eff. 7/1/10)

FC = Patient Paid Amount - The amount the provider has received from the patient toward payment of this bill (7/1/08).

FD = Credit Received from the Manufacturer for a Replaced Medical Device - the amount the provider has received from a medical device manufacturer as credit for a replaced device. (eff. 7/1/08)

G8 = Facility Where Inpatient Hospice Service Is Delivered - MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice is delivered. (Eff. 1/1/08)

Q0 = ACO Payment Adjustment Amount (Pioneer Reduction)-

the amount that would have been paid if not for the Pioneer reduction. (eff. 1/2014)
Q1 = ACO Payment Reduction Amount (Pioneer Reduction)- the actual amount of the Pioneer reduction. (eff. 1/2014)
Q4 = Pennsylvania (PA) Rural Health Exclusion - Physician Services Claim Reimbursement
Q5 = EHR Reduction
Q7 = ISLET Add-On Payment Amount (eff. 10/2016)
Q8 = Total Transitional Drug Add-On Payment Adjustment (TDAPA) Amount (eff. 1/2018)
Q9 = Medicare Advantage (MA) Plan Amount (eff. 10/2014)
QB = OCM+ Payment Adjustment Amount (payer only) (eff. 1/2020)
QG = Total TPNIES Amount - used to capture the TPNIES add-on payment. eff. 4/2021
QN = First APC device offset
QO = Second APC device offset
QP = Placeholder reserved for future use
QQ = Terminated procedure with pass-through device OR condition for device credit present
QR = First APC pass-through drug or biological offset
QS = Second APC pass-through drug or biological offset
QT = Third APC pass-through drug or biological offset
QU = Reserved for future use
QV = Home Health Value Based Purchasing (HHVBP) adjustment amount (negative or positive) - eff. 4/2018
QW = Reserved for future use
XX = Total Charge Amount for all Part A visits on RIC 'U' claims - for Home Health claims containing both Part A and Part B services this code identifies the total charge amount for the Part A visits (based on revenue center codes 042X, 043X, 044X, 055X, 056X, & 057X). Code created internally in the CWFMQA system (eff. 10/31/01 with HHPPS).
XY = Total Charge Amount for all Part B visits on RIC 'U' claims - for Home Health claims containing both Part A and Part B services this code identifies the total charge amount for the Part B visits (based on revenue center codes 042X, 043X, 044X, 055X, 056X, & 057X). Code created internally in the CWFMQA system (eff. 10/31/01 with HHPPS).
XZ = Total Charge Amount for all Part B non-visit charges on the RIC 'U' claims - for Home Health claims containing both Part A & Part B services, this code identifies the total charge amount for the Part B non-visit charges. Code created internally in the CWFMQA system (eff. 10/31/01 with HHPPS).
Y1 = Part A demo payment - Portion of the payment designated as reimbursement for Part A services under the demonstration.

This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included in this amount.

Y2 = Part B demo payment - Portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.

Y3 = Part B coinsurance - Amount of Part B coinsurance applied by the intermediary to this demo claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).

Y4 = Conventional Provider Payment Amount for Non-Demonstration Claims - This the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operating IME and DSH.

Y5 = Part B deductible, applicable for a Model 4 demonstration 64 claims

CLM_WC_IND_TB Workers' Compensation Indicator Table

Y = The diagnosis codes on the claims are related to the diagnosis codes on the MSP auxiliary file in CWF.

Spaces

CMS_PRVDR_SPCLTY_TB CMS Provider Specialty Table

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

04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Interventional Pain Management (IPM) (eff. 4/1/03)
09 = Gynecology (osteopaths only)
(discontinued 5/92 use code 16)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative therapy
13 = Neurology
14 = Neurosurgery
15 = Speech Language Pathologists
15 = Obstetrics (osteopaths only)
(discontinued 5/92 use code 16)
16 = Obstetrics/gynecology
17 = Hospice and Palliative Care
17 = Ophthalmology, otology, laryngology,
rhinology (osteopaths only)
(discontinued 5/92 use codes 18 or 04
depending on percentage of practice)
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Cardiac Electrophysiology
21 = Pathologic anatomy, clinical
pathology (osteopaths only)
(discontinued 5/92 use code 22)
22 = Pathology
23 = Sports medicine
23 = Peripheral vascular disease, medical
or surgical (osteopaths only)
(discontinued 5/92 use code 76)
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Geriatric Psychiatry Colorectal Surgery
27 = Psychiatry, neurology (osteopaths
only) (discontinued 5/92 use code 86)
28 = Colorectal surgery (formerly
proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Intensive Cardiac Rehabilitation
31 = Roentgenology, radiology (osteopaths
only) (discontinued 5/92 use code 30)
32 = Anesthesiologist Assistants (eff. 4/1/03--previously
grouped with Certified Registered Nurse Anesthetists
(CRNA))
32 = Radiation therapy (osteopaths only)
(discontinued 5/92 use code 92)
33 = Thoracic surgery
34 = Urology

35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry (revised 10/93 to
mean optometrist)
42 = Certified nurse midwife (eff 1/87)
43 = CRNA (eff. 1/87) (Anesthesiologist Assistants
were removed from this specialty 4/1/03)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology (eff 5/92)
47 = Independent Diagnostic Testing Facility
(IDTF) (eff. 6/98)
48 = Podiatry
49 = Ambulatory surgical center
(formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with
certified orthotist (certified by
American Board for Certification in
Prosthetics And Orthotics)
52 = Medical supply company with
certified prosthetist
(certified by American Board for
Certification In Prosthetics And
Orthotics)
53 = Medical supply company with
certified prosthetist-orthotist
(certified by American Board for
Certification in Prosthetics
and Orthotics)
54 = Medical supply company not included
in 51, 52, or 53. (Revised 10/93
to mean medical supply company for DMERC)
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-orthotist
58 = Individuals not included in 55, 56, or 57,
(revised 10/93 to mean medical supply company
with registered pharmacist)
59 = Ambulance service supplier, e.g.,
private ambulance companies, funeral homes, etc.
60 = Public health or welfare agencies
(federal, state, and local)
61 = Voluntary health or charitable agencies (e.g.
National Cancer Society, National Heart
Association, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier
64 = Audiologist (billing independently)
65 = Physical therapist (private practice added 4/1/03)

(independently practicing removed 4/1/03)
66 = Rheumatology (eff 5/92)
Note: during 93/94 DMERC also used this to mean
medical supply company with
respiratory therapist
67 = Occupational therapist (private practice added 4/1/03)
(independently practicing removed 4/1/03)
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Multispecialty clinic or group practice
71 = Registered Dietician/Nutrition Professional (eff. 1/1/02)
72 = Pain Management (eff. 1/1/02)
73 = Mass Immunization Roster Biller (eff. 4/1/03)
74 = Radiation Therapy Centers (added to differentiate
them from Independent Diagnostic Testing Facilities
(IDTF --eff. 4/1/03)
74 = Occupational therapy (GPPP)
(not to be assigned after 5/92)
75 = Slide Preparation Facilities (added to differentiate
them from Independent Diagnostic Testing Facilites
(IDTFs -- eff. 4/1/03)
75 = Other medical care (GPPP) (not to
assigned after 5/92)
76 = Peripheral vascular disease
(eff 5/92)
77 = Vascular surgery (eff 5/92)
78 = Cardiac surgery (eff 5/92)
79 = Addiction medicine (eff 5/92)
80 = Licensed clinical social worker
81 = Critical care (intensivists)
(eff 5/92)
82 = Hematology (eff 5/92)
83 = Hematology/oncology (eff 5/92)
84 = Preventive medicine (eff 5/92)
85 = Maxillofacial surgery (eff 5/92)
86 = Neuropsychiatry (eff 5/92)
87 = All other suppliers (e.g. drug and
department stores) (note: DMERC used
87 to mean department store from 10/93
through 9/94; recoded eff 10/94 to A7;
NCH cross-walked DMERC reported 87 to A7.
88 = Unknown supplier/provider specialty
(note: DMERC used 87 to mean grocery
store from 10/93 - 9/94; recoded eff
10/94 to A8; NCH cross-walked DMERC
reported 88 to A8.
89 = Certified clinical nurse specialist
90 = Medical oncology (eff 5/92)
91 = Surgical oncology (eff 5/92)
92 = Radiation oncology (eff 5/92)
93 = Emergency medicine (eff 5/92)
94 = Interventional radiology (eff 5/92)
95 = Competative Acquisition Program (CAP)
Vendor (eff. 07/01/06). Prior to

07/01/06, known as Independent
physiological laboratory (eff. 5/92)
96 = Optician (eff 10/93)
97 = Physician assistant (eff 5/92)
98 = Gynecologist/oncologist (eff 10/94)
99 = Unknown physician specialty
A0 = Hospital (eff 10/93) (DMERCs only)
A1 = SNF (eff 10/93) (DMERCs only)
A2 = Intermediate care nursing facility
(eff 10/93) (DMERCs only)
A3 = Nursing facility, other (eff 10/93)
(DMERCs only)
A4 = HHA (eff 10/93) (DMERCs only)
A5 = Pharmacy (eff 10/93) (DMERCs only)
A6 = Medical supply company with respiratory
therapist (eff 10/93) (DMERCs only)
A7 = Department store (for DMERC use:
eff 10/94, but cross-walked from
code 87 eff 10/93)
A8 = Grocery store (for DMERC use:
eff 10/94, but cross-walked from
code 88 eff 10/93)
A9 = Indian Health Service (IHS), tribe and
tribal organizations (non-hospital or
non-hospital based facilities. DMERCs shall
process claims submitted by IHS, tribe and
non-tribal organizations for DMEPOS and drugs
covered by the DMERCs. (eff. 1/2005)
B1 = Supplier of oxygen and/or oxygen related
equipment (eff. 10/2/07)
B2 = Pedorthic Personnel (eff. 10/2/07)
B3 = Medical Supply Company with Pedorthic Personnel
(eff. 10/2/07)
B4 = Rehabilitation Agency (eff. 10/2/07)
B5 = Ocularist
C0 = Sleep medicine
C1 = Centralized Flu
C4 = Non-Provider Convener Participants in the BPCI Advanced
Model (eff. 7/2019)
C5 = Dentist (eff. 7/2016)
D5 = Opiod Treatment Progrm (eff. 1/2020)

CTGRY_EQTBL_BENE_IDENT_TB Category Equatable Beneficiary Identification Code (BIC) Table

NCH BIC	SSA Categories
A	A;J1;J2;J3;J4;M;M1;T;TA
B	B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6; TB(F);TD(F);TE(F);TW(F)
B1	B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M) TD(M);TE(M);TW(M)

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

RRB Categories

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

END_REC_TB End of Record Code Table

EOR = End of record/segment
EOC = End of claim

FI_CLM_ACTN_TB Fiscal Intermediary Claim Action Table

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

FI_NUM_TB Fiscal Intermediary Number / Medicare Administrative Contractor Table

00010 = Alabama BC - Alabama (term. 05/2009)
(replaced with MAC #10101 -- see below)
00011 = Alabama BC - Iowa (term. 10/2007)
replaced by MAC # 03401 -- see below)
00011 = Cahaba - (RHHI) (term. 06/2011)
replaced by MAC # 03401 -- see below)
00012 = Iowa (terminated)
replaced by MAC # 05101 -- see below)
00012 = Arizona - Noridian - J3 A MAC (AZA)
(term. 05/2008)
00020 = Arkansas BC - Arkansas
00021 = Arkansas BC - Rhode Island
(term. 05/2009)
00030 = Arizona BC (term. 09/2007)
(replaced by MAC # 03101 -- see below)
00040 = California BC (term. 11/2000)
00041 = California - Oakland BC (terminated)
00050 = New Mexico BC/CO (term. 06/89)
00050 = Colorado BC (terminated)
00060 = Connecticut BC (term. 06/99)

00070 = Delaware BC - (term. 02/98)
00080 = Florida BC (term. 03/88)
00080 = District of Columbia BC (terminated)
00090 = Florida BC (term. 02/2009)
(replaced with MAC #09101 -- see below)

00100 = Georgia - Atlantic BC (terminated)
00101 = Georgia BC (term. 05/2009)
(replaced with MAC #10201 -- see below)
00110 = Idaho BC (terminated)
00121 = Illinois - HCSC (term. 08/98)
00122 = Illinois - BC (terminated)
00123 = Michigan - HCSC (term. 08/98)
00130 = Indiana BC/Administar Federal (term. 7/22/2012)
(replaced with MAC # 08101 -- see below)
00131 = Illinois - Anthem
00140 = Iowa - Wellmark (term. 05/2000)
00141 = Iowa - Souix City BC (terminated)
00150 = Kansas BC (term. 02/2008)
(replaced with MAC # 05201 -- see below)
00160 = Kentucky - Anthem (term. 4/30/2011)
(replaced with MAC # 15101 -- see below)
00170 = Louisiana - Baton Rouge BC (terminated)
00171 = Louisiana - New Orleans BC (terminated)
00180 = Maine BC (term. 05/2009)
(replaced with MAC #14004 & 14101 -- see below)
00180 = Connecticut, Maine, Massachusetts,
New Hampshire, Rhode Island (Maine RHHI)
(term. 05/2009)
(replaced with MAC #14004 & 14101 -- see below)
00181 = Massachusetts - Maine BC (term. 05/2009)
00190 = Carefirst of Maryland (term. 09/2005)
00191 = District of Columbia - Maryland BC (terminated)

00200 = Massachusetts BC (term. 7/97)
00210 = Michigan BC (term. 9/94)
00220 = Minnesota BC (term. 07/99)
00230 = Mississippi BC
00230 = Trispan Health Services (LA-MS) (term. 09/2009)
(previously also MOA)
00231 = Mississippi BC - Louisiana (term. 09/1992)
00232 = Mississippi BC
00233 = Louisiana, Mississippi (J7 Interim)
(eff 10/01/2009)
00234 = PBSI J7 A TEMP ROLLUP AK,LA,MS
(terminated)
00240 = Kansas City BC - Missouri (terminated)
00241 = Missouri BC (term. 9/92)
00242 = Missouri (terminated)
(replaced with MAC # 05301 --see below)
00242 = BCBS of MS (MOA) (term. 04/2008)
(replaced with MAC # 05301 --see below)
00250 = Montana BC (term. 11/2006)
(replaced by MAC # 03201 -- see below)

00260 = Nebraska BC (term. 11/2007)
(replaced with MAC # 05401 --see below)
00270 = New Hampshire BC - New Hampshire, Vermont
(term. 06/2009)
(replaced with MAC #14501 -- see below)
00280 = New Jersey BC (term. 07/2000)
00290 = New Mexico BC - (term. 11/1995)
00291 = New Mexico BC - Colorado (terminated)

00300 = New York - Albany BC (terminated)
00301 = New York - Buffalo BC (terminated)
00302 = New York - Jamestown BC (terminated)
00303 = New York - New York City BC (terminated)
00304 = New York - Rochester BC (terminated)
00305 = New York - Syracuse BC (terminated)
00306 = New York - Utica BC (terminated)
00307 = New York - Watertown BC (terminated)
00308 = Empire BC - New York, Connecticut, Delaware
(term. 11/2008)
(replaced with MAC # 12101, 13201 & 13101 -- see below)
00310 = North Carolina BC (term. 09/2002)
00312 (terminated)
00320 = North Dakota BC - North Dakota (term. 12/1/2006)
(replaced with MAC # 03301 -- see
below)
00322 = North Dakota BC - Washington & Alaska
00323 = North Dakota BC - Idaho, Oregon & Utah
(term. 11/2006)
(replaced with MAC # 03501 --see below)
00325 = Noridian - Idaho, Oregon
00326 = J2 Rollup (Merge into a single CICS region)
(temporary) (terminated)
00330 NA (terminated)
00331 = Canton BC - Ohio (terminated)
00332 = Administar - Ohio
Anthem - Ohio
00333 = Cleveland BC - Ohio (terminated)
Ohio-Administar
00334 = Columbus BC - Ohio (terminated)
00335 = Lima BC - Ohio (terminated)
00337 = Toledo BC - Ohio (terminated)
00338 = Youngstown BC - Ohio (terminated)
00340 = Oklahoma BC (term. 02/2008)
(replaced with MAC # 04301 -- see below)
00350 = Regence - Oregon, Idaho, Utah
(term. 11/2005)
00351 = Oregon BC/ID. (term. 09/88)
00355 = Regence CWF - Oregon (term. 09/2004)
00360 = Allentown BC - Pennsylvania (terminated)
00361 = Harrisburg BC - Pennsylvania (terminated)
00361 = Independence BC - Pennsylvania (terminated)
00362 = Independence BC - terminated 8/97
00363 = Pennsylvania/Highmark - Veritus
(term. 07/2008)

00364 = Wilkes Barre BC - Pennsylvania (terminated)
00366 = Highmark (MD & DC) - Part A (eff. 10/2005)
(term. 07/2008)
00370 = Rhode Island BC
(term. 03/2004)
(replaced with MAC #14401 - see below)
00380 = South Carolina BC - South Carolina
(term. 01/2011)
(replaced with MAC #11004 & 11201 - see below)
00380 = Palmetto GBA - AL, AR, GA, FL, IL, IN, KY,
LA, MS, MN, NC, OK, OH, SC, TN, TX
(term. 01/2011)
00381 NA (terminated)
00382 = South Carolina BC - North Carolina
(term. 10/2010)
(replaced with MAC #11501 - see below)
00388 = Palmetto Drugs (terminated)
00390 = Riverbend BC - New Jersey, Tennessee
(term. 08/2009)
(replaced with MAC # 12001 & 10301 -- see below)
00392 = Memphis BC - Tennessee (terminated)

00400 = Texas BC - Colorado, New Mexico, Texas
(term. 05/2008)
(replaced with MAC #04101, 04201, 04401 -- see below)
00401 NA (terminated)
00410 = Utah BC (term. 09/2000)
00423 = Trigon - Virginia, West Virginia (term. 07/1999)
00424 = Roanoke BC - Virginia (terminated)
00425 = Virginia BC - West Virginia (term. 08/1992)
00430 = Premera BC - Washington, Alaska
(term. 09/2004)
00440 = Bluefield BC - West Virginia (terminated)
00441 = West Virginia BC (term. 11/1990)
00443 = Parkersburg BC - West Virginia (terminated)
00444 = Wheeling BC - West Virginia (terminated)
00450 = Wisconsin BC - Wisconsin
00450 = Michigan, Minnesota, New Jersey, New York,
Wisconsin (RHHI)
00452 = Wisconsin BC - Michigan (term. 7/22/2012)
(replaced with MAC # 08201 -- see below)
00453 = Wisconsin BC - Virginia & West Virginia
(term. 05/2011)
(replaced with MAC #11301 & 11401 - see below)
00454 = Wisconsin BC - California, Hawaii, Nevada (RHHI)
(term. 08/2008)
(replaced by MAC #01101, 01201 & 01301 -- see below)
00456 = United Government Services, LLC (CAR)
(eff 08/15/2008)
00460 = Wyoming BC
(term. 10/2006)
(replaced by MAC # 03601 -- see below)
00468 = N Carolina BC/CPRTIVA (terminated)
00470 = Puerto Rico BC (terminated)

00993 = BC/BS Assoc.
17120 = Hawaii Medical Service (term. 06/99)
18390 = Inter-County (terminated)
19050 = Kaiser Foundation (terminated)
20330 = New York State Dept of Health (terminated)
21230 = Community Health Association (term. 05/1969)
22400 = Puerto Rico - Cooperative De Saluda
(term. 01/1970)
50050 = Travelers - Long Beach, California (terminated)
50051 = Travelers - Los Angeles, California (terminated)
50052 = Travelers - Pomona, California (terminated)
50053 = Travelers - San Francisco, California (terminated)
50070 = Travelers - Hartford, Connecticut (terminated)
50072 = Travelers - Hamden, Connecticut (terminated)
50100 = Travelers - Jacksonville, Florida (terminated)
50101 = Travelers - Miama, Florida (terminated)
50102 = Travelers - Tampa, Florida (terminated)
50110 = Travelers - Atlanta, Georgia (terminated)
50333 = Travelers; Connecticut United Healthcare
(term. 07/2000)
50334 = Travelers; Syracuse, New York (terminated)
50390 = Travelers; Erie, Pennsylvania (terminated)
50391 = Travelers; Pittsburgh, PA (terminated)
50392 = Travelers; Wyomissing, PA (terminated)
50393 = Travelers; Philadelphia, PA (terminated)
50410 = Travelers; Providence, Rhode Island (terminated)

51050 = Aetna-Los Angeles - California (terminated)
51051 = Aetna California - terminated 6/97
51070 = Aetna Connecticut - terminated 6/97
51100 = Aetna Florida - terminated 6/97
51140 = Aetna Illinois - terminated 6/97
51220 = Aetna-Worcester - Massachusetts
51290 = Aetna-Reno, Nevada (terminated)
51390 = Aetna Pennsylvania - terminated 6/97
51440 = Aetna-Nashville, Tennessee (terminated)
51441 = Aetna-Memphis, Tennessee (terminated)
51490 = Aetna-Newport News - Virginia (terminated)
51500 = Seattle, Washington (terminated)
52280 = NE - Mutual of Omaha
53310 = Prudential-New Jersey (terminated)
56360 = Nationwide-Ohio (terminated)
57400 = Puerto Rico - Cooperativa (term.02/2009)
(replaced with MAC # 09201)
61000 = Aetna (term. 06/97)
80883 = Contractor ID for Inpatient & Outpatient
Risk Adjustment Data (data not sent through
CWF; but through Palmetto)
99990 = SSA (terminated)

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Medicare Administrative Contractor Numbers
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JURISDICTION 1 - PART A MACs

01001 = J1 Roll-up
01101 = California (eff. 8/15/2008)
(replaces FI #00454)
01201 = Hawaii (eff. 8/15/2008)
(replaces FI #00454)
01301 = Nevada (eff. 8/15/2008)
(replaces FI #00454)
01901 = Palmetto GBA J1
(Mutual of Omaha Legacy)

JURISDICTION 2 - Part A MACs

02001 = JF Roll-up(2/3)
02101 = Alaska (eff 02/01/2012)
02201 = Idaho (eff 02/01/2012)
02301 = Oregon (eff 02/01/2012)
02401 = Washington (eff 02/01/2012)

JURISDICTION 3 - Part A MACs

03001 = JF Roll-up(2/3)
(Orig. J3 term. 09/2007)
03101 = Arizona (eff. 10/1/2007)
(replaces FI #00030)
03201 = Montana (eff. 12/1/2006)
(replaces FI #00250)
03301 = N. Dakota (eff. 12/1/2006)
(replaces FI #00320)
03401 = S. Dakota (eff. 3/1/2007)
(replaces FI #00011)
03501 = Utah (eff. 12/1/2006)
(replaces FI #00323)
03601 = Wyoming (eff. 11/1/2006)
(replaces FI #00460)

JURISDICTION 4 - Part A MACs

04001 = J4 Roll-up
04101 = Colorado (eff. 6/1/2008) (terminated)
(replaces FI #00400)
04201 = New Mexico (eff. 6/16/2008)
(replaces FI #00400)
04301 = Oklahoma (eff. 3/1/2008)
(replaces FI #00340)
04401 = Texas (eff. 6/16/2008)
(replaces FI #00400)
04901 = Trailblazer Health Enterprises
(Mutual of Omaha Legacy)

JH Roll-up (4/7)
04111 = Colorado (eff. 10/29/2012)
(CR 7812)

04211 = New Mexico (eff. 10/29/2012)
04311 = Oklahoma (eff. 10/29/2012)
04411 = Texas (eff. 10/29/2012)
04911 = WPS (Mutual of Omaha Legacy)
(eff. 10/29/2012)

JURISDICTION 5 - Part A MACs

05001 = J5 Roll-up
05101 = Iowa (eff. 5/1/2008)
(replaces FI #00012)
05201 = Kansas (eff. 03/01/2008)
(replaces FI #00150)
05301 = W. Missouri (eff. 5/1/2008)
(replaces FI #00242)
05392 = E. Missouri (eff. 6/1/2008)
05402 = Nebraska (eff. 12/1/2007)
(replaces FI #00260)
05902 = WPS J5 (Mutual of Omaha Legacy)

06001 = J6 Roll-up
06004 = (HHH D RHHI)
06101 = Illinois
06201 = Minnesota
06301 = Wisconsin

07001 = JH Roll-up (4/7)
07101 = Arkansas (eff. 08/20/2012) (CR7812)
07201 = Louisiana (eff. 08/20/2012)
07301 = Mississippi (eff. 08/20/2012)

JURISDICTION 8 - PART A MACs

08001 = J8 Roll-up
08101 = Indiana, WPS J8 (eff. 07/23/2012)
(replaces FI #00130)
08201 = Michigan, WPS J8(eff. 07/23/2012)
(replaces FI #00452)

JURISDICTION 9 - PART A MACs

09001 = J9 Roll-up
09101 = Florida (eff. 2/13/2009)
(replaces FI #00090)
09201 = Puerto Rico (eff. 03/02/2009)
(replaces FI #57400)
09301 = Virgin Island (eff. 03/02/2009)
(replaces FI #57400)

JURISDICTION 10 - PART A MACs

10001 = J10 Roll-up
10101 = Alabama (eff. 5/18/2009)
(replaces FI #00010)

10201 = Georgia (eff. 05/04/2009)
(replaces FI #00101)
10301 = Tennessee (eff. 8/3/2009)
(replaces FI #00390)

JURISDICTION 11 - PART A MACs

11001 = J11 Roll-up
11003 = J11 Roll-up (Shared CICS Region - 11301 & 11401)
11004 = Region C (HHH C RHHI) (eff. 1/24/2011)
(replaces FI #00380)
11201 = South Carolina (eff. 1/24/2011)
(replaces FI #00380)
11301 = Virginia (eff. 5/16/2011)
(replaces FI #00453)
11401 = West Virginia (eff. 5/16/2011)
(replaces FI #00453)
11501 = North Carolina (eff. 10/01/2010)
(replaces FI #00390)

JURISDICTION 12 - PART A MACs

12001 = J12 Roll-up
12101 = Delaware (eff. 11/14/2008)
(replaces FI # 00308)
12201 = District of Columbia (eff. 08/01/2008)
12301 = Maryland (eff. 08/01/2008)
12401 = New Jersey (eff. 9/1/2008)
(replaces FI # 00390)
12501 = Pennsylvania (eff. 08/01/2008)
12901 = Novitas Solutions J12
(Mutual of Omaha Legacy)

JURISDICTION 13 - PART A MACs

13001 = J13 Roll-up
13101 = Connecticut (eff. 8/1/2008)
(replaces FI #00308)
13201 = NGS-New York (eff. 7/18/2008)
(replaces FI #00308)
13282 = NGS-New York (eff. 9/1/2008)
(replaces FI #00308)
13292 = NGS-New York (eff. 7/18/2008)
(replaces FI #00308)

JURISDICTION 14 - PART A MACs

14001 = J14 Roll-up
14003 = J11 Roll-up (Shared CICS Region)
14004 = Region A (HHH A RHHI) (eff.5/15/2009)
(replaces FI #00180)
14101 = Maine (eff. 5/15/2009)
(replaces FI #00180)
14201 = Massachusetts (eff. 5/15/2009)

(replaces FI #00181)
14301 = New Hampshire (eff. 6/15/2009)
(replaces FI #00270)
14401 = Rhode Island (eff. 6/1/2009)
(replaces FI #00370)
14501 = Vermont (eff. 6/5/2009)
(replaces FI #00270)

JURISDICTION 15 - PART A MACs

15001 = J15 Roll-up
15004 = CGS Government Services (HHH B RHHI)
(eff. 06/13/2011)
15101 = Kentucky (eff. 10/17/2011)
(replaces FI #00160)
15201 = Ohio (eff. 10/17/2011)
(replaces FI #00160)
52280 = Mutual of Omaha (NT)
Note: Nebraska - 00260 (NE) & 52280 (NT)

FI_RQST_CLM_CNCL_RSN_TB Claim Cancel Reason Code Table

C = Coverage Transfer
D = Duplicate Billing
H = Other or blank
L = Combining two beneficiary master records
P = Plan Transfer
S = Scramble
**********For Action Code 4 **********
*********Effective with HHPPS - 10/00**********
A = RAP/Final claim/LUPA is cancelled by 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.

GEO_SSA_STATE_TB State Table

01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut

08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = California
56 = Canada & Islands
57 = Central America and West Indies
58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines

62 = South America
63 = U.S. Possessions
64 = American Samoa
65 = Guam
66 = Commonwealth of the Northern Marianas Islands
67 = Texas
68 = Florida (eff. 10/2005)
69 = Florida (eff. 10/2005)
70 = Kansas (eff. 10/2005)
71 = Louisiana (eff. 10/2005)
72 = Ohio (eff. 10/2005)
73 = Pennsylvania (eff. 10/2005)
74 = Texas (eff. 10/2005)
75 - California
76 - Iowa
77 - Minnesota
78 - Illinois
79 - Missouri
80 = Maryland (eff. 8/2000)
96 = New Mexico
97 = Texas
98 = Hawaii
99 = With 000 county code is AS (American Samoa);
otherwise - unknown
A0 = California (eff. 4/2019)
A1 = California (eff. 4/2019)
A2 = Florida (eff. 4/2019)
A3 = Louisianna (eff. 4/2019)
A4 = Michigan (eff. 4/2019)
A5 = Mississippi (eff. 4/2019)
A6 = Ohio (eff. 4/2019)
A7 = Pennsylvania (eff. 4/2019)
A8 = Tennessee (eff. 4/2019)
A9 = Texas (eff. 4/2019)
B0 = Kentucky (eff. 4/2020)
B1 = West Virginia (eff. 4/2020)
B2 = California (eff. 4/2020)

MCO_OPTN_TB MCO Option Table

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

***** For non-lock-in beneficiaries*****
1 = HCFA to process all provider bills
2 = MCO to process only in-plan Part A and
Part B bills
4 = Cost Plan-Chronic Care Organizations (eff. 10/2005)

NCH_CLM_BIC_MDFY_TB NCH Claim BIC Modify H Code Table

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

NCH_CLM_TYPE_TB NCH Claim Type Table

10 = HHA claim
20 = Non swing bed SNF claim
30 = Swing bed SNF claim
40 = Outpatient claim
50 = Hospice claim
60 = Inpatient claim
61 = Inpatient 'Full-Encounter' claim
62 = Medicare Advantage IME/GME Claims
63 = Medicare Advantage (no-pay) claims
64 = Medicare Advantage (paid as FFS) claims
71 = RIC O local carrier non-DMEPOS claim
72 = RIC O local carrier DMEPOS claim
81 = RIC M DMERC non-DMEPOS claim
82 = RIC M DMERC DMEPOS claim

NOTE: In the data element NCH_CLM_TYPE_CD (derivation rules) the numbers for these claim types need to be changed - dictionary reflects 61 for all three.

NCH_COND_TRLR_IND_TB NCH Condition Trailer Indicator Table

C = Condition code trailer present

NCH_DEMO_TRLR_IND_TB NCH Demonstration Trailer Indicator Table

D = Demo trailer present

NCH_DGNS_E_TRLR_IND_TB NCH Diagnosis E Trailer Indicator Code Table

Valid Value:
W = NCH Diagnosis E Code trailer

NCH_DGNS_TRLR_IND_TB NCH Diagnosis Trailer Indicator Table

Y = Diagnosis code trailer present

NCH_EDIT_DISP_TB NCH Edit Disposition Table

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

NCH_EDIT_TB NCH EDIT TABLE

A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
A000 = (C) REIMB > $100,000 OR UNITS > 150
A002 = (C) CLAIM IDENTIFIER (CAN)
A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
A004 = (C) PATIENT SURNAME BLANK
A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
A006 = (C) DATE OF BIRTH IS NOT NUMERIC
A007 = (C) INVALID GENDER (0, 1, 2)
A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
A009 = (C) TYPE OF BILL RECEIVED IS 41A, 41B, OR 41D
A010 = (C) DISPOSITION CODE VS. ACTION/ENTRY CODE
A023 = (C) PORTABLE X-RAY WITHOUT MODIFIER
A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
A031 = (C) HOSPITAL CLAIMS--CLAIM SHOWS SERVICES WERE PAID
BY AN HMO AND CODITION CODE '04' IS NOT PRESENT.
(TOB '11' & '12')
A041 = (C) HHA CLAIMS--TOB 32X OR 33X WITH >4 VISITS; DATE
OF SERVICE > 9/30/00 AND LUPA IND IS PRESENT.
BYPASS FOR NON-PAYMENT CODE B, C, Q, T-Y.
A1X1 = (C) PERCENT ALLOWED INDICATOR
A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589
A1X3 = (C) DT>96365,DIAG=V725
A1X4 = (C) INVALID DIAGNOSTIC CODES
C050 = (U) HOSPICE - SPELL VALUE INVALID
D102 = (C) DME DATE OF BIRTH INVALID
D2X2 = (C) DME SCREEN SAVINGS INVALID
D2X3 = (C) DME SCREEN RESULT INVALID
D2X4 = (C) DME DECISION IND INVALID
D2X5 = (C) DME WAIVER OF PROV LIAB INVALID
D3X1 = (C) DME NATIONAL DRUG CODE INVALID
D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID
D4X2 = (C) DME OUT OF DMERC SERVICE AREA
D4X3 = (C) DME STATE CODE INVALID
D5X1 = (C) TOS INVALID FOR DME HCPCS
D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING
D5X3 = (C) DME INVALID USE OF MS MODIFIER

D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED
D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS
D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID
D5X7 = (C) ANTI-EMETIC/ANTI-CANCER DRUG W/0 CANCER
DIAGNOSIS
D5X8 = (C) TWO ANTI-EMETIC DRUGS PRESENT ON SAME CLAIM
WITH IDENTICAL DATES OF SERVICE.
D6X1 = (C) DME SUPPLIER NUMBER MISSING
D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1
D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6
D922 = (C) THERAPEUTIC SHOE CODES 'A5505-A5501'
W/MODIFIER 'LT' OR 'RT' MUST HAVE
UNITS = '001'
XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1
Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
Y003 = (C) HCPCS R0075/UNITS=SERVICES
Y010 = (C) TOB=13X/14X AND T.C.>$7,500
Y011 = (C) INP CLAIM/REIM > $350,000
Z001 = (C) RVNU 820-859 REQ COND CODE 71-76
Z002 = (C) CC M2 PRESENT/REIMB > $150,000
Z003 = (C) CC M2 PRESENT/UNITS > 150
Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX
Z005 = (C) REIMB>99999 AND REIMB<150000
Z006 = (C) UNITS>99 AND UNITS<150
Z007 = (C) TOB VS TOTAL CHARGE
Z008 = (C) TOB VS TOTAL CHARGE W/O 20/21
CONDITION CODE
Z237 = (E) HOSPICE OVERLAP - DATE ZERO
0011 = (C) ACTION CODE INVALID
0012 = (C) IME/GME CLAIM -- '04' OR '69'
CONDITION CODE
0013 = (C) CABG/PCOE/MPPD AND INVALID ADMIT DATE
0014 = (C) DEMO NUM INVALID
0015 = (C) ESRD PLAN VS DEMO NUM
0016 = (C) INVALID VA CLAIM
0017 = (C) DEMO=38 W/O CONTRACTOR #80881/80882
0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
0019 = (C) DEMO 07/08 WITH CONDITION CODE B1
0020 = (C) CANCEL ONLY CODE INVALID
0021 = (C) DEMO COUNT > 1
0022 = (C) TOB '32X' OR '33X' W/DATES OF SERVICE >9/30/00
AND HAS CANCEL ONLY CODE OTHER THAN A,B,E,F
0023 = (C) DEMO '46' AND HCPCS INCONSISTENT
0301 = (C) INVALID HI CLAIM NUMBER
0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK
04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)
04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
0401 = (C) BILL TYPE/PROVIDER INVALID
0402 = (C) BILL TYPE/REV CODE/PROVR RANGE
0403 = (C) TOB '41X'/PRVDR # 1990-1999) OR TOB '51X'/
PRVDR #6990-6999, TRANS CODE SHOULD BE
'0' OR '3'

0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092 OR SEX NOT F
0407 = (C) RESPITE CARE BILL TYPE NOT 34X,NO REV 66
0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974
041A = (C) TOB '11A' OR '11D' AND DEMO #'07' OR '08'
NOT PRESENT
0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636
0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES
0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS
0414 = (C) VALU CD 61,MSA AMOUNT MISSING
0415 = (C) HOME HEALTH INCORRECT ALPHA RIC
0416 = (C) REVENUE CENTER '0022', TOB MUST BE
'18X' OR '21X'
0417 = (C) REVENUE CENTER '0023', TOB MUST BE '32X'
OR '33X'
0418 = (C) HHA--TOB '3X5' AND DATES OF SERVICE
>9/30/00
0419 = (C) HHA--RIC 'W' MUST HAVE VALUE CODE '63'/
RIC 'V' MUST HAVE VALUE CODE '62' AND
RIC 'U' MUST HAVE VALUE CODES '62' AND
'63' PRESENT FOR DATES OF SERVICE >
9/30/00.
0420 = (C) HHA W/O REVENUE CODE '0023'
0421 = (C) START DATE MISSING
0422 = (C) COB VS. OVERRIDE CODE
05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE
05X5 = (C) UPIN REQUIRED FOR DME
0501 = (C) REFFERING UPIN REQUIRED FOR CLINICAL LAB
0502 = (C) REFERRING UPIN INVALID
0601 = (C) GENDER INVALID
0701 = (C) CONTRACTOR/POS 1-2 PROVIDER NUM INVALID
0702 = (C) PROVIDER NUMBER VS. TOB
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
0704 = (C) INVALID CONT FOR CABG DEMO
0705 = (C) INVALID CONT FOR PCOE DEMO
0706 = (C) REVENUE CENTER CODE MAMMOGRAPHY AND
BENEFICIARY <35
0901 = (C) INVALID DISP CODE OF 02
0902 = (C) INVALID DISP CODE OF SPACES
0903 = (C) INVALID DISP CODE
1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE
13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
1301 = (C) LINE COUNT NOT NUMERIC OR > 13
1302 = (C) RECORD LENGTH INVALID
1401 = (C) INVALID MEDICARE STATUS CODE
1501 = (C) ADMIT DATE/START DATE/ENTRY CODE INVALID
1502 = (C) ADMIT DATE/START CARE DATE > STAY FROM DATE
1503 = (C) ADMIT DATE INVALID WITH THRU DATE
1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
1505 = (C) HCPCS W SERVICE DATES > 09-30-94
1601 = (C) INVESTIGATION IND INVALID
1701 = (C) SPLIT IND INVALID
1801 = (C) PAY-DENY CODE INVALID
1802 = (C) HEADER AMT/LINE ITEMS DENIED
1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME

1901 = (C) AB CROSSOVER IND INVALID
2001 = (C) HOSPICE OVERRIDE INVALID
2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
2102 = (C) PATIENT STATUS VS. TOB
2103 = (C) HIPPS RATE/CMG CODE VS. PATIENT STATUS
2201 = (C) FROM DATE/HCPCS YR INVALID
2202 = (C) STAY-FROM DATE > THRU-DATE
2203 = (C) THRU DATE INVALID
2204 = (C) FROM DATE BEFORE EFFECTIVE DATE
2205 = (C) DATE YEARS DIFFERENT ON OUTPAT
2207 = (C) MAMMOGRAPHY BEFORE 1991
2208 = (C) TOB '21X', REV CODE 0022 FROM DATE
< 06-03-98
2209 = (C) HHA WITH OVERLAPPING DATES JUNE/JULY,
SEPT/OCT
2210 = (C) TOB 41X, SERVICE DATES 6/30/00,
EXCEP/NONEXCEP IND = 1,2
2212 = (C) TOB 51X WITH SERVICE DATES >6/30/00
2213 = (C) TOB 32X OR 33X, SERVICE >9/30/00 DAYS
CAN NOT = 60
2215 = (C) DEMO 37 WITH VALUE CODES 'A2', 'B2', 'C2'
2216 = (C) DEMO 37 OR CONDITION CODE 78 AND CHARGES
SUB TO DED > 0
2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID
2302 = (C) COVERED DAYS INVALID OR INCONSIST
2303 = (C) COST REPORT DAYS > ACCOMIDATION
2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL
2305 = (C) LATE CHARGE BILL WITH DATA FIELD PRESENT
2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT
2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09
2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
2401 = (C) NON-UTIL DAYS INVALID
2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL
2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
2504 = (C) COINSURANCE AMOUNT EXCESSIVE
2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT
2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST
2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR
2508 = (C) COINSURANCE DAYS INVALID FOR TRAN
2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
2602 = (C) LR-DAYS, NO VAL 08,10/PD/DEN>CUR+27
2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
2604 = (C) PPS BILL, NO DAY OUTLIER
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
28XA = (C) UTIL DAYS > FROM TO BENEF EXH
28XB = (C) BENEFITS EXH DATE > FROM DATE
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN = (C) INVALID OCC CODE

28XO = (C) AN 'N' NO-PAY CODE IS PRESENT AND OCCURRENCE
CODE '23' OR '42' IS NOT PRESENT AND THE
DATE ASSOCIATED WITH CODE IS MISSING OR NOT
EQUAL TO THRU DATE.
28XP = (C) THE OCCURRENCE CODE 23 DATE DOES NOT EQUAL THE
THRU DATE
28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES
28X1 = (C) OCCUR DATE INVALID
28X2 = (C) OCCUR = 20 AND TRANS = 4
28X3 = (C) OCCUR 20 DATE < ADMIT DATE
28X4 = (C) OCCUR 20 DATE > ADMIT + 12
28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM
28X6 = (C) OCCUR 20 DATE < BENE EXH DATE
28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
28X8 = (C) OCCUR 22 DATE < FROM OR > THRU
28X9 = (C) UTIL > FROM - THRU LESS NCOV
33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)
33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)
33X3 = (C) QS DAYS/ADMISSION ARE INVALID
33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)
33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE
33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091
33X7 = (C) TOB<>18/21/28/51,COND=WO
33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001
33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT
33#A = (C) MULTIPLE PET SCANS
33#B = (C) MULITIPLE PET SCANS W/O MODIFIER 26
OR TC
3401 = (C) DEMO ID = 04 AND RIC NOT = 1 OR 2
34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN
34#3 = (C) CONDITION CODE = W0 AND DEMO NOT = 04
35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS
35X2 = (C) COND = 60 OR 61 AND NO VALU 17
35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0
35#3 = (C) (SECOND CONDITION) CONDITION CODE = C3
REQUIRES SPAN CODE 76 OR 77
35#4 = (C) CONDITION CODE = 69 AND TOB NOT 11X
36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU
36#1 = (C) SURGICAL DATE = ZEROES OR < FROM OR >
THRU DATES
3701 = (C) ASSIGN CODE INVALID
3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA
3706 = (C) INVALID IDE NUMBER-NOT IN FILE
3710 = (C) NUM OF IDE# > REV 0624
3715 = (C) NUM OF IDE# < REV 0624
3720 = (C) IDE AND LINE ITEM NUMBER > 2
3801 = (C) AMT BENE PD INVALID
3XA/ = (C) COLORECTAL/PROSTATE SCREENING BILLED
MULTIPLE TIMES
4001 = (C) BLOOD PINTS FURNISHED INVALID
4002 = (C) BLOOD FURNISHED/REPLACED INVALID
4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
4201 = (C) BLOOD PINTS UNREPLACED INVALID
4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED

4203 = (C) INVALID CPO PROVIDER NUMBER
4301 = (C) BLOOD DEDUCTABLE INVALID
4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
4304 = (C) BLOOD DEDUCT > 3 - REPLACED
4501 = (C) PRIMARY DIAGNOSIS INVALID
4502 = (C) SERVICE DATES > CURRENT DATE
46#A = (C) MSP VET AND VET AT MEDICARE
46#B = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
46#C = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
46#G = (C) VALU CODE 20 INVALID
46#L = (C) BLOOD FURNISHED < BLOOD REPLACED
46#N = (C) VALUE CODE 37,38,39 INVALID
46#O = (C) VALUE CDE 37,38,39 AMOUNT NOT > 00
46#P = (C) BLD UNREP VS REV CDS AND/OR UNITS
46#Q = (C) VALUE CDE 37=39 AND 38 IS PRESENT
46#R = (C) BLD FIELDS VS REV CDE 380,381,382
46#S = (C) VALU CODE 39, AND 37 IS NOT PRESENT
46#T = (C) CABG/PCOE/MPPD,VC<>Y1,Y2,Y3,Y4,VA NOT>0
46#U = (C) MSP VALUES ON CABG/PCOE/MPPD (INP)
TOB '32X'/'33X' MUST HAVE VALUE 62/64
OR 63/65 (HHA)
46#V = (C) TOB '32X'/'33X' VISITS IN 62/63 NOT =
REVENUE CODE 42X-44X, 55X-57X
46#W = (C) CONDITION CODE =30/78 AND WITH VALUE
CODE = A1, B1, C1
46#1 = (C) VALUE AMOUNT INVALID
46#2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
46#3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
46#4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
46#5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
46#6 = (C) VALU 17 AND NO COND CODE 60 OR 61
46#7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
46#8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
4601 = (C) CABG/PCOE, MSP CODE PRESENT
4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
4604 = (C) DEMO = 03 WITH DATES OF SERVICE
> 09/31/01
4901 = (C) PCOE/CABG,DEN CD NOT D
4902 = (C) PCOE/CABG BUT DME
50#1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
50#2 = (C) REV CD=054X,MOD NOT = QM,QN
5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
51#A = (C) HCPCS EYEWARE & REV CODE NOT 274
51#C = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51#D = (C) HCPCS REQUIRES UNITS > ZERO
51#E = (C) HCPCS REQUIRES REVENUE CODE 636/294
51#F = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51#G = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
51#H = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044

51#I = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045
51#J = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
51#K = (C) TOB 21X/P82=2/3/4,REV CD = NNX
51#L = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83
51#M = (C) 21X,RC>9041/<9045,RC<>4/234
51#N = (C) 21X,RC>9032/<9042,RC<>4/234
51#O = (C) TWO ANTI-EMETIC/ANTI-CANCER DRUGS
ON SAME CLAIM
51#P = (C) HHA/OUTPATIENT RC DATE OF SRVC MISSING
51#Q = (C) NO RC 0636 OR DTE INVALID
51#R = (C) DEMO ID=01,RIC NOT=2
51#S = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21
51#V = (C) TOB 72X W HCPCS 'J1955' MISSING REVENUE
CENTER 636
51#W = (C) TOB 12X, 13X, 22X, 23X, 34X, 74X, 75X,
83X, HCPCS '97504', '97116', PRESENT
ON SAME DAY
51#X = (C) TOB '32X-34X' REQUIRE HCPCS FOR REVENUE
CODE '29X', '60X', '636'
51X0 = (C) REV CENTER CODE INVALID
51X1 = (C) REV CODE CHECK
51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
51X3 = (C) UNITS MUST BE > 0
51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR
51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
51X9 = (C) HCPCS/REV CODE/BILL TYPE
5100 = (U) TRANSITION SPELL / SNF
5160 = (U) LATE CHG HSP BILL STAY DAYS > 0
5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT
5168 = (E) CLAIM IN HOSPICE WITH 2ND START DATE
PRESENT
5169 = (U) PROVIDER NE TO WORK PROVIDER
5170 = (E) OCCURRENCE CODE = 42 AND < DOLBA
5177 = (U) PROVIDER NE TO WORK PROVIDER
5178 = (U) HOSPICE BILL THRU < DOLBA
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
5200 = (E) ENTITLEMENT EFFECTIVE DATE
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
5202 = (U) HOSPICE TRAILER ERROR
5203 = (E) ENTITLEMENT HOSPICE PERIODS
5203 = (U) HOSPICE START DATE ERROR
5204 = (U) HOSPICE DATE DIFFERENCE NE 90
5205 = (U) HOSPICE DATE DISCREPANCY
5206 = (U) HOSPICE DATE DISCREPANCY
5207 = (U) HOSPICE THRU > TERM DATE 2ND
5208 = (U) HOSPICE PERIOD NUMBER BLANK
5209 = (U) HOSPICE DATE DISCREPANCY
5210 = (E) ENTITLEMENT FRM/TRU/END DATES
5211 = (E) ENTITLEMENT DATE DEATH/THRU

5212 = (E) ENTITLEMENT DATE DEATH/THRU
5213 = (E) ENTITLEMENT DATE DEATH MBR
5220 = (E) ENTITLEMENT FROM/EFF DATES
5225 = (E) ENT INP PPS SPAN 70 DATES
5232 = (E) ENTL HMO NO HMO OVERRIDE CDE
5233 = (E) ENTITLEMENT HMO PERIODS
5234 = (E) ENTITLEMENT HMO NUMBER NEEDED
5235 = (E) ENTITLEMENT HMO HOSP+NO CC07
5236 = (E) ENTITLEMENT HMO HOSP + CC07
5237 = (E) ENTITLEMENT HOSP OVERLAP
5238 = (U) HOSPICE CLAIM OVERLAP > 90
5239 = (U) HOSPICE CLAIM OVERLAP > 60
524Z = (E) HOSP OVERLAP NO OVD NO DEMO
5240 = (U) HOSPICE DAYS STAY+USED > 90
5241 = (U) HOSPICE DAYS STAY+USED > 60
5242 = (C) INVALID CARRIER FOR RRB
5243 = (C) HMO=90091,INVALID SERVICE DTE
5244 = (E) DEMO CABG/PCOE MISSING ENTL
5245 = (C) INVALID CARRIER FOR NON RRB
525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO
5250 = (U) HOSPICE DOEBA/DOLBA
5255 = (U) HOSPICE DAYS USED
5256 = (U) HOSPICE DAYS USED > 999
526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0
526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0
5270 = (C) CONDITION CODE = 30 AND HMO REQUIRES
MODIFIER = 'QV' OR 'KZ'/DED IND
5271 = (C) RISK HMO NOT PRESENT AND MOD 'KZ'/
OR CONDITION CODE 78 PRESENT
527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0
527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
5299 = (U) HOSPICE PERIOD NUMBER ERROR
52#K = (C) HCPCS VS DIAGNOSIS
52#L = (C) HCPCS VS MODIFIER
52#M = (C) HCPCS VS DATES OF SERVICE
52#N = (C) TOB '71X' OR '73X' WITH REVENUE
CENTER CODE 0403 MISSING REVENUE
CENTER CODE 0521
52#O = (C) REVENUE CENTER CODE 0022/0024 WITH
CHARGES >0
52#P = (C) REVENUE CENTER CODE 010X-021X MINUS
18X <> 0022
52#Q = (C) REVENUE CENTER CODE 0022 AND HIPPS
MISSING
52#R = (C) REVENUE CENTER CODE 0022 MISSING DATE
OF SERVICE
52#T = (C) REVENUE CENTER CODE 0022 MISSING REVENUE
CENTER CODE 042X-044X
5320 = (U) BILL > DOEBA AND IND-1 = 2
5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
5355 = (U) HOSPICE DAYS USED SECONDARY
5362 = (C) MAMMOGRAPHY AND BENE <35
5378 = (C) SERVICE DATE < AGE 50
5379 = (C) HCPCS 'G0160' PRESENT MORE THAN

ONCE
5381 = (C) HCPCS 'G0161' PRESENT MORE THAN
ONCE
5382 = (C) HCPCS 'G0102-03' AND BENE <50
538Q = (C) SERVICE DATES WITHIN ALIEN RECORD
5397 = (C) DEMO '37' AND NOT CAT 74
5398 = (C) HCPCS 'G9001-G9005 & G9009-G9011 >1
OR 2 ARE PRESENT
5399 = (U) HOSPICE PERIOD NUM MATCH
539A = (C) HCPCS 'G9008' PRESENT MORE THAN ONCE
539C = (C) HCPCS 'G9013-G9015' PRESENT MORE THAN
ONCE OR 2 PRESENT
5410 = (U) INPAT DEDUCTABLE
5425 = (U) PART B DEDUCTABLE CHECK
5430 = (U) PART B DEDUCTABLE CHECK
5450 = (U) PART B COMPARE MED EXPENSE
5460 = (U) PART B COMPARE MED EXPENSE
5499 = (U) MED EXPENSE TRAILER MISSING
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS
5510 = (U) COIN DAYS/SNF COIN DAYS
5515 = (U) FULL DAYS/COIN DAYS
5516 = (U) SNF FULL DAYS/SNF COIN DAYS
5520 = (U) LIFE RESERVE DAYS
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS
5540 = (U) HH VISITS NE AFT PT B TRLR
5550 = (E) SNF LESS THAN PT A EFF DATE
5600 = (D) LOGICAL DUPE, COVERED
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123
5602 = (D) LOGICAL DUPE, PANDE C, E OR I
5603 = (D) LOGICAL DUPE, COVERED
5604 = (D) LOGICAL DUPE, DATES
5605 = (D) POSS DUPE, OUTPAT REIMB
5606 = (D) POSS DUPE, HOME HEALTH COVERED U
5623 = (U) NON-PAY CODE IS P
57X1 = (C) PROVIDER SPECIALITY CODE INVALID
57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL
57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND
57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID
57X5 = (C) HCPCS 98940-2 MODIFIER NOT = 'AT'
5700 = (U) LINKED TO THREE SPELLS
5701 = (C) DEMO ID=02,RIC NOT = 5
5702 = (C) DEMO ID=02,INVALID PROVIDER NUM
58X1 = (C) PROVIDER TYPE INVALID
58X9 = (C) TYPE OF SERVICE INVALID
5802 = (C) REIMB > $150,000
5803 = (C) UNITS/VISITS > 150
5804 = (C) UNITS/VISITS > 99
5805 = (C) OUTPATIENT CHARGE > $150,000
5806 = (C) REVENUE CENTER CODE '042X-044X'
WITHOUT MODIFIER 'GN-GP'
58#4 = (C) REVENUE CENTER CODE MISSING REQUIRED
HCPCS OR MODIFIER
59XA = (C) PROST ORTH HCPCS/FROM DATE
59XB = (C) HCPCS/FROM DATE/TYPE P OR I

59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE
59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE
59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS
59XG = (C) INVALID TOS FOR DME
59XH = (C) HCPCS E0620/TYPE/DATE
59XI = (C) HCPCS E0627-9/ DATE < 1991
59XJ = (C) GLOBAL HCPCS TOS MUST = 2
59XK = (C) HCPCS PEN PUMP AND TOS <>9
59XL = (C) HCPCS 00104 - TOS/POS
59X1 = (C) INVALID HCPCS/TOS COMBINATION
59X2 = (C) ASC IND/TYPE OF SERVICE INVALID
59X3 = (C) TOS INVALID TO MODIFIER
59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB
59X5 = (C) MAMMOGRAPHY FOR MALE
59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS
59X7 = (C) CAPPED-HCPCS/FROM DATE
59X8 = (C) FREQUENTLY MAINTAINED HCPCS
59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R
5901 = (U) ERROR CODE OF Q
5A#1 = (C) DEMO=37, UNITS >1 FOR 'G9001-05'
'G9007-11', G9013-G9015'
60X1 = (C) ASSIGN IND INVALID
6000 = (U) ADJUSTMENT BILL SPELL DATA
6020 = (U) CURRENT SPELL DOEBA < 1990
6030 = (U) ADJUSTMENT BILL SPELL DATA
6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA
61X1 = (C) PAY PROCESS IND INVALID
61X2 = (C) DENIED CLAIM/NO DENIED LINE
61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
61X4 = (C) RATE MISSING OR NON-NUMERIC
61#E = (C) PROVIDER PAYMENT INCONSISTENCIES
61#F = (C) BENEFICIARY PAYMENT INCONSISTENCIES
61#G = (C) PATIENT RESPONSIBILITY INCONSISTENCIES
61#H = (C) MEDICARE PAYMENT INCONSISTENCIES
61#I = (C) LINE DATE OF SERVICE < FROM DATE
> THRU DATE
61#J = (C) DUPLICATE HCPCS CODE '55873'
61#K = (C) HCPCS 'G0117-8' >2 OR BOTH PRESENT
61#L = (C) REVENUE CENTER CODE 0024 > 2
61#M = (C) REVENUE CENTER CODE 0024 VS PROVIDER
NUMBER
61#N = (C) REVENUE CENTER CODE 0024 REQUIRES
VALID HIPPS RATE CMG CODE
61#R = (C) HCPCS/TOB/REVENUE CENTER CODE
61#S = (C) HCPCS 'G0247' REQUIRES 'G0245-6' TO
BE COVERED
61#T = (C) HCPCS CODE '0245-0246' PRESENT MULTIPLE
TIMES
61#0 = (C) REVENUE CENTER CODE VS SPAN CODE '74'
61#6 = (C) PAYMENT METHOD INVALID
61#7 = (C) ANSI CODE MISSING
61#8 = (C) BLOOD CASH DEDUCTIBLE INCONSISTENCIES
61#9 = (C) CASH DEDUCTIBLE INCONSISTENCIES
6100 = (C) REV 0001 NOT PRESENT ON CLAIM

6101 = (C) REV COMPUTED CHARGES NOT=TOTAL
6102 = (C) REV COMPUTED NON-COVERED/NON-COV
6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER
6105 = (C) REVE CODE 0001 > 1
6106 = TOB 3X2 REVENUE CENTER CODE 0023 NOT =
TOTAL CHARGE
6109 = (C) REIMBURSEMENT > 4 OR 6 TIMES
62XA = (C) PSYC OT PT/REIM/TYPE
62XC = (C) DEMO 37 WITH REIMBURSEMENT/DED IND
<>1
62X1 = (C) DME/DATE/100% OR INVAL REIMB IND
62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED
62X8 = (C) KIDNEY DONO/TYPE/100%
62X9 = (C) PNEUM VACCINE/TYPE/100%
6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV
6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE
6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA
6260 = (U) HOSPICE ADJUSTMENT STAY DAYS
6261 = (U) HOSPICE ADJUSTMENT DAYS USED
6265 = (U) HOSPICE ADJUSTMENT DAYS USED
6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)
63X1 = (C) DEDUCT IND INVALID
63X2 = (C) DED/HCFA COINS IN PCOE/CABG
6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS
6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)
64X1 = (C) PROVIDER IND INVALID
6430 = (U) PART B DEDUCTABLE CHECK
65X1 = (C) PAYSCREEN IND INVALID
66?? = (D) POSS DUPE, CR/DB, DOC-ID
66XX = (D) POSS DUPE, CR/DB, DOC-ID
66X1 = (C) UNITS AMOUNT INVALID
66X2 = (C) UNITS IND > 0; AMT NOT VALID
66X3 = (C) UNITS IND = 0; AMT > 0
66X4 = (C) MT INDICATOR/AMOUNT
66X7 = (C) DEMO 37/HCPCS/UNITS
6600 = (U) ADJUSTMENT BILL FULL DAYS
6610 = (U) ADJUSTMENT BILL COIN DAYS
6620 = (U) ADJUSTMENT BILL LIFE RESERVE
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
67X1 = (C) UNITS INDICATOR INVALID
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0
67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS
68XA = (C) HCPCS G0117-8 >1 OR BOTH PRESENT
68XB = (C) HCPCS CODE G0245-46 > 1
68X1 = (C) INVALID HCPCS CODE
68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092
68X3 = (C) TYPE OF SERVICE = G /PROC CODE
68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE

68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC
68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC
68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.
68X8 = (C) ANTI-EMETIC WITHOUT ANTI-CANCER DRUG
6812 = (C) DEMO 37 WITH PRIMARY PAYER CODE
69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
69XB = (C) HCPCS CODE 97504/97116 PRESENT ON
SAME DAY
69XC = (C) HCPCS CODE VS PAY PROCESS INDICATOR
69X3 = (C) PROC CODE MOD = LL / TYPE = R
69X6 = (C) PROC CODE MOD/NOT CAPPED
69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL
69X9 = (C) NURSE PRACTITIONER, MOD INVALID
6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO
6902 = (C) KRON IND AND NO-PAY CODE B OR N
6903 = (C) KRON IND AND INPATIENT DEDUCT = 0
6904 = (C) KRON IND AND TRANS CODE IS 4
6910 = (C) REV CODES ON HOME HEALTH
6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY
6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO
6913 = (C) REV CODE INVAL FOR OXYGEN
6914 = (C) REV CODE INVAL FOR DME
6915 = (C) PURCHASE OF RENT DME INVAL ON DATES
6916 = (C) PURCHASE OF RENT DME INVAL ON DATES
6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000
6918 = (C) HCPCS INVALID ON DATE RANGES
6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89
6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33
6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X
6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274
6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291
6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL
6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X
6929 = (U) ADJUSTMENT BILL LIFE RESERVE
6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
7000 = (U) INVALID DOEBA/DOLBA
7002 = (U) LESS THAN 60/61 BETWEEN SPELLS
7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD
71X1 = (C) SUBMITTED CHARGES INVALID
71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG
71X3 = (C) HCPCS 76092 PAY INDICATOR <> A,R,S
& 76085 PAY INDICATOR A,R,S
72X1 = (C) ALLOWED CHGS INVALID
72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
72X3 = (C) DENIED LINE/ALLOWED CHARGES
7230 = (C) FRAMES >1, LENSES >2
73X1 = (C) SS NUMBER INVALID
73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING
74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT
76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL
77X1 = (C) PLACE OF SERVICE INVALID
77X2 = (C) PHYS THERAPY/PLACE
77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE
77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND

77X6 = (C) TOS=F, PL OF SER NOT = 24
7701 = (C) INCORRECT MODIFIER
7777 = (D) POSS DUPE, PART B DOC-ID
78XA = (C) MAMMOGRAPHY BEFORE 1991
78XB = (C) ANTI-CANCER BEFORE 01/01/1998
78X1 = (C) FROM DATE IMPOSSIBLE
78X2 = (C) FROM DATE > CURRENT DATE OR
< 07/01/1966
78X3 = (C) FROM DATE GREATER THAN THRU DATE
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY
78X5 = (C) FROM DATE > PAID DATE/TYPE/100%
78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE
79X1 = (C) THRU DATE IMPOSSIBLE
79X2 = (C) THRU DATE > CURRENT DATE
79X3 = (C) THRU DATE>RECD DATE/NOT DENIED
79X4 = (C) THRU DATE>PAID DATE/NOT DENIED
8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90
8028 = (E) NO ENTITLEMENT
8029 = (U) HH BEFORE PERIOD NOT PRESENT
8030 = (U) HH BILL VISITS > PT A REMAINING
8031 = (U) HH PT A REMAINING > 0
8032 = (U) HH DOLBA+59 NOT GT FROM-DATE
8050 = (U) HH QUALIFYING INDICATOR = 1
8051 = (U) HH # VISITS NE AFT PT B APPLIED
8052 = (U) HH # VISITS NE AFT TRAILER
8053 = (U) HH BENEFIT PERIOD NOT PRESENT
8054 = (U) HH DOEBA/DOLBA NOT > 0
8060 = (U) HH QUALIFYING INDICATOR NE 1
8061 = (U) HH DATE NE DOLBA IN AFT TRLR
8062 = (U) HH NE PT-A VISITS REMAINING
81X1 = (C) NUM OF SERVICES INVALID
83X1 = (C) DIAGNOSIS INVALID
8301 = (C) HCPCS/GENDER DIAGNOSIS
8302 = (C) HCPCS G0101 V-CODE/SEX CODE
8303 = (C) HCPCS/GENDER
8304 = (C) BILL TYPE INVALID FOR G0123/4
8305 = (C) HCPCS/SERVICE DATES/GENDER
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
84X2 = (C) INVALID DME START DATE
84X3 = (C) INVALID DME START DATE W/HCPCS
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
84X5 = (C) HCPCS CODE WITH INV DIAG CODE
84X6 = (C) HCPCS/GENDER
84X7 = (C) HCPCS/SERVICE DATES/GENDER
84X8 = (C) DUPLICATE HCPCS
86X1 = (C) CLINICAL LAB HCPCS W/O CLINICAL
LAB ID
86X2 = (C) NON-WAIVER HCPCS/PAY DENIAL CODE/
MODIFIER
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD
9000 = (U) DOEBA/DOLBA CALC
9005 = (U) FULL/COINS HOSP DAYS CALC
9010 = (U) FULL/COINS SNF DAYS CALC

9015 = (U) LIFE RESERVE DAYS CALC
9020 = (U) LIFE PSYCH DAYS CALC
9030 = (U) INPAT DEDUCTABLE CALC
9040 = (U) DATA INDICATOR 1 SET
9050 = (U) DATA INDICATOR 2 SET
91X1 = (C) PATIENT REIMB/PAY-DENY CODE
92X1 = (C) PATIENT REIMB INVALID
92X2 = (C) PROVIDER REIMB INVALID
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
92X7 = (C) REIMB/PAY-DENY INCONSISTANT
9201 = (C) UPIN REF NAME OR INITIAL MISSING
9202 = (C) UPIN REF FIRST 3 CHAR INVALID
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
93X1 = (C) CASH DEDUCTABLE INVALID
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
93X4 = (C) FROM DATE/CASH DEDUCTIBLE
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
9300 = (C) UPIN OTHER, NOT PRESENT
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
9351 = (C) OTHER UPIN PRESENT/MISSING OTHER FIELDS
9352 = (C) OTHER UPIN INVALID
9353 = (C) OTHER UPIN INVALID
94A1 = (C) NON-COVERED FROM DATE INVALID
94A2 = (C) NON-COVERED FROM > THRU DATE
94A3 = (C) NON-COVERED THRU DATE INVALID
94A4 = (C) NON-COVERED THRU DATE > ADMIT
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
94C1 = (C) PR-PSYCH DAYS INVALID
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
94F1 = (C) REIMBURSEMENT AMOUNT INVALID
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
94G1 = (C) NO-PAY CODE INVALID
94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
94G4 = (C) NO PAY CODE = R & REIMB PRESENT
94X1 = (C) BLOOD LIMIT INVALID
94X2 = (C) TYPE/BLOOD DEDUCTIBLE
94X3 = (C) TYPE/DATE/LIMIT AMOUNT
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
9401 = (C) BLOOD DEDUCTIBLE AMT > 3
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
9404 = (C) INVALID GENDER CODE ON PRO-PAY
9407 = (C) INVALID DIAGNOSIS
9408 = (C) INVALID DRG NUMBER (GLOBAL)
9409 = (C) HCFA DRG<>DRG ON BILL
940X = (C) INVALID DRG
9410 = (C) CABG/PCOE,INVALID DRG

95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
95X2 = (C) MSP AMOUNT APPLIED INVALID
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
95X5 = (C) MSP CODE = G/DATE BEFORE 1987
95X6 = (C) MSP CODE = X AND NOT AVOIDED
95X7 = (C) MSP CODE VALID, CABG/PCOE
96X1 = (C) OTHER AMOUNTS INVALID
96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB
97X1 = (C) OTHER AMOUNTS INDICATOR INVALID
97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0
98X1 = (C) COINSURANCE INVALID
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
9801 = (C) REV CENTER CODE 0910 WITH SERVICE
DATE > 10/15/2004
99XX = (D) POSS DUPE, PART B DOC-ID
9901 = (C) REV CODE INVALID OR TRAILER CNT=0
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
9903 = (C) NO CLINIC VISITS FOR RHC
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE
991X = (C) NO DATE OF SERVICE
9910 = (C) BLOOD DEDUCTIBLE NON NUMERIC
9911 = (C) BLOOD DEDUCTIBLE PRESENT WITHOUT
BLOOD FURNISHED
9920 = (C) CASH DEDUCTIBLE INVALID
9930 = (C) COINSURANCE INVALID
9931 = (C) OUTPAT COINSURANCE VALUES
9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT
9934 = (C) HCPCS 76092 NON COVERED/76085 COVERED
9940 = (C) PROVIDER PAYMENT INVALID
9941 = (C) REIMBURSEMENT AMOUNT/COND/NON-PAYMENT/
PRIMARY PAYER
9942 = (C) PATIENT DISTRIBUTION INVALID
9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
9945 = (C) HCPCS INVALID FOR SERVICE DATES
9946 = (C) TOB INVALID FOR HCPCS
9947 = (C) INVALID DATE FOR HCPCS
9948 = (C) STAY FROM>96365,DIAG=V725
9960 = (C) MED CHOICE BUT HMO DATA MISSING
9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER
9999 = (U) MAIN SPELL TRAILER NUMBER DOES NOT MATCH SPELL

NCH_EDIT_TRLR_IND_TB NCH Edit Trailer Indicator Table

E = Edit code trailer present

NCH_MCO_TRLR_IND_TB NCH Managed Care Organization (MCO) Trailer Indicator Table

M = MCO trailer present

NCH_MQA_QUERY_PATCH_TB NCH MQA Query Patch Table

Y = MQA changed bill query code on a action
code 6 (force action code 2)
bill to a zero. (Eff. 10/12/93)
Z = MQA changed bill query code on a action
code 4 (cancel only adjustment)
bill to zero. (Eff. 5/16/94)

NCH_MQA_RIC_TB NCH MQA Record Identification Code Table

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

NCH_NEAR_LINE_REC_VRSN_TB NCH Near Line Record Version Table

A = Record format as of January 1991
B = Record format as of April 1991
C = Record format as of May 1991
D = Record format as of January 1992
E = Record format as of March 1992
F = Record format as of May 1992
G = Record format as of October 1993
H = Record format as of September 1998
I = Record format as of July 2000
J = Record format as of January 2011
K = Record format as of April 2013
L = Record format as of January 2021

NCH_NEAR_LINE_RIC_TB NCH Near-Line Record Identification Code Table

O = Part B physician/supplier claim
record (processed by local carriers;
can include DMEPOS services)
V = Part A institutional claim record
(inpatient (IP), skilled nursing
facility (SNF), christian science
(CS), home health agency (HHA), or

hospice)
W = Part B institutional claim record (outpatient (OP), HHA)
U = Both Part A and B institutional home health agency (HHA) claim records -- due to HHPPS and HHA A/B split. (effective 10/00)
M = Part B DMEPOS claim record (processed by DME Regional Carrier) (effective 10/93)

NCH_OCRNC_TRLR_IND_TB NCH Occurrence Trailer Indicator Table

O = Occurrence code trailer present

NCH_PATCH_TB NCH Patch Table

01 = RRB Category Equatable BIC - changed (all claim types) -- applied during the Nearline 'G' conversion to claims with NCH weekly process date before 3/91. Prior to Version 'H', patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 2.
02 = Claim Transaction Code made consistent with NCH payment/edit RIC code (OP and HHA) -- effective 3/94, CWFMQA began patch. During 'H' conversion, patch applied to claims with NCH weekly process date prior to 3/94. Prior to version 'H', patch indicator stored in redefined Claim Edit Group, 4th occurrence, position 1.
03 = Garbage/nonnumeric Claim Total Charge Amount set to zeroes (Instnl) -- during the Version 'G' conversion, error occurred in the derivation of this field where the claim was missing revenue center code = '0001'. In 1994, patch was applied to the OP and HHA SAFs only. (This SAF patch indicator was stored in the redefined Claim Edit Group, 4th occurrence, position 2). During the 'H' ocnversion, patch applied to Nearline claims where garbage or nonnumeric values.
04 = Incorrect bene residence SSA standard county code '999' changed (all claim types) -- applied during the Nearline 'G' conversion and ongoing through 4/21/94, calling EQSTZIP routine to claims with NCH weekly process date prior to 4/22/94. Prior to Version 'H' patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 4.
05 = Wrong century bene birth date corrected (all

claim types) -- applied during Nearline 'H' conversion to all history where century greater than 1700 and less than 1850; if century less than 1700, zeroes moved.

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

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

08 = Invalid NCH primary payer code set to blanks (Instnl) -- applied during Version 'H' conversion to claims with NCH weekly process date 10/1/93-10/30/95, where MSP values = invalid '0', '1', '2', '3' or '4' (caused by erroneous logic in HCFA program code, which was corrected on 11/1/95).

09 = Zero CWF claim accretion date replaced with NCH weekly process date (all claim types) -- applied during Version 'H' conversion to Instnl and DMERC claims; applied during Version 'G' conversion to non-institutional (non-DMERC) claims. Prior to Version 'H', patch indicator stored in redefined claim edit group, 3rd occurrence, position 1.

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

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

12 = Missing claim-level HHA Total Visit Count -- service years 1998, 1999 & 2000 patch applied during Version 'I' conversion of both the

Nearline and SAFs. Problem occurs in those claims recovered during the missing claims effort.

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

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

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

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

The patch applied date is 06/29/2001.

NCH_PATCH_TRLR_IND_TB NCH Patch Trailer Indicator Table

P = Patch code trailer present

NCH_REV_TRLR_IND_TB NCH Revenue Center Trailer Indicator Table

R = Revenue code trailer present

NCH_SPAN_TRLR_IND_TB NCH Span Trailer Indicator Table

S = Span code trailer present

NCH_STATE_SGMT_TB NCH State Segment Table

NCH State Segment	State Codes
B =	01;02;03;04;06;07;08;09; 12;13;16;17;19;20;21;25; 27;28;29;30;32;35;37;38; 40;41;42;43;44;46;47;48; 50;51;53-99
C =	11;14;15;18;24;26;49;52
D =	11;14;15;18;24;26;31;34; 45;49;52
E =	22;23;31;34;36;45
F =	10;22;23;31;34;36;45
G =	10;22;23;36;39
H =	05;10;22;23;39
I =	05;10;39
J =	05;10;33;39
K =	05;33;39
L =	05;33;39
M =	05;33
N =	05;33
O =	33
P =	33
Q =	33
R =	33

NCH_VAL_TRLR_IND_TB NCH Value Trailer Indicator Table

V = Value code trailer present

NG_ACO_IND_TB Next Generation (NG) Accountable Care Organization (ACO) Indicator Code Table

0 = Base record (no enhancements)
1 = Population Based Payments (PBP)
2 = Telehealth
3 = Post Discharge Home Health Visits
4 = 3-Day SNF Waiver
5 = Capitation
6 = CEC Telehealth
7 = Care Management Home Visits
8 = Primary Care Capitation (PCC)
9 = Home Health Benefit Enhancement - eff. 4/2021
B = Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit - eff. 4/2021
C = Kidney Disease Education (KDE) eff. 4/2021
D = Seriously Ill Population (SIP)
E = Flat Visit Fee (FVF)
F = Quarterly Capitation Payment (QCP) eff. 4/2021

PMT_EDIT_RIC_TB Payment And Edit Record Identification Code Table

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

PRVDR_NUM_TB Provider Number Table

- First two positions are the GEO SSA State Code.

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

- A 'V' in the 5th position identifies a VA demo.

0001-0879 Short-term (general and specialty) hospitals where TOB = 11X; ESRD clinic where TOB = 72X
0880-0899 Reserved for hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB = 72X
0900-0999 Multiple hospital component in a medical complex (numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1000-1199 Reserved for future use
1200-1224 Alcohol/drug hospitals (excluded from PPS-numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1225-1299 Medical assistance facilities (Montana project); ESRD clinic where TOB = 72X
1300-1399 Rural Primary Care Hospital (RCPH) - eff. 10/97 changed to Critical Access Hospitals (CAH)
1400-1499 Continuation of 4900-4999 series (CMHC)
1500-1799 Hospices
1800-1989 Federally Qualified Health Centers (FQHC) where TOB = 73X; SNF (IP PTB) where TOB = 22X; HHA where TOB = 32X, 33X, 34X
1990-1999 Christian Science Sanatoria (hospital services) - eff. 7/00 changed to Religious Nonmedical Health Care Institutions (RNHCI)
2000-2299 Long-term hospitals
2300-2499 Chronic renal disease facilities (hospital based)
2500-2899 Non-hospital renal disease treatment centers
2900-2999 Independent special purpose renal dialysis facility (1)
3000-3024 Formerly tuberculosis hospitals (numbers retired)
3025-3099 Rehabilitation hospitals
3100-3199 Continuation of Subunits of Nonprofit and Proprietary Home Health Agencies (7300-7399) Series (3) (eff. 4/96)
3200-3299 Continuation of 4800-4899 series (CORF)
3300-3399 Children's hospitals (excluded from PPS) where TOB = 11X; ESRD clinic where TOB = 72X
3400-3499 Continuation of rural health clinics (provider-based) (3975-3999)

3500-3699 Renal disease treatment centers (hospital satellites)
3700-3799 Hospital based special purpose renal dialysis facility (1)
3800-3974 Rural health clinics (free-standing)
3975-3999 Rural health clinics (provider-based)
4000-4499 Psychiatric hospitals
4500-4599 Comprehensive Outpatient Rehabilitation Facilities (CORF)
4600-4799 Community Mental Health Centers (CMHC); 9/30/91 - 3/31/97 used for clinic OPT where TOB = 74X
4800-4899 Continuation of 4500-4599 series (CORF) (eff. 10/95)
4900-4999 Continuation of 4600-4799 series (CMHC) (eff. 10/95); 9/30/91 - 3/31/97 used for clinic OPT where TOB = 74X
5000-6499 Skilled Nursing Facilities
6500-6989 CMHC / Outpatient physical therapy services where TOB = 74X; CORF where TOB = 75X
6990-6999 Christian Science Sanatoria (skilled nursing services) - eff. 7/00 Numbers Reserved (formerly CS)
7000-7299 Home Health Agencies (HHA) (2)
7300-7399 Subunits of 'nonprofit' and 'proprietary' Home Health Agencies (3)
7400-7799 Continuation of 7000-7299 series
7800-7999 Subunits of state and local governmental Home Health Agencies (3)
8000-8499 Continuation of 7400-7799 series (HHA)
8500-8899 Continuation of rural health center (provider based) (3400-3499)
8900-8999 Continuation of rural health center (free-standing) (3800-3974)
9000-9799 Continuation of 8000-8499 series (HHA) (eff. 10/95)
9800-9899 Transplant Centers (eff. 10/1/07)
9900-9999 Freestanding Opioid Treatment Program (eff. 1/2021)

Exception:

P001-P999 Organ procurement organization

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

(2) The 6400-6499 series of provider numbers in Iowa (16), South Dakota (43) and Texas (45)

have been used in reducing acute care costs (RACC) experiments.

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

(4) Parent agency must have a number in the 7000-7299, 7400-7799 or 8000-8499 series.

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

M = Psychiatric Unit in Critical Access Hospital
R = Rehabilitation Unit in Critical Access Hospital
S = Psychiatric unit (excluded from PPS)
T = Rehabilitation unit (excluded from PPS)
U = Swing-Bed Hospital Designation for Short-Term Hospitals
V = Alcohol drug unit (prior to 10/87 only)
W = Swing-Bed Hospital Designation for Long Term Care Hospitals
Y = Swing-Bed Hospital Designation for Rehabilitation Hospitals
Z = Swing Bed Designation for Critical Access Hospitals

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

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

PTNT_DSCHRG_STUS_TB Patient Discharge Status Table

01 = Discharged to home/self care (routine charge).
02 = Discharged/transferred to other short term general hospital for inpatient care.
03 = Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care -- (For hospitals with an

approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/ transfers to a non-certified SNF, the hospital must use Code 04 - ICF.

04 = Discharged/transferred to a facility that provides custodial or supportive care (includes intermediate care facilities (ICF). Also used to designate patients that are dischared/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to Assisted Living Facilities.

05 = Discharged/transferred to a designated cancer center or children's hospital (eff. 10/09). Prior to 10/1/09, discharged/transferred to another type of institution for inpatient care (including distinct parts). NOTE: Effective 1/2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is '65'.

06 = Discharged/transferred to home care of organized home health service organization in anticipation of covered skilled care.

07 = Left against medical advice or discontinued care.

08 = Discharged/transferred to home under care of a home IV drug therapy provider. (discontinued effective 10/1/05)

09 = Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.

20 = Expired

21 = Discharged/transferred to Court/Law Enforcement.

30 = Still patient.

40 = Expired at home (Hospice claims only).

41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)

42 = Expired - place unknown (Hospice claims only)

43 = Discharged/transferred to a federal hospital (eff. 10/1/03). Discharges and transfers to a government operated health facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not.

50 = Hospice - home (eff. 10/96)

51 = Hospice - medical facility (certified) providing hospice level of care

61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/01)
62 = Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital. (eff. 1/2002)
63 = Discharged/transferred to a Medicare certified long term care hospital. (eff. 1/2002)
64 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare (eff. 10/2002)
65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code). (eff. 1/2005).
66 = Discharged/transferred to a Critical Access Hospital (CAH) (eff. 1/1/06)
69 = Discharge/transfers to a Designated Disaster Alternative Care site (eff. 10/2013)
70 = Discharged/transferred to another type of health care institution not defined elsewhere in code list.
71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)
72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)
81 = Discharged to home or self-care with a planned acute care hospital inpatient (eff. 10/2013)
82 = Discharged/transferred to a short term general hospital for inpatient care readmission (eff. 10/2013)
83 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare (eff. 10/2013)
84 = Discharged/transferred to a facility that provides custodial supportative care with a planned acute care hospital inpatient readmission certification with a planned acute care hospital inpatient readmission (eff. 10/2013)
85 = Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission (eff. 10/2013)
86 = Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission (eff. 10/2013)
87 = Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (eff. 10/2013)
88 = Discharged/transferred to a Federal health care facility with a planned acute care hospital inpatient readmission

(eff. 10/2013)
89 = Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hosptial inpatient readmission (eff. 10/2013)
90 = Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct units of a hospital with a planned acute care hospital inpatient readmission (eff. 10/2013)
91 = Discharged/transferred to a Medicare certified Long Term Care Hospital (LTCH) with a planned acute care hospital inpatient readmission (eff. 10/2013)
92 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (eff. 10/2013)
93 = Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (eff. 10/2013)
94 = Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (eff. 10/2013)
95 = Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission. (eff. 10/2013)

REV_CNTR_ANSI_TB Revenue Center ANSI Code Table

*******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*******
**********POSITIONS 1 & 2 OF ANSI CODE**********
CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

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

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

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

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

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

1 = Deductible Amount
2 = Coinsurance Amount
3 = Co-pay Amount
4 = The procedure code is inconsistent with the modifier
used or a required modifier is missing.
5 = The procedure code/bill type is inconsistent with the
place of service.
6 = The procedure code is inconsistent with the patient's
age.
7 = The procedure code is inconsistent with the patient's
gender.
8 = The procedure code is inconsistent with the provider
type.
9 = The diagnosis is inconsistent with the patient's age.
10 = The diagnosis is inconsistent with the patient's
gender.
11 = The diagnosis is inconsistent with the procedure.
12 = The diagnosis is inconsistent with the provider type.
13 = the date of death precedes the date of service.
14 = The date of birth follows the date of service.
15 = Claim/service adjusted because the submitted auth-
orization number is missing, invalid, or does not
apply to the billed services or provider.
16 = Claim/service lacks information which is needed for
adjudication.
17 = Claim/service adjusted because requested information
was not provided or was insufficient/incomplete.
18 = Duplicate claim/service.
19 = Claim denied because this is a work-related injury/
illness and thus the liability of the Worker's Com-
pensation Carrier.
20 = Claim denied because this injury/illness is covered
by the liability carrier.
21 = Claim denied because this injury/illness is the
liability of the no-fault carrier.
22 = Claim adjusted because this care may be covered by
another payer per coordination of benefits.
23 = Claim adjusted because charges have been paid by
another payer.
24 = Payment for charges adjusted. Charges are covered
under a capitation agreement/managed care plan.
25 = Payment denied. Your Stop loss deductible has not
been met.
26 = Expenses incurred prior to coverage.
27 = Expenses incurred after coverage terminated.

28 = Coverage not in effect at the time the service was provided.
29 = The time limit for filing has expired.
30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31 = Claim denied as patient cannot be identified as our insured.
32 = Our records indicate that this dependent is not an eligible dependent as defined.
33 = Claim denied. Insured has no dependent coverage.
34 = Claim denied. Insured has no coverage for newborns.
35 = Benefit maximum has been reached.
36 = Balance does not exceed copayment amount.
37 = Balance does not exceed deductible amount.
38 = Services not provided or authorized by designated (network) providers.
39 = Services denied at the time authorization/pre-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
83 = Total visits. INACTIVE
84 = Capital adjustments. INACTIVE
85 = Interest amount. INACTIVE
86 = Statutory adjustment. INACTIVE
87 = Transfer amounts.
88 = Adjustment amount represents collection against
receivable created in prior overpayment.
89 = Professional fees removed from charges.
90 = Ingredient cost adjustment.
91 = Dispensing fee adjustment.
92 = Claim paid in full. INACTIVE
93 = No claim level adjustment. INACTIVE
94 = Process in excess of charges.
95 = Benefits adjusted. Plan procedures not followed.
96 = Non-covered charges.
97 = Payment is included in allowance for another
service/procedure.
98 = The hospital must file the Medicare claim for this
inpatient non-physician service. INACTIVE
99 = Medicare Secondary Payer Adjustment Amount. INACTIVE
100 = Payment made to patient/insured/responsible party.
101 = Predetermination: anticipated payment upon comple-

tion of services or claim ajudication.
102 = Major medical adjustment.
103 = Provider promotional discount (i.e. Senior citizen
discount).
104 = Managed care withholding.
105 = Tax withholding.
106 = Patient payment option/election not in effect.
107 = Claim/service denied because the related or qualifying
claim/service was not paid or identified on the claim.
108 = Claim/service reduced because rent/purchase guidelines
were not met.
109 = Claim not covered by this payer/contractor. You must
send the claim to the correct payer/contractor.
110 = Billing date predates service date.
111 = Not covered unless the provider accepts assignment.
112 = Claim/service adjusted as not furnished directly
to the patient and/or not documented.
113 = Claim denied because service/procedure was provided
outside the United States or as a result of war.
114 = Procedure/PRODuct not approved by the Food and Drug
Administration.
115 = Claim/service adjusted as procedure postponed or
canceled.
116 = Claim/service denied. The advance indemnification
notice signed by the patient did not comply with
requirements.
117 = Claim/service adjusted because transportation is only
covered to the closest facility that can provide
the necessary care.
118 = Charges reduced for ESRD network support.
119 = Benefit maximum for this time period has been reached.
120 = Patient is covered by a managed care plan. INACTIVE
121 = Indemnification adjustment.
122 = Psychiatric reduction.
123 = Payer refund due to overpayment. INACTIVE
124 = Payer refund amount - not our patient. INACTIVE
125 = Claim/service adjusted due to a submission/billing
error(s).
126 = Deductible - Major Medical.
127 = Coinsurance - Major Medical.
128 = Newborn's services are covered in the mother's
allowance.
129 = Claim denied - prior processing information appears
incorrect.
130 = Paper claim submission fee.
131 = Claim specific negotiated discount.
132 = Prearranged demonstration project adjustment.
133 = The disposition of this claim/service is pending
further review.
134 = Technical fees removed from charges.
135 = Claim denied. Interim bills cannot be processed.
136 = Claim adjusted. Plan procedures of a prior payer
were not followed.
137 = Payment/Reduction for Regulatory Surcharges, Assess-

ments, Allowances or Health Related Taxes.
138 = Claim/service denied. Appeal procedures not followed or time limits not met.
139 = Contracted funding agreement - subscriber is employed by the provider of services.
140 = Patient/Insured health identification number and name do not match.
141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.
142 = Claim adjusted by the monthly Medicaid patient liability amount.
A0 = Patient refund amount
A1 = Claim denied charges.
A2 = Contractual adjustment.
A3 = Medicare Secondary Payer liability met. INACTIVE
A4 = Medicare Claim PPS Capital Day Outlier Amount.
A5 = Medicare Claim PPS Capital Cost Outlier Amount.
A6 = Prior hospitalization or 30 day transfer requirement not met.
A7 = Presumptive Payment Adjustment.
A8 = Claim denied; ungroupable DRG.
B1 = Non-covered visits.
B2 = Covered visits. INACTIVE
B3 = Covered charges. INACTIVE
B4 = Late filing penalty.
B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.
B6 = This service/procedure is adjusted when performed/ billed by this type of provider, by this type of facility, or by a provider of this specialty.
B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.
B9 = Services not covered because the patient is enrolled in a Hospice.
B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/ service not covered by this payer/processor.
B12 = Services not documented in patients' medical records.
B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.
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.

REV_CNTR_APC_BUFR_TB Revenue Center Ambulatory Payment Classification (APC) Buffer Code Table

00 = No composite group assigned
01 = First composite group on claim
02 = Second composite group on claim
NN = nth composite group on claim

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00 = N/A in this case
01-99 = 1st composite - 99th composite
A1-A9 = 100th composite - 108th composite
B1-B9 = 109th composite - 117th composite
C1-C9 = 118th composite - 126th composite
D1-D9 = 127th composite - 135th composite
E1-E9 = 136th composite - 144th composite
F1-F9 = 145th composite - 153rd composite
G1-G9 = 154th composite - 162nd composite
H1-H9 = 163rd composite - 171st composite
I1-I9 = 172nd composite - 180th composite
J1-J9 = 181st composite - 189th composite
K1-K9 = 190th composite - 198th composite
L1-L9 = 199th composite - 207th composite
M1-M9 = 208th composite - 216th composite
N1-N9 = 217th composite - 225th composite
O1-O9 = 226th composite - 234th composite
P1-P9 = 235th composite - 243rd composite
Q1-Q9 = 244th composite - 252nd composite
R1-R9 = 253rd composite - 261st composite
S1-S9 = 262nd composite - 270th composite
T1-T9 = 271st composite - 279th composite
U1-U9 = 280th composite - 288th composite

V1-V9 = 289th composite - 297th composite
W1-W9 = 298th composite - 306th composite
X1-X9 = 307th composite - 315th composite
Y1-Y9 = 316th composite - 324th composite
Z1-Z9 = 325th composite - 333rd composite

AA-AZ = 334th composite - 359th composite
BA-BZ = 360th composite - 385th composite
CA-CZ = 386th composite - 411th composite
DA-DZ = 412th composite - 437th composite
EA-EZ = 438th composite - 463rd composite
FA-FZ = 464th composite - 489th composite
GA-GZ = 490th composite - 515th composite
HA-HZ = 516th composite - 541st composite
IA-IZ = 542nd composite - 567th composite
JA-JZ = 568th composite - 593rd composite
KA-KZ = 594th composite - 619th composite
LA-LZ = 620th composite - 645th composite
MA-MZ = 646th composite - 671st composite
NA-NZ = 672nd composite - 697th composite
OA-OZ = 698th composite - 723rd composite
PA-PZ = 724th composite - 749th composite
QA-QZ = 750th composite - 775th composite
RA-RZ = 776th composite - 801st composite
SA-SZ = 802nd composite - 827th composite
TA-TZ = 828th composite - 853rd composite
UA-UZ = 854th composite - 879th composite
VA-VZ = 880th composite - 905th composite
WA-WZ = 906th composite - 931st composite
XA-XZ = 932nd composite - 957th composite
ZA-ZZ = 958th composite - 983rd composite

REV_CNTR_APC_TB Revenue Center Ambulatory Payment Classification (APC)

0000 = Code used when Payment Method Indicator equals 'N9'
0001 = Photochemotherapy
0002 = Fine needle Biopsy/Aspiration
0003 = Bone Marrow Biopsy/Aspiration
0004 = Level I Needle Biopsy/ Aspiration Except Bone Marrow
0005 = Level II Needle Biopsy /Aspiration Except Bone Marrow
0006 = Level I Incision & Drainage
0007 = Level II Incision & Drainage
0008 = Level III Incision & Drainage
0009 = Nail Procedures
0010 = Level I Destruction of Lesion
0011 = Level II Destruction of Lesion
0012 = Level I Debridement & Destruction
0013 = Level II Debridement & Destruction
0014 = Level III Debridement & Destruction

0015 = Level IV Debridement & Destruction
0016 = Level V Debridement & Destruction
0017 = Level VI Debridement & Destruction
0018 = Biopsy Skin, Subcutaneous Tissue or Mucous Membrane
0019 = Level I Excision/ Biopsy
0020 = Level II Excision/ Biopsy
0021 = Level III Excision/ Biopsy
0022 = Level IV Excision/ Biopsy
0023 = Exploration Penetrating Wound
0024 = Level I Skin Repair
0025 = Level II Skin Repair
0026 = Level III Skin Repair
0027 = Level IV Skin Repair
0028 = Level I Incision/Excision Breast
0029 = Incision/Excision Breast (obsolete 12/00);
Level II Incision/Excision Breast (effective 1/01)
0030 = Breast Reconstruction/Mastectomy
0031 = Hyperbaric Oxygen (obsolete 1/01)
0032 = Placement Transvenous Catheters/Arterial Cutdown
0033 = Partial Hospitalization
0040 = Arthrocentesis & Ligament/Tendon Injection
0041 = Arthroscopy
0042 = Arthroscopically-Aided Procedures
0043 = Closed Treatment Fracture Finger/Toe/Trunk
0044 = Closed Treatment Fracture/Dislocation Except
Finger/Toe/Trunk
0045 = Bone/Joint Manipulation Under Anesthesia
0046 = Open/Percutaneous Treatment Fracture or Dislocation
0047 = Arthroplasty without Prosthesis
0048 = Arthroplasty with Prosthesis
0049 = Level I Musculoskeletal Procedures Except Hand
and Foot
0050 = Level II Musculoskeletal Procedures Except Hand
and Foot
0051 = Level III Musculoskeletal Procedures Except Hand
and Foot
0052 = Level IV Musculoskeletal Procedures Except Hand
and Foot
0053 = Level I Hand Musculoskeletal Procedures
0054 = Level II Hand Musculoskeletal Procedures
0055 = Level I Foot Musculoskeletal Procedures
0056 = Level II Foot Musculoskeletal Procedures
0057 = Bunion Procedures
0058 = Level I Strapping and Cast Application
0059 = Level II Strapping and Cast Application
0060 = Manipulation Therapy
0070 = Thoracentesis/Lavage Procedures
0071 = Level I Endoscopy Upper Airway
0072 = Level II Endoscopy Upper Airway
0073 = Level III Endoscopy Upper Airway
0074 = Level IV Endoscopy Upper Airway
0075 = Level V Endoscopy Upper Airway
0076 = Endoscopy Lower Airway
0077 = Level I Pulmonary Treatment

0078 = Level II Pulmonary Treatment
0079 = Ventilation Initiation and Management
0080 = Diagnostic Cardiac Catheterization
0081 = Non-Coronary Angioplasty or Atherectomy
0082 = Coronary Atherectomy
0083 = Coronary Angiosplasty
0084 = Level I Electrophysiologic Evaluation
0085 = Level II Electrophysiologic Evaluation
0086 = Ablate Heart Dysrhythm Focus
0087 = Cardiac Electrophysiologic Recording/Mapping
0088 = Thrombectomy
0089 = Level I Implantation/Removal/Revision of Pacemaker, AICD Vascular Device (obsolete 12/00); Insertion/Replacement of Permanent Pacemaker and Electrodes (eff. 1/01)
0090 = Level II Implantation/Removal/Revision of Pacemaker AICD Vascular Device (obsolete 12/00); Insertion/Replacement of Permanent Pacemaker and Pulse Generator
0091 = Level I Vascular Ligation
0092 = Level II Vascular Ligation
0093 = Vascular Repair/Fistula Construction
0094 = Resuscitation and Cardioversion
0095 = Cardiac Rehabilitation
0096 = Non-Invasive Vascular Studies
0097 = Cardiovascular Stress Test (obsolete 12/00); Cardiac Monitoring for 30 days (eff. 1/01)
0098 = Injection of Sclerosing Solution
0099 = Continuous Cardiac Monitoring (obsolete 12/00); Electrocardiograms (eff. 1/01)
0100 = Stress test and continuous ECG
0101 = Tilt Table Evaluation
0102 = Electronic Analysis of Pacemakers/other Devices
0103 = Miscellaneous Vascular Procedures (eff. 1/01)
0104 = Transcatheter Placement of Intracoronary Stents (eff. 1/01)
0105 = Revision/Removal of Pacemakers, AICD or Vascular (eff. 1/01)
0106 = Insertion/Replacement/Repair of Pacemaker Electrode (eff. 1/01)
0107 = Insertion of Cardioverter-Defibrillator (eff. 1/01)
0108 = Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads (eff. 1/01)
0109 = Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant (obsolete 12/00); Removal of Implanted Devices (eff. 1/01)
0110 = Transfusion
0111 = Blood PRODuct Exchange
0112 = Extracorporeal Photopheresis
0113 = Excision Lymphatic System
0114 = Thyroid/Lymphadenectomy Procedures
0115 = Cannula/Access Device Procedures (eff. 1/01)

0116 = Chemotherapy Administration by Other Technique
Except Infusion
0117 = Chemotherapy Administration by Infusion Only
0118 = Chemotherapy Administration by Both Infusion and
Other Technique
0119 = Implantation of Devices (eff. 1/01)
0120 = Infusion Therapy Except Chemotherapy
0121 = Level I Tube changes and Repositioning
0122 = Level II Tube changes and Repositioning
0123 = Bone Marrow Harvesting and Bone Marrow/Stem
Cell Transplant
0124 = Revision of Implanted Infusion Pump
(eff. 1/01)
0130 = Level I Laparoscopy
0131 = Level II Laparoscopy
0132 = Level III Laparoscopy
0140 = Esophageal Dilation without Endoscopy
0141 = Upper GI Procedures
0142 = Small Intestine Endoscopy
0143 = Lower GI Endoscopy
0144 = Diagnostic Anoscopy
0145 = Therapeutic Anoscopy
0146 = Level I Sigmoidoscopy
0147 = Level II Sigmoidoscopy
0148 = Level I Anal/Rectal Procedure
0149 = Level II Anal/Rectal Procedure
0150 = Level III Anal/Rectal Procedure
0151 = Endoscopic Retrograde Cholangio-Pancreatography (ERCP)
0152 = Percutaneous Biliary Endoscopic Procedures
0153 = Peritoneal and Abdominal Procedures
0154 = Hernia/Hydrocele Procedures
0157 = Colorectal Cancer Screening: Barium Enema
(Not subject to National coinsurance)
0158 = Colorectal Cancer Screening: Colonoscopy
Not subject to National coinsurance. Minimum
unadjusted coinsurance is 25% of the payment rate.
Payment rate is lower of the HOPD payment rate or
the Ambulatory Surgical Center payment.
0159 = Colorectal Cancer Screening: Flexible Sigmoidoscopy
Not subject to National coinsurance. Minimum
unadjusted coinsurance is 25% of the payment rate.
Payment rate is lower of the HOPD payment rate or
the Ambulatory Surgical Center payment.
0160 = Level I Cystourethroscopy and other Genitourinary
Procedures
0161 = Level II Cystourethroscopy and other Genitourinary
Procedures
0162 = Level III Cystourethroscopy and other Genitourinary
Procedures
0163 = Level IV Cystourethroscopy and other Genitourinary
Procedures
0164 = Level I Urinary and Anal Procedures
0165 = Level II Urinary and Anal Procedures
0166 = Level I Urethral Procedures

0167 = Level II Urethral Procedures
0168 = Level III Urethral Procedures
0169 = Lithotripsy
0170 = Dialysis for Other Than ESRD Patients
0180 = Circumcision
0181 = Penile Procedures
0182 = Insertion of Penile Prosthesis
0183 = Testes/Epididymis Procedures
0184 = Prostate Biopsy
0190 = Surgical Hysteroscopy
0191 = Level I Female RePRODuctive Procedures
0192 = Level II Female RePRODuctive Procedures
0193 = Level III Female RePRODuctive Procedures
0194 = Level IV Female RePRODuctive Procedures
0195 = Level V Female RePRODuctive Procedures
0196 = Dilatation & Curettage
0197 = Infertility Procedures
0198 = Pregnancy and Neonatal Care Procedures
0199 = Vaginal Delivery
0200 = Therapeutic Abortion
0201 = Spontaneous Abortion
0210 = Spinal Tap
0211 = Level I Nervous System Injections
0212 = Level II Nervous System Injections
0213 = Extended EEG Studies and Sleep Studies
0214 = Electroencephalogram
0215 = Level I Nerve and Muscle Tests
0216 = Level II Nerve and Muscle Tests
0217 = Level III Nerve and Muscle Tests
0220 = Level I Nerve Procedures
0221 = Level II Nerve Procedures
0222 = Implantation of Neurological Device
0223 = Level I Revision/Removal Neurological Device (obsolete 12/00); Implantation of Pain Management Device (eff. 1/01)
0224 = Level II Revision/Removal Neurological Device (obsolete 12/00); Implantation of Reservoir/ Pump/Shunt (eff. 1/01)
0225 = Implantation of Neurostimulator Electrodes
0226 = Implantation of Drug Infusion Reservior (eff. 1/01)
0227 = Implantation of Drug Infusion Device (eff. 1/01)
0228 = Creation of Lumbar Subarachnoid Shunt (eff. 1/01)
0229 = Transcatherter Placement of Intravascular Shunts (eff. 1/01)
0230 = Level I Eye Tests
0231 = Level II Eye Tests
0232 = Level I Anterior Segment Eye
0233 = Level II Anterior Segment Eye
0234 = Level III Anterior Segment Eye Procedures
0235 = Level I Posterior Segment Eye Procedures
0236 = Level II Posterior Segment Eye Procedures

0237 = Level III Posterior Segment Eye Procedures
0238 = Level I Repair and Plastic Eye Procedures
0239 = Level II Repair and Plastic Eye Procedures
0240 = Level III Repair and Plastic Eye Procedures
0241 = Level IV Repair and Plastic Eye Procedures
0242 = Level V Repair and Plastic Eye Procedures
0243 = Strabismus/Muscle Procedures
0244 = Corneal Transplant
0245 = Cataract Procedures without IOL Insert
0246 = Cataract Procedures with IOL Insert
0247 = Laser Eye Procedures Except Retinal
0248 = Laser Retinal Procedures
0250 = Nasal Cauterization/Packing
0251 = Level I ENT Procedures
0252 = Level II ENT Procedures
0253 = Level III ENT Procedures
0254 = Level IV ENT Procedures
0256 = Level V ENT Procedures
0257 = Implantation of Cochlear Device (obsolete 1/01)
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
0345 = Transfusion Laboratory Procedures Level I (eff. 1/01)
0346 = Transfusion Laboratory Procedures Level II (eff. 1/01)
0347 = Transfusion Laboratory Procedures Level III (eff. 1/01)
0348 = Fertility Laboratory Procedures (eff. 1/01)
0349 = Miscellaneous Laboratory Procedures (eff. 1/01)
0354 = Administration of Influenza Vaccine (Not subject to national coinsurance)
0355 = Level I Immunizations
0356 = Level II Immunizations
0357 = Level III Immunizations (obsolete 1/01)
0358 = Level IV Immunizations (obsolete 1/01)
0359 = Injections
0360 = Level I Alimentary Tests
0361 = Level II Alimentary Tests
0362 = Fitting of Vision Aids
0363 = Otorhinolaryngologic Function Tests
0364 = Level I Audiometry
0365 = Level II Audiometry

0366 = Electrocardiogram (ECG) (obsolete 1/01)
0367 = Level I Pulmonary Test
0368 = Level II Pulmonary Test
0369 = Level III Pulmonary Test
0370 = Allergy Tests
0371 = Allergy Injections
0372 = Therapeutic Phlebotomy
0373 = Neuropsychological Testing
0374 = Monitoring Psychiatric Drugs
0600 = Low Level Clinic Visits
0601 = Mid Level Clinic Visits
0602 = High Level Clinic Visits
0603 = Interdisciplinary Team Conference (obsolete 1/01)
0610 = Low Level Emergency Visits
0611 = Mid Level Emergency Visits
0612 = High Level Emergency Visits
0620 = Critical Care
0701 = Strontium (eligible for pass-through payments) (obsolete 12/00); SR 89 chloride, per mCi (eff. 1/01)
0702 = Samariam (eligible for pass-through payments) (obsolete 12/00); SM 153 lexidronam, 50 mCi (eff. 1/01)
0704 = IN 111 Satumomab Pendetide (eligible for pass-through payments)
0705 = Tc99 Tetrofosmin (eligible for pass-through payments)
0725 = Leucovorin Calcium (eligible for pass-through payments)
0726 = Dexrazoxane Hydrochloride (eligible for pass-through payments)
0727 = Injection, Etidronate Disodium (eligible for pass-through payments)
0728 = Filgrastim (G-CSF) (eligible for pass-through payments)
0730 = Pamidronate Disodium (eligible for pass-through payments)
0731 = Sargramostim (GM-CSF) (eligible for pass-through payments)
0732 = Mesna (eligible for pass-through payments)
0733 = Non-ESRD Epoetin Alpha (eligible for pass-through payments)
0750 = Dolasetron Mesylate 10 mg (eligible for pass-through payments)
0754 = Metoclopramide HCL (eligible for pass-through payments)
0755 = Thiethylperazine Maleate (eligible for pass-through payments)
0761 = Oral Substitute for IV Antiemtic (eligible for pass-through payments)
0762 = Dronabinol (elibible for pass-through payments)
0763 = Dolasetron Mesylate 100 mg Oral (eligible for pass-through payments)
0764 = Granisetron HCL, 100 mcg (eligible for pass-

through payments)
0765 = Granisetron HCL, 1mg Oral (eligible for pass-through payments)
0768 = Ondansetron Hydrochloride per 1 mg Injection (eligible for pass-through payments)
0769 = Ondansetron Hydrochloride 8 mg oral (eligible for pass-through payments)
0800 = Leuprolide Acetate per 3.75 mg (eligible for pass-through payments)
0801 = Cyclophosphamide (eligible for pass-through payments)
0802 = Etoposide (eligible for pass-through payments)
0803 = Melphalan (eligible for pass-through payments)
0807 = Aldesleukin single use vial (eligible for pass-through payments)
0809 = BCG (Intravesical) one vial (eligible for pass-through payments)
0810 = Goserelin Acetate Implant, per 3.6 mg (eligible for pass-through payments)
0811 = Carboplatin 50 mg (eligible for pass-through payments)
0812 = Carmustine 100 mg (eligible for pass-through payments)
0813 = Cisplatin 10 mg (eligible for pass-through payments)
0814 = Asparaginase, 10,000 units (eligible for pass-through payments)
0815 = Cyclophosphamide 100 mg (eligible for pass-through payments)
0816 = Cyclophosphamide, Lyophilized 100 mg (eligible for pass-through payments)
0817 = Cytrabine 100 mg (eligible for pass-through payments)
0818 = Dactinomycin 0.5 mg (eligible for pass-through payments)
0819 = Dacarbazine 100 mg (eligible for pass-through payments)
0820 = Daunorubicin HCI 10 mg (eligible for pass-through payments)
0821 = Daunorubicin Citrate, Liposomal Formulation, 10 mg (eligible for pass-through payments)
0822 = Diethylstibestrol Diphosphate 250 mg (eligible for pass-through payments)
0823 = Docetaxel 20 mg (eligible for pass-through payments)
0824 = Etoposide 10 mg (eligible for pass-through payments)
0826 = Methotrexate Oral 2.5 mg (eligible for pass-through payments)
0827 = Floxuridine injection 500mg
0828 = Gemcitabine HCL 200 mg (eligibile for pass-through payments)
0830 = Irinotecan 20 mg (eligible for pass-through payments)

0831 = Ifosfamide injection 1 gm (eligible for pass-through payments)
0832 = Idarubicin HCL injection 5 mg (eligible for pass-through payments)
0833 = Interferon Alfacon-1, 1 mcg (eligible for pass-through payments)
0834 = Interferon, Alfa-2A, Recombinant 3 million units (eligible for pass-through payments)
0836 = Interferon, Alfa-2B, Recombinant, 1 million units (eligible for pass-through payments)
0838 = Interferon, Gamma 1-B injection, 3 million units (eligible for pass-through payments)
0839 = Mechlorethamine HCL injection 10 mg (eligible for pass-through payments)
0840 = Melphalan HCL 50 mg (eligible for pass-through payments)
0841 = Methotrexate sodium injection 5 mg (eligible for pass-through payments)
0842 = Fludarabine Phosphate injection 50 mg (eligible for pass-through payments)
0843 = Pegaspargase, single dose vial (eligible for pass-through payments)
0844 = Pentostatin injection, 10 mg (eligible for pass-through payments)
0847 = Doxorubicin HCL 10 mg (eligible for pass-through payments)
0849 = Rituximab, 100 mg (eligible for pass-through payments)
0850 = Streptozocin injection, 1 gm (eligible for pass-through payments)
0851 = Thiotepa injection, 15 mg (eligible for pass-through payments)
0852 = Topotecan 4 mg (eligible for pass-through payments)
0853 = Vinblastine Sulfate injection, 1 mg (eligible for pass-through payments)
0854 = Vincristine Sulfate 1 mg (eligible for pass-through payments)
0855 = Vinorelbine Tartrate per 10 mg (eligible for pass-through payments)
0856 = Porfimer Sodium 75 mg (eligible for pass-through payments)
0857 = Bleomycin Sulfate injection 15 units (eligible for pass-through payments)
0858 = Cladribine, 1mg (eligible for pass-through payments)
0859 = Fluorouracil injection 500 mg
0860 = Plicamycin (mithramycin) injection, 2.5 mg
0861 = Leuprolide Acetate 1 mg (eligible for pass-through payments)
0862 = Mitomycin, 5mg (eligible for pass-through payments)
0863 = Paclitaxel, 30mg (eligible for pass-through payments)
0864 = Mitoxantrone HCl, per 5mg (eligible for pass-through payments)
0865 = Interferon alfa-N3, 250,000 IU (eligible for pass-through payments)

0884 = Rho (D) Immune Globulin, Human one dose pack
(eligible for pass-through payments)
0886 = Azathioprine, 50 mg oral
(Not subject to national coinsurance)
0887 = Azathioprine, Parenteral 100 mg, 20 ml each injection
(Not subject to national coinsurance)
0888 = Cyclosporine, Oral 100 mg
(Not subject to national coinsurance)
0889 = Cyclosporine, Parenteral
(Not subject to national coinsurance)
0890 = Lymphocyte Immune Globulin 250 mg
(Not subject to national coinsurance)
0891 = Tacrolimus per 1 mg oral
(Not subject to national coinsurance)
0892 = Daclizumab, Parenteral, 25 mg (obsolete 1/01)
(eligible for pass-through payments)
0900 = Injection, Alglucerase per 10 units
(eligible for pass-through payments)
0901 = Alpha I, Proteinase Inhibitor, Human per 10mg
(eligible for pass-through payments)
0902 = Botulinum Toxin, Type A per unit
(eligible for pass-through payments)
0903 = CMV Immune Globulin (obsolete 12/00);
Cytomegalovirus imm IV, vial
(eligible for pass-through payments) (eff. 1/01)
0905 = Immune Globulin per 500 mg
(eligible for pass-through payments)
0906 = RSV-ivig 50 mg
(eligible for pass-through payments)
0907 = Ganciclovir Sodium 500 mg injection
(Not subject to national coinsurance)
0908 = Tetanus Immune Globulin, injection up to 250 units
(Not subject to national coinsurance)
0909 = Interferon Beta - 1a   33 mcg (eligible for pass-
through payments)
0910 = Interferon Beta - 1b   0.25 mg (eligible for pass-
through payments)
0911 = Streptokinase per 250,000 iu
(Not subject to national coinsurance)
0913 = Ganciclovir long act implant 4.5 mg (eligible for
pass-through payments)
0914 = Reteplase, 37.6 mg
(Not subject to national coinsurance)
0915 = Alteplase injection,recombinant, 10mg
(Not subject to national coinsurance)
0916 = Imiglucerase per unit (eligible for pass-through
payments)
0917 = Dipyridamole, 10mg / Adenosine 6MG
(Not subject to national coinsurance) (obsolete 1/01)
Pharmalogic stresses (eff. 1/01)
0918 = Brachytherapy Seeds, Any type, Each (eligible
for pass-through payments) (obsolete 4/01)
0925 = Factor VIII (Antihemophilic Factor, Human) per iu
(eligible for pass-through payments)

0926 = Factor VIII (Antihemophilic Factor, Porcine) per iu (eligible for pass-through payments)
0927 = Factor VIII (Antihemophilic Factor, Recombinant) per iu (eligible for pass-through payments)
0928 = Factor IX, Complex (eligible for pass-through payments)
0929 = Other Hemophilia Clotting Factors per iu (eligible for pass-through payments) (obsolete 1/01)
Anti-inhibitor per iu (eff. 1/01)
0930 = Antithrombin III (Human) per iu (eligible for pass-through payments)
0931 = Factor IX (Antihemophilic Factor, Purified, Non-Recombinant) (eligible for pass-through payments)
0932 = Factor IX (Antihemophilic Factor, Recombinant) (eligible for pass-through payments)
0949 = Plasma, Pooled Multiple Donor, Solvent/Detergent Treated, Frozen (not subject to national coinsurance)
0950 = Blood (Whole) For Transfusion (not subject to national coinsurance)
0952 = Cryoprecipitate (not subject to national coinsurance)
0953 = Fibrinogen Unit (not subject to national coinsurance)
0954 = Leukocyte Poor Blood (not subject to national coinsurance)
0955 = Plasma, Fresh Frozen (not subject to national coinsurance)
0956 = Plasma Protein Fraction (not subject to national coinsurance)
0957 = Platelet Concentrate (not subject to national coinsurance)
0958 = Platelet Rich Plasma (not subject to national coinsurance)
0959 = Red Blood Cells (not subject to national coinsurance)
0960 = Washed Red Blood Cells (not subject to national coinsurance)
0961 = Infusion, Albumin (Human) 5%, 500 ml (not subject to national coinsurance)
0962 = Infusion, Albumin (Human) 25%, 50 ml (not subject to national coinsurance)
0970 = New Technology - Level I ($0 - $50) (not subject to national coinsurance)
0971 = New Technology - Level II ($50 - $100) (not subject to national coinsurance)
0972 = New Technology - Level III ($100 - $200) (not subject to national coinsurance)
0973 = New Technology - Level IV ($200 - $300) (not subject to national coinsurance)
0974 = New Technology - Level V ($300 - $500) (not subject to national coinsurance)
0975 = New Technology - Level VI ($500 - $750) (not subject to national coinsurance)
0976 = New Technology - Level VII ($750 - $1000) (not subject to national coinsurance)
0977 = New Technology - Level VIII ($1000 - $1250) (not subject to national coinsurance)

0978 = New Technology - Level IX ($1250 - $1500)
(not subject to national coinsurance)
0979 = New Technology - Level X ($1500 - $1750)
(not subject to national coinsurance)
0980 = New Technology - Level XI ($1750 - $2000)
(not subject to national coinsurance)
0981 = New Technology - Level XII ($2000 - $2500)
(not subject to national coinsurance)
0982 = New Technology - Level XIII ($2500 - $3500)
(not subject to national coinsurance)
0983 = New Technology - Level XIV ($3500 - $5000)
(not subject to national coinsurance)
0984 = New Technology - Level XV ($5000 - $6000)
(not subject to national coinsurance)
0987 = New Device Technology - Level I ($0 - $250)
(eff. 1/01)
0988 = New Device Technology - Level II ($250 - $500)
(eff. 1/01)
0989 = New Device Technology - Level III ($500 - $750)
(eff. 1/01)
0990 = New Device Technology - Level IV ($750 - $1000)
(eff. 1/01)
0991 = New Device Technology - Level V ($1000 - $1500)
(eff. 1/01)
0992 = New Device Technology - Level VI ($1500 - $2000)
(eff. 1/01)
0993 = New Device Technology - Level VII ($2000 - $3000)
(eff. 1/01)
0994 = New Device Technology - Level VIII ($3000 - $4000)
(eff. 1/01)
0995 = New Device Technology - Level IX ($4000 - $5000)
(eff. 1/01)
0996 = New Device Technology - Level X ($5000 - $7000)
(eff. 1/01)
0997 = New Device Technology - Level XI ($7000 - $9000)
(eff. 1/01)
1000 = Perclose Closer Prostar Arterial Vascular
Closure (eff. 1/01)
1001 = AcuNav-diagnostic ultrasound ca (eff. 1/01)
1002 = Cochlear Implant System (eff. 1/01)
1003 = Cath, ablation, livewire TC (eff. 1/01)
1004 = Fast-Cath, Swartz, SAFL, CSTA (eff. 1/01)
1006 = ARRAY post chamb IOL (eff. 1/01)
1007 = Ams 700 penile prosthesis (eff. 1/01)
1008 = Urolume-implant urethral stent (eff. 1/01)
1009 = Plasma, cryoprecipitate-reduced, unit
(eff. 1/01)
1010 = Blood, L/R CMV-neg (eff. 1/01)
1011 = Platelets, L/R, CMV-neg (eff. 1/01)
1012 = Platelet concentrate, L/R, irradiated, unit
(eff. 1/01)
1013 = Platelet concentrate, L/R, unit (eff. 1/01)
1014 = Platelets, aph/pher, L/R, unit (eff. 1/01)
1016 = Blood, L/R, froz/deglycerol/washed (eff. 1/01)

1017 = Platelets, aph/pher, L/R CMV-neg, unit
(eff. 1/01)
1018 = Blood, L/R, irradiated (eff. 1/01)
1019 = Platelets, aph/pher, L/R, irradiated, unit
(eff. 1/01)
1024 = Quinupristin 150 mg/dalfopriston 350 mg
(eff. 1/01)
1025 = Marinr CS catheter (eff. 1/01)
1026 = RF Perfrmr cath 5F RF Marinr (eff. 1/01)
1027 = Magic x/short, radius 14m (eff. 1/01)
1028 = Prcis Twst trnsvg anch sys (eff. 1/01)
1029 = CRE guided balloon dil cath (eff. 1/01)
1030 = Cthtr:Mrshal, Blu Max Utr Dmnd (eff. 1/01)
1033 = Sonicath mdl 37-410 (eff. 1/01)
1034 = SURPASS, Long30 SURPASS-cath (eff. 1/01)
1035 = Cath, Ultra ICE (eff. 1/01)
1036 = R port/reservior impl dev (eff. 1/01)
1037 = Vaxcelchronic dialysis cath (eff. 1/01)
1038 = UltraCross Imaging Cath (eff. 1/01)
1039 = Wallstent/RP:Trach (eff. 1/01)
1040 = Wallstent/RP TIPS -- 20/40/60 (eff. 1/01)
1042 = Wallstent, UltraFlex: Bil (eff. 1/01)
1045 = I-131 MIBG (ioben-sulfate) 0.5mCi
(eff. 1/01)
1047 = Navi-Star, Noga-Star cath (eff. 1/01)
1048 = NeuroCyberneticPros: gen (eff. 1/01)
1051 = Oasis Thrombectomy Cath (eff. 1/01)
1053 = EnSite 3000 catheter (eff. 1/01)
1054 = Hydrolyser Thromb Cath 6/7F (eff. 1/01)
1055 = Transesoph 210, 210-S Cath (eff. 1/01)
1056 = Thermachoice II Cath (eff. 1/01)
1057 = Micromark Tissue Marker (eff. 1/01)
1059 = Carticel, auto cult-chndr cyte (eff. 1/01)
1060 = ACS multi-link tristor stent (eff. 1/01)
1061 = ACS Viking Guiding cath (eff. 1/01)
1063 = EndoTak Endurance EZ,RX leads (eff. 1/01)
1067 = Megalink biliary stent (eff. 1/01)
1068 = Pulsar DDD pmkr (eff. 1/01)
1069 = Discovery DR, pmaker
1071 = Pulsar Max, Pulsar SR pmkr (eff. 1/01)
1072 = Guidant: blln dil cath (eff. 1/01)
1073 = Gynecare Morcellator (eff. 1/01)
1074 = RX/OTW Viatrac-peri dil cath (eff. 1/01)
1075 = Guidant: lead (eff. 1/01)
1076 = Ventak minisc defib (eff. 1/01)
1077 = Ventak VR Prizm VR, sc defib (eff. 1/01)
1078 = Ventak: Prizm, AVIIIDR defib
1079 = CO 57/58 0.5 mCi (eff. 1/01)
1084 = Denileukin diftitox, 300 mcg (eff. 1/01)
1086 = Temozolomide, 5 mg (eff. 1/01)
1087 = I-123 per uCi capsule (eff. 1/01)
1089 = CO 57, 0.5 mCi (eff. 1/01)
1090 = IN 111 Chloride, per mCi (eff. 1/01)
1091 = IN 111 Oxyquinoline, per 5 mCi (eff. 1/01)

1092 = IN 111 Pentetate, per 1.5 mCi (eff. 1/01)
1094 = TC 99M Albumin aggr, per vial
1095 = TC 99M Depreotide, per vial (eff. 1/01)
1096 = TC 99M Exametazime, per dose (eff. 1/01)
1097 = TC 99M Mebrofenin, per vial (eff. 1/01)
1098 = TC 99M Pentetate, per vial (eff. 1/01)
1099 = TC 99M Pyrophosphate, per vial (eff. 1/01)
1100 = Medtronic AVE GT1 guidewire (eff. 1/01)
1101 = Medtronic AVE, AVE Z2 cath (eff. 1/01)
1102 = Synergy Neurostim Genrtr (eff. 1/01)
1103 = Micro Jewell Defibrillator (eff. 1/01)
1104 = RF ConductorAblative Cath (eff. 1/01)
1105 = Sigman 300VDD pacmkr (eff. 1/01)
1106 = SynergyEZ Pt Progmr (eff. 1/01)
1107 = Torqr, Solist cath (eff. 1/01)
1108 = Reveal Cardiac Recorder (eff. 1/01)
1109 = Implantable anchor: Ethicon (eff. 1/01)
1110 = Stable Mapper, cath electrd (eff. 1/01)
1111 = AneuRxAort-Uni-llicstnt & cath (eff. 1/01)
1112 = AneuRx Stent graft/del cath (eff. 1/01)
1113 = Tlnt Endo Sprng Stnt Grft Sys (eff. 1/01)
1114 = TalntSprgStnt + Graf endo pros (eff. 1/01)
1115 = 5038S, 5038, 5038L pace lead (eff. 1/01)
1116 = CapSureSP pacing lead (eff. 1/01)
1117 = Ancure Endograft Del Sys (eff. 1/01)
1118 = Sigma300DR LegIIDR, pacemkr (eff. 1/01)
1119 = Sprint6932, 6943 defib lead (eff. 1/01)
1120 = Sprint6942, 6945 defi lead (eff. 1/01)
1121 = Gem defibrillator (eff. 1/01)
1122 = TC 99M arcitumomab per dose (eff. 1/01)
1123 = Gem II VR defibrillator (eff. 1/01)
1124 = InterStim Test Stim Kit (eff. 1/01)
1125 = Kappa 400SR, Ttopaz II SR pmkr (eff. 1/01)
1126 = Kappa 700 DR pacemkr (eff. 1/01)
1127 = Kappa 700SR, pmkr sgl chamber (eff. 1/01)
1128 = Kappa 700D, Ruby IID pmkr (eff. 1/01)
1129 = Kappa 700VDD, pacmkr (eff. 1/01)
1130 = Sigma 200D, LGCY IID sc pmkr (eff. 1/01)
1131 = Sigma 200DR pmker (eff. 1/01)
1132 = Sigma 200SR Leg II:sc pac (eff. 1/01)
1133 = Sigma SR, Vita SR, pmaker (eff. 1/01)
1134 = Sigma 300D pmker (eff. 1/01)
1135 = Entity DR 5326L/R, DC, pmkr (eff. 1/01)
1136 = Affinity DR 5330L/R, DC, pmkr (eff. 1/01)
1137 = CardioSEAL implant syst (eff. 1/01)
1143 = AddVent mod 2060BL, VDD (eff. 1/01)
1144 = Afnty SP 5130, Integrity SR, pmkr (eff. 1/01)
1145 = Angio-Seal 6fr, 8fr (eff. 1/01)
1147 = AV Plus DX 1368: lead (eff. 1/01)
1148 = Contour MD sc defib (eff. 1/01)
1149 = Entity DC 5226R-pmker (eff. 1/01)
1151 = Passiveplus DXlead, 10mdls (eff. 1/01)
1152 = LifeSite Access System (eff. 1/01)
1153 = Regency SC+ 2402L pmkr (eff. 1/01)

1154 = SPL:SPOI, 0204- defib lead (eff. 1/01)
1155 = Repliform 8 sq cm (eff. 1/01)
1156 = Tr 1102TrSR+ 2260L, 2264L, 5131 (eff. 1/01)
1157 = Trilogy DCT 23/8L pmkr (eff. 1/01)
1158 = TVL lead SV01, SV02, SV04 (eff. 1/01)
1159 = TVL RV02, RV06, RV07: lead (eff. 1/01)
1160 = TVL-ADX 1559: lead (eff. 1/01)
1161 = Tendril DX, 1338 pacing lead (eff. 1/01)
1162 = TempoDr, TrilogyDR+ DC pmkr (eff. 1/01)
1163 = Tendril SDX, 1488T pacing lead (eff. 1/01)
1164 = Iodine-125 brachytx seed (eff. 1/01)
1166 = Cytarabine liposomal, 10 mg (eff. 1/01)
1167 = Epirubicin hcl, 2 mg (eff. 1/01)
1171 = Autosuture site marker stple (eff. 1/01)
1172 = Spacemaker dissect ballon (eff. 1/01)
1173 = Cor stntS540, S670, o-wire stn (eff. 1/01)
1174 = Bard brachytx needle (eff. 1/01)
1178 = Busulfan IV, 6 mg (eff. 1/01)
1180 = Vigor SR, SC, pmkr (eff. 1/01)
1181 = Meridian SSI, SC pmkr (eff. 1/01)
1182 = Pulsar SSI, SC, pmkr (eff. 1/01)
1183 = Jade IIS, Sigma 300S, SC, pmkr (eff. 1/01)
1184 = Sigma 200S, SC, pmkr (eff. 1/01)
1188 = I 131, per mCi (eff. 1/01)
1200 = TC 99M Sodium Clucoheptonate, per vial (eff. 1/01)
1201 = TC 99M succimer, per vial (eff. 1/01)
1202 = TC 99M Sulfur Colloid, per dose (eff. 1/01)
1203 = Verteporfin for Injection (eff. 1/01)
1205 = TC 99M Disofenin, per vial (eff. 1/01)
1207 = Octreotide acetate depot 1 mg (eff. 1/01)
1302 = SQ01:lead (eff. 1/01)
1303 = CapSure Fix 6940/4068-110, lead (eff. 1/01)
1304 = Sonicath mdl 37-416,-418 (eff. 1/01)
1305 = Apligraf (eff. 1/01)
1306 = NeuroCyberneticsPros: lead (eff. 1/01)
1311 = Trilogy DR + DAO pmkr (eff. 1/01)
1312 = Magic WALLSTENT stent-mini (eff. 1/01)
1313 = Magic medium, radius 31mm (eff. 1/01)
1314 = Magic WALLSTENT stent-Long (eff. 1/01)
1315 = Vigor DR, Meridian DR pmkr (eff. 1/01)
1316 = Meridian DDD pmkr (eff. 1/01)
1317 = Discovery SR, pmkr (eff. 1/01)
1318 = Meridian SR pmkr (eff. 1/01)
1319 = Wallstent/RP Enteral--60mm (eff. 1/01)
1320 = Wallstent/RP lliac Del Sys (eff. 1/01)
1325 = Pallidium - 103 seed (eff. 1/01)
1326 = Angio-jet rheolytic thromb cath (eff. 1/01)
1328 = ANS Renew NS trnsmtr (eff. 1/01)
1333 = PALMZA Corinthian bill stent (eff. 1/01)
1334 = Crown, Mini-crown,CrossLC (eff. 1/01)
1335 = Mesh, Prolene (eff. 1/01)
1336 = Constant Flow Imp Pump (eff. 1/01)
1337 = IsoMed 8472-20/35/60 (eff. 1/01)

1348 = I 131 per mCi solution (eff. 1/01)
1350 = Prosta/OncoSeed, RAPID strand, I-125 (eff. 1/01)
1351 = CapSure (Fix) pacing lead (eff. 1/01)
1352 = Gem II defib (eff. 1/01)
1353 = Itrel Interstm neurostim + ext (eff. 1/01)
1354 = Kappa 400DR, Diamond II 820 DR (eff. 1/01)
1355 = Kappa 600 DR, Vita DR (eff. 1/01)
1356 = Profile MD V-186HV3 sc defib (eff. 1/01)
1357 = Angstrom MD V-190HV3 sc defib (eff. 1/01)
1358 = Affinity DC 5230R-Pacemaker (eff. 1/01)
1359 = Pulsar, Pulsar Max DR, pmkr (eff. 1/01)
1363 = Gem DR, DC, defib (eff. 1/01)
1364 = Photon DR V-230HV3 DC defib (eff. 1/01)
1365 = Guidewire, Hi-Torque 14/18/35 (eff. 1/01)
1366 = Guidewire, PTCA, Hi-Torque (eff. 1/01)
1367 = Guidewire, Hi-Torque Crosslt (eff. 1/01)
1369 = ANS Renew Stim Sys recvr (eff. 1/01)
1370 = Tension-Free Vaginal Tape (eff. 1/01)
1371 = Symp Nitinol Transhep Bil Sys (eff. 1/01)
1372 = Cordis Nitinol bil Stent (eff. 1/01)
1375 = Stent, corornary, NIR (eff. 1/01)
1376 = ANS Renew Stim Sys lead (eff. 1/01)
1377 = Specify 3988 neuro lead (eff. 1/01)
1378 = InterStim Tx 3080/3886 lead (eff. 1/01)
1379 = Pisces-Quad 3887 lead (eff. 1/01)
1400 = Diphenhydramine hcl 50 mg (eff. 1/01)
1401 = Prochlorperazine maleate 5 mg (eff. 1/01)
1402 = Promethazine hcl 12.5 mg oral (eff. 1/01)
1403 = Chlorpromazine hcl 10mg oral (eff. 1/01)
1404 = Trimethobenzamide hcl 250mg (eff. 1/01)
1405 = Thiethylperazine maleate 10 mg (eff. 1/01)
1406 = Perphenazine 4 mg oral (eff. 1/01)
1407 = Hydroxyzine pamoate 25 mg (eff. 1/01)
1409 = Factor via recombinant, per 1.2 mg (eff. 1/01)
1410 = Prosorba column (eff. 1/01)
1411 = Herculink, OTW SDS bil stent (eff. 1/01)
1420 = StapleTac2 Bone w/Dermis (eff. 1/01)
1421 = StapleTac2 Bone w/o Dermis (eff. 1/01)
1450 = Orthosphere Arthroplasty (eff. 1/01)
1451 = Orthosphere Arthroplasty Kity (eff. 1/01)
1500 = Atherectomy sys, peripheral (eff. 1/01)
1600 = TC 99M sestamibi, per syringe (eff. 1/01)
1601 = TC 99M medronate, per dose (eff. 1/01)
1602 = TC 99M apcitide, per vial (eff. 1/01)
1603 = TL 201, mCi (eff. 1/01)
1604 = IN 111 capromab pendetide, per dose (eff. 1/01)
1605 = Abciximab injection, 10 mg (eff. 1/01)
1606 = Anistreplase, 30 u (eff. 1/01)
1607 = Eptifibatide injection, 5 mg (eff. 1/01)
1608 = Etanercept injection, 25 mg (eff. 1/01)
1609 = Rho(D) Immune globulin h, sd 100 iu (eff. 1/01)
1611 = Hylan G-F 20 injection, 16 mg (eff. 1/01)
1612 = Daclizumab, parenteral, 25 mg (eff. 1/01)
1613 = Trastuzumab, 10 mg (eff. 1/01)

1614 = Valrubicin, 200 mg (eff. 1/01)
1615 = Basiliximab, 20 mg (eff. 1/01)
1616 = Histrelin Acetate, 0.5 mg (eff. 1/01)
1617 = Lepirdin, 50 mg (eff. 1/01)
1618 = Von Willebrand factor, per iu (eff. 1/01)
1619 = Ga 67, per mCi (eff. 1/01)
1620 = TC 99M Bicisate, per vial (eff. 1/01)
1621 = Xe 133, per mCi (eff. 1/01)
1622 = TC 99M Mertiatide, per vial (eff. 1/01)
1623 = TC 99M Gluceptate (eff. 1/01)
1624 = P32 sodium, per mCi (eff. 1/01)
1625 = IN 111 Pentetreotide, per mCi (eff. 1/01)
1626 = TC 99M Oxidronate, per vial (eff. 1/01)
1627 = TC-99 labeled red blood cell, per test (eff. 1/01)
1628 = P32 phosphate chromic,per mCi (eff. 1/01)
1700 = Authen Mick TP brachy needle (eff. 1/01)
(obsolete 4/01)
1701 = Medtec MT-BT-5201-25 ndl (eff. 1/01)
(obsolete 4/01)
1702 = WWMT brachytx needle (eff. 1/01)
(obsolete 4/01)
1703 = Mentor Prostate Brachy (eff. 1/01)
(obsolete 4/01)
1704 = MT-BT-5001-25/5051-25 (eff. 1/01)
(obsolete 4/01)
1705 = Best Flexi Brachy Needle (eff. 1/01)
(obsolete 4/01)
1706 = Indigo Prostate Seeding Ndl (eff. 1/01)
(obsolete 4/01)
1707 = Varisource Implt Ndl (eff. 1/01)
(obsolete 4/01)
1708 = UroMed Prostate Seed Ndl (eff. 1/01)
(obsolete 4/01)
1709 = Remington Brachytx Needle (eff. 1/01)
(obsolete 4/01)
1710 = US Biopsy Prostate Needle (eff. 1/01)
(obsolete 4/01)
1711 = MD Tech brachytx needle (eff. 1/01)
(obsolete 4/01)
1712 = Imagyn brachytx needle (eff. 1/01)
(obsolete 4/01)
1713 = Anchor/screw bn/bn,tis/bn (eff. 4/01)
1714 = Cath, trans atherectomy, dir (eff. 4/01)
1715 = Brachytherapy needle (eff. 4/01)
1716 = Brachytx seed, Gold 198 (eff. 4/01)
1717 = Brachytx seed, HDR Ir-192 (eff. 4/01)
1718 = Brachytx seed, Iodine 125 (eff. 4/01)
1719 = Brachytx seed, Non-HDR Ir-192 (eff. 4/01)
1720 = Brachytx, Palladium 103 (eff. 4/01)
1721 = AICD, dual chamber (eff. 4/01)
1722 = AICD, single chamber (eff. 4/01)
1723 = Cath, ablation, non-cardiac (eff. 4/01)
1724 = Cath, trans atherec, rotation (eff. 4/01)
1725 = Cath, translumin non-laser (eff. 4/01)

1726 = Cath, bal dil, non-vascular (eff. 4/01)
1727 = Cath, bal tis, dis, nonvas (eff. 4/01)
1728 = Cath, brachytx seed adm (eff. 4/01)
1729 = Cath, drainage, biliary (eff. 4/01)
1730 = Cath, EP, 19 or fewer elect (eff. 4/01)
1731 = Cath, EP, 20 or more elect (eff. 4/01)
1732 = Cath, EP, diag/abl, 3D/vect (eff. 4/01)
1733 = Cath, EP, other than temp (eff. 4/01)
1750 = Cath, hemodialysis, long-term (eff. 4/01)
1751 = Cath, inf pr/cent/midline (eff. 4/01)
1752 = Cath, hemodialysis, short-term (eff. 4/01)
1753 = Cath, intravas ultrasound (eff. 4/01)
1754 = Catheter, intradiscal (eff. 4/01)
1755 = Catheter, intraspinal (eff. 4/01)
1756 = Cath, pacing, transesoph (eff. 4/01)
1757 = Cath, thrombectomy/embolect (eff. 4/01)
1758 = Cath, ureteral (eff. 4/01)
1759 = Cath, intra echocardiography (eff. 4/01)
1760 = Closure dev, vasc, imp/insert (eff. 4/01)
1762 = Conn tiss, human (inc fascia) (eff. 4/01)
1763 = Conn tiss, non-human (eff. 4/01)
1764 = Event recorder, cardiac (eff. 4/01)
1767 = Generator, neurostim, imp (eff. 4/01)
1768 = Graft, vascular (eff. 4/01)
1769 = Guide wire (eff. 4/01)
1770 = Imaging coil, MR insertable (eff. 4/01)
1771 = Rep dev, urinary , w/sling (eff. 4/01)
1772 = Infusion pump, programmable (eff. 4/01)
1773 = Retrieval dev, insert (eff. 4/01)
1776 = Joint device (implantable) (eff. 4/01)
1777 = Lead, AICD, endo single coil (eff. 4/01)
1778 = Lead, neurostimulator (eff. 4/01)
1779 = Lead, pmkr, transvenous VDD (eff. 4/01)
1780 = Lens, intraocular (eff. 4/01)
1781 = Mesh (implantable) (eff. 4/01)
1782 = Morcellator (eff. 4/01)
1784 = Ocular dev, intraop, det ret (eff. 4/01)
1785 = Pmkr, dual, rate-resp (eff. 4/01)
1786 = Pmkr, single, rate-resp (eff. 4/01)
1787 = Patient progr, neurostim (eff. 4/01)
1788 = Port, indwelling, imp (eff. 4/01)
1789 = Prosthesis, breast, imp. (eff. 4/01)
1790 = Iridium 192 HDR (eff. 1/01)
(obsolete 4/01)
1791 = OncoSeed, Rapid Strand I-125 (eff. 1/01)
(obsolete 4/01)
1792 = UroMed I-125 Brachy seed (eff. 1/01)
(obsolete 4/01)
1793 = Bard InterSource P-103 seed (eff. 1/01)
(obsolete 4/01)
1794 = Bard IsoSeed P-103 seed (eff. 1/01)
(obsolete 4/01)
1795 = Bard BrachySource I-125 (eff. 1/01)
(obsolete 4/01)

1796 = Source Tech Med I-125 (eff. 1/01)
(obsolete 4/01)
1797 = Draximage I-125 seed (eff. 1/01)
(obsolete 4/01)
1798 = Syncor I-125 PharmaSeed (eff. 1/01)
(obsolete 4/01)
1799 = I-Plant I-125 Brachytx seed (eff. 1/01)
(obsolete 4/01)
1800 = Pd-103 brachytx seed (eff. 1/01)
(obsolete 4/01)
1801 = IoGold I-125 brachytx seed (eff. 1/01)
(obsolete 4/01)
1802 = Iridium 192 brachytx seed (eff. 1/01)
(obsolete 4/01)
1803 = Best Iodine 125 brachytx seeds (eff. 1/01)
(obsolete 4/01)
1804 = Best Palladium 103 seeds (eff. 1/01)
(obsolete 4/01)
1805 = IsoStar Iodine-125 seeds (eff. 1/01)
(obsolete 4/01)
1806 = Gold 198 (eff. 1/01)
(obsolete 4/01)
1810 = D114S Dilatation Cath (eff. 1/01)
(obsolete 4/01)
1811 = Surgical Dynamics Anchors (eff. 1/01)
(obsolete 4/01)
1812 = OBL Anchors (eff. 1/01)
(obsolete 4/01)
1813 = Prosthesis, penile, inflatab (eff. 4/01)
1815 = Pros, urinary sph, imp (eff. 4/01)
1816 = Receiver/transmitter, neuro (eff. 4/01)
1817 = Septal defect imp sys (eff. 4/01)
1850 = Repliform 14/21 sq cm (eff. 1/01)
(obsolete 4/01)
1851 = Repliform 24/28 sq cm (eff. 1/01)
(obsolete 4/01)
1852 = TransCyte, per 247 sq cm (eff. 1/01)
(obsolete 4/01)
1853 = Suspend, per 8/14 sq cm (eff. 1/01)
(obsolete 4/01)
1854 = Suspend, per 24/28 sq cm (eff. 1/01)
(obsolete 4/01)
1855 = Suspend, per 36 sq cm (eff. 1/01)
(obsolete 4/01)
1856 = Suspend, per 48 sq cm (eff. 1/01)
(obsolete 4/01)
1857 = Suspend, per 84 sq cm (eff. 1/01)
(obsolete 4/01)
1858 = DuraDerm, per 8/14 sq cm (eff. 1/01)
(obsolete 4/01)
1859 = DuraDerm, per 21/24 sq cm (eff. 1/01)
(obsolete 4/01)
1860 = DuraDerm, per 48 sq cm (eff. 1/01)
(obsolete 4/01)

1861 = DuraDerm, per 36 sq cm (eff. 1/01)
(obsolete 4/01)
1862 = DuraDerm, per 72 sq cm (eff. 1/01)
(obsolete 4/01)
1863 = DuraDerm, per 84 sq cm (eff. 1/01)
(obsolete 4/01)
1864 = SpermaTex, per 13/44 sq cm (eff. 1/01)
(obsolete 4/01)
1865 = FasLata, per 8/14 sq cm (eff. 1/01)
(obsolete 4/01)
1866 = FasLata, per 24/28 sq cm (eff. 1/01)
(obsolete 4/01)
1867 = FasLata, per 36/48 sq cm (eff. 1/01)
(obsolete 4/01)
1868 = FasLata, per 96 sq cm (eff. 1/01)
(obsolete 4/01)
1869 = Gore Thyroplasty Dev (eff. 1/01)
(obsolete 4/01)
1870 = DermMatrix, per 16 sq cm (eff. 1/01)
(obsolete 4/01)
1871 = DermMatrix, 32 or 64 sq cm (eff. 1/01)
(obsolete 4/01)
1872 = Dermagraft, per 37.5 sq cm (eff. 1/01)
(obsolete 4/01)
1873 = Bard 3DMax Mesh (eff. 1/01)
(obsolete 4/01)
1874 = Stent, coated/cov w/del sys (eff. 4/01)
1875 = Stent, coated/cov w/o del sys (eff. 4/01)
1876 = Stent, non-coated/no-cov w/del (eff. 4/01)
1877 = Stent, non-coated/cov w/o del (eff. 4/01)
1878 = Martl for vocal cord (eff. 4/01)
1879 = Tissue marker, imp (eff. 4/01)
1880 = Vena cava filter (eff. 4/01)
1881 = Dialysis access system (eff. 4/01)
1882 = AICD, other than sing/dual (eff. 4/01)
1883 = Adapt/ext, pacing/neuro lead (eff. 4/01)
1885 = Cath, translumin angio laser (eff. 4/01)
1887 = Catheter, guiding (eff. 4/01)
1891 = Infusion pump, non-prog, perm (eff. 4/01)
1892 = Intro/sheath , fixed, peel-away (eff. 4/01)
1893 = Intro/sheath, fixed, non-peel (eff. 4/01)
1894 = Intro/sheath, non-laser (eff. 4/01)
1895 = Lead, AICD, endo dual coil (eff. 4/01)
1896 = Lead, AICD, non sing/dual (eff. 4/01)
1897 = Lead, neurostim test kit (eff. 4/01)
1898 = Lead, pmkr, other than trans (eff. 4/01)
1899 = Lead, pmkr/AICD combination (eff. 4/01)
1929 = Maverick PTCA Cath (eff. 1/01) (obsolete 4/01)
1930 = Coyote Dil Cath, 20/30/40mm (eff. 1/01)
(obsolete 4/01)
1931 = Talon Dil Cath (eff. 1/01) (obsolete 4/01)
1932 = Scimed remedy Dil Cath (eff. 1/01)
(obsolete 4/01)
1933 = Opti-Plast XL/Centurion Cath (eff. 1/01)

(obsolete 4/01)
1934 = Ultraverse 3.5F Bal Dil Cath (eff. 1/01)
(obsolete 4/01)
1935 = Workhorse PTA Bal Cath (eff. 1/01)
(obsolete 4/01)
1936 = Uromax Ultra Bal Dil Cath (eff. 1/01)
(obsolete 4/01)
1937 = Synergy Balloon Dil Cath (eff. 1/01)
(obsolete 4/01)
1938 = Uroforce Bal Dil Cath (eff. 1/01) (obsolete 4/01)
1939 = Raptur, Ninja PTCA Dil Cath (eff. 1/01)
(obsolete 4/01)
1940 = PowerFlex, OPTA 5/LP Bal Cath (eff. 1/01)
(obsolete 4/01)
1941 = Jupiter PTA Dil Cath (eff. 1/01)
(obsolete 4/01)
1942 = Cordis Maxi LD PTA Bal Cath (eff. 1/01)
(obsolete 4/01)
1943 = RXCrossSail OTW OpenSail (eff. 1/01)
(obsolete 4/01)
1944 = Rapid Exchange Bil Dil Cath (eff. 1/01)
(obsolete 4/01)
1945 = Savvy PTA Dil Cath (eff. 1/01)
(obsolete 4/01)
1946 = R1s Rapid Dil Cath (eff. 1/01)
(obsolete 4/01)
1947 = Gazelle Bal Dil Cath (eff. 1/01)
(obsolete 4/01)
1948 = Pursuit Balloon Cath (eff. 1/01)
(obsolete 4/01)
1949 = Oracle Megasonics Cath (eff. 1/01)
(obsolete 4/01)
1979 = Visions PV/Avanar US Cath (eff. 1/01)
(obsolete 4/01)
1980 = Atlantis SR Coronary Cath (eff. 1/01)
(obsolete 4/01)
1981 = PTCA Catheters (eff. 1/01)
(obsolete 4/01)
2000 = Orbiter ST Steerable Cath (eff. 1/01)
(obsolete 4/01)
2001 = Constellation Diag Cath (eff. 1/01)
(obsolete 4/01)
2002 = Irvine 5F Inquiry Diag EP Cath (eff. 1/01)
(obsolete 4/01)
2003 = Irvine 6F Inquiry Diag EP Cath (eff. 1/01)
(obsolete 4/01)
2004 = Biosense EP Cath -- Octapolar (eff. 1/01)
(obsolete 4/01)
2005 = Biosense EP Cath -- Hexapolar (eff. 1/01)
(obsolete 4/01)
2006 = Biosense EP Cath -- Decapolar (eff. 1/01)
(obsolete 4/01)
2007 = Irvine 6F Luma-Cath EP Cath (eff. 1/01)
(obsolete 4/01)

2008 = 7F Luma-Cath EP Cath 81910-15 (eff. 1/01)
(obsolete 4/01)
2009 = Irvine 7F Luma-Cath EP Cath (eff. 1/01)
(obsolete 4/01)
2010 = Fixed Curve EP Cath (eff. 1/01)
(obsolete 4/01)
2011 = Deflectable Tip Cath--Quad (eff. 1/01)
(obsolete 4/01)
2012 = Celsius Abln Cath (eff. 1/01)
(obsolete 4/01)
2013 = Celsius Large Abln Cath (eff. 1/01)
(obsolete 4/01)
2014 = Celsius II Asym Abln Cath (eff. 1/01)
(obsolete 4/01)
2015 = Celsius II Sym Abln Cath (eff. 1/01)
(obsolete 4/01)
2016 = Navi-Star DS, Navi-Star Ther (eff. 1/01)
(obsolete 4/01)
2017 = Navi-Star Abln Cath (eff. 1/01)
(obsolete 4/01)
2018 = Polaris T Ablation Cath (eff. 1/01)
(obsolete 4/01)
2019 = EP Deflectable Cath (eff. 1/01)
(obsolete 4/01)
2020 = Blazer II XP Abln Cath (eff. 1/01)
(obsolete 4/01)
2021 = SilverFlex EP Cath (eff. 1/01)
(obsolete 4/01)
2022 = CP Chilli Cooled Abln Cath (eff. 1/01)
(obsolete 4/01)
2023 = Chilli Cld AblnCath-std, lg (eff. 1/01)
(obsolete 4/01)
2100 = CP CS Reference Cath (eff. 1/01)
(obsolete 4/01)
2102 = CP Radii 7F EP Cath (eff. 1/01)
(obsolete 4/01)
2103 = CP Radii 7F EP Cath w/Track (eff. 1/01)
(obsolete 4/01)
2104 = Lasso Deflectable Cath (eff. 1/01)
(obsolete 4/01)
2151 = Veripath Guiding Cath (eff. 1/01)
(obsolete 4/01)
2152 = Cordis Vista Brite Tip Cath (eff. 1/01)
(obsolete 4/01)
2153 = Bard Viking Cath (eff. 1/01)
(obsolete 4/01)
2200 = Arrow-Trerotola PTD Cath (eff. 1/01)
(obsolete 4/01)
2300 = Varisource Stnd Catheters (eff. 1/01)
(obsolete 4/01)
2597 = Clinicath/kit 16/18 sgl/dbl (eff. 1/01)
(obsolete 4/01)
2598 = Clinicath 18/20/24-G single (eff. 1/01)
(obsolete 4/01)

2599 = Clinicath 16/18-G-double (eff. 1/01)
(obsolete 4/01)
2601 = Bard DL Ureteral Cath (eff. 1/01)
(obsolete 4/01)
2602 = Vitesse Laser Cath 1.4/1.7mm (eff. 1/01)
(obsolete 4/01)
2603 = Vitesse Laser Cath 2.0mm (eff. 1/01)
(obsolete 4/01)
2604 = Vitesse E Laser Cath 2.0mm (eff. 1/01)
(obsolete 4/01)
2605 = Extreme Laser Catheter (eff. 1/01)
(obsolete 4/01)
2606 = SpineCath XL Catheter (eff. 1/01)
(obsolete 4/01)
2607 = SpineCath Intradiscal Cath (eff. 1/01)
(obsolete 4/01)
2608 = Scimed 6F Wiseguide Cath (eff. 1/01)
(obsolete 4/01)
2609 = Flexima Bil Draingage Cath (eff. 1/01)
(obsolete 4/01)
2610 = FlexTipPlus Intraspinal Cath (eff. 1/01)
(obsolete 4/01)
2611 = AlgoLine Intraspinal Cath (eff. 1/01)
(obsolete 4/01)
2612 = InDura Catheter (eff. 1/01)
(obsolete 4/01)
2615 = Sealant, pulmonary, liquid (eff. 4/01)
2616 = Brachytx seed, Yttrium-90 (eff. 4/01)
2617 = Stent, non-cor, tem w/o del (eff. 4/01)
2618 = Probe, cryoablation (eff. 4/01)
2619 = Pmkr, dual, non rate-resp (eff. 4/01)
2620 = Pmkr, single, non rate-resp (eff. 4/01)
2621 = Pmkr, other than single/dual (eff. 4/01)
2622 = Prosthesis, penile, non-inf (eff. 4/01)
2625 = Stent, non-cor , tem w/del sys (eff. 4/01)
2626 = Infusion pump, non-prog, temp (eff. 4/01)
2627 = Cath, suprapubic/cystoscopic (eff. 4/01)
2628 = Catheter, occlusion (eff. 4/01)
2629 = Intro/sheath, laser (eff. 4/01)
2630 = Cath, EP, temp-controlled (eff. 4/01)
2631 = Rep dev, urinary, w/o sling (eff. 4/01)
2700 = MycroPhylax Plus CS defib (eff. 1/01)
(obsolete 4/01)
2701 = Phylax XM SC defib (eff. 1/01)
(obsolete 4/01)
2702 = Ventak Prizm 2VR Defib (eff. 1/01)
(obsolete 4/01)
2703 = Ventak Prizm VR HE Defib (eff. 1/01)
(obsolete 4/01)
2704 = Ventak Mini IV + Defib (eff. 1/01)
(obsolete 4/01)
2801 = Defender IV DR 612 DC defib (eff. 1/01)
(obsolete 4/01)
2802 = Phylax AV DC defib (eff. 1/01)

(obsolete 4/01)
2803 = Ventak Prizm DR HE Defib (eff. 1/01)
(obsolete 4/01)
2804 = Ventak Prizm 2 DR Defib (eff. 1/01)
(obsolete 4/01)
2805 = Jewel AF 7250 Defib (eff. 1/01)
(obsolete 4/01)
2806 = GEM VR 7227 Defib (eff. 1/01)
(obsolete 4/01)
2807 = Contak CD 1823 (eff. 1/01)
(obsolete 4/01)
2808 = Contak TR 1241 (eff. 1/01)
(obsolete 4/01)
3001 = Kainox SL/RV defib lead (eff. 1/01)
(obsolete 4/01)
3002 = EasyTrak Defib Lead (eff. 1/01)
(obsolete 4/01)
3003 = Endotak SQ Array XP lead (eff. 1/01)
(obsolete 4/01)
3004 = Intervene Defib lead (eff. 1/01)
(obsolete 4/01)
3400 = Siltex Spectrum, Contour Prof (eff. 1/01)
(obsolete 4/01)
3401 = Saline-Filled Spectrum (eff. 1/01)
(obsolete 4/01)
3500 = Mentor alpha I Inf Penile Pros (eff. 1/01)
(obsolete 4/01)
3510 = AMS 800 Urinary Pros (eff. 1/01)
(obsolete 4/01)
3551 = Choice/PT Graphix/Luge/Trooper (eff. 1/01)
(obsolete 4/01)
3552 = Hi-Torque Whisper (eff. 1/01)
(obsolete 4/01)
3553 = Cordis guidewires (eff. 1/01)
(obsolete 4/01)
3554 = Jindo guidewire (eff. 1/01)
(obsolete 4/01)
3555 = Wholey Hi-Torque Plus GW (eff. 1/01)
(obsolete 4/01)
3556 = Wave/FlowWire Guidewire (eff. 1/01)
(obsolete 4/01)
3557 = HyTek guidewire (eff. 1/01)
(obsolete 4/01)
3800 = SynchroMed EL infusion pump (eff. 1/01)
(obsolete 4/01)
3801 = Arrow/Microject PCAQ Sys (eff. 1/01)
(obsolete 4/01)
3851 = Elastic UV IOL AA-4203T/TF/TL (eff. 1/01)
(obsolete 4/01)
4000 = Opus G 4621, 4624 SC pmkr (eff. 1/01)
(obsolete 4/01)
4001 = Opus S 4121/4124 SC pmkr (eff. 1/01)
(obsolete 4/01)
4002 = Talent 113 SC pmkr (eff. 1/01)

(obsolete 4/01)
4003 = Kairos SR SC pmkr (eff. 1/01)
(obsolete 4/01)
4004 = Actros SR, Actros SLR SC pmkr (eff. 1/01)
(obsolete 4/01)
4005 = Philos SR/SR-B SC pmkr (eff. 1/01)
(obsolete 4/01)
4006 = Pulsar Max II SR pmkr (eff. 1/01)
(obsolete 4/01)
4007 = Marathon SR pmkr (eff. 1/01)
(obsolete 4/01)
4008 = Discovery II SSI pmkr (eff. 1/01)
(obsolete 4/01)
4009 = Discovery II SR pmkr (eff. 1/01)
(obsolete 4/01)
4300 = Integrity AFx DR 5342 pmkr (eff. 1/01)
(obsolete 4/01)
4301 = Integrity AFx DR 5346 pmkr (eff. 1/01)
(obsolete 4/01)
4302 = Affinity VDR 5430 DR (eff. 1/01)
(obsolete 4/01)
4303 = Brio 112 DC pmkr (eff. 1/01)
(obsolete 4/01)
4304 = Brio 212, Talent 213/223 DC pmkr (eff. 1/01)
(obsolete 4/01)
4305 = Brio 222 DC pmkr (eff. 1/01)
(obsolete 4/01)
4306 = Brio 220 DC pmkr (eff. 1/01)
(obsolete 4/01)
4307 = Kairos DR DC pmkr (eff. 1/01)
(obsolete 4/01)
4308 = Inos2, Inos2+ DC pmkr (eff. 1/01)
(obsolete 4/01)
4309 = Actros DR,D,DR-A, SLR DC pmkr (eff. 1/01)
(obsolete 4/01)
4310 = Actros DR-B DC pmkr (eff. 1/01)
(obsolete 4/01)
4311 = Philos DR/DR-B/SLR DC (eff. 1/01)
(obsolete 4/01)
4312 = Pulsar Max II DR pmkr (eff. 1/01)
(obsolete 4/01)
4313 = Marathon DR pmkr (eff. 1/01)
(obsolete 4/01)
4314 = Momentum DR pmkr (eff. 1/01)
(obsolete 4/01)
4315 = Selection AFm pmkr (eff. 1/01)
(obsolete 4/01)
4316 = Discovery II DR (eff. 1/01)
(obsolete 4/01)
4317 = Discovery II DDD (eff. 1/01)
(obsolete 4/01)
4600 = Snynox, Polyrox, Elox, Retrox (eff. 1/01)
(obsolete 4/01)
4602 = Tendril SDX, 1488K pmkr lead (eff. 1/01)

(obsolete 4/01)
4603 = Oscor/Flexion pmkr lead (eff. 1/01)
(obsolete 4/01)
4604 = CrystallineActFix, CapsureFix (eff. 1/01)
(obsolete 4/01)
4605 = CapSure Epi pmkr lead (eff. 1/01)
(obsolete 4/01)
4606 = Flextend pmkr lead (eff. 1/01)
(obsolete 4/01)
4607 = FinelineII/EZ, ThinlineII/EZ (eff. 1/01)
(obsolete 4/01)
5000 = BX Velocity w/Hepacoat (eff. 1/01)
(obsolete 4/01)
5001 = Memotherm Bil Stent, sm, med (eff. 1/01)
(obsolete 4/01)
5002 = Memotherm Bil Stent, large (eff. 1/01)
(obsolete 4/01)
5003 = Memotherm Bil Stent, x-large (eff. 1/01)
(obsolete 4/01)
5004 = PalmazCorinthian IQ Bil Stent (eff. 1/01)
(obsolete 4/01)
5005 = PalmazCorinthian IQ Trans/Bil (eff. 1/01)
(obsolete 4/01)
5006 = PalmazTran Bil Stent Sys-Med (eff. 1/01)
(obsolete 4/01)
5007 = PalmazTran XL Bil Stent--40mm (eff. 1/01)
(obsolete 4/01)
5008 = PalmazTran XL Bil Stent--50mm (eff. 1/01)
(obsolete 4/01)
5009 = VistaFlex Biliary Stent (eff. 1/01)
(obsolete 4/01)
5010 = Rapid Exchange Bil Stent Sys (eff. 1/01)
(obsolete 4/01)
5011 = IntraStent, IntraStent LP (eff. 1/01)
(obsolete 4/01)
5012 = IntraStent DoubleStrut LD (eff. 1/01)
(obsolete 4/01)
5013 = IntraStent DoubleStrut XS (eff. 1/01)
(obsolete 4/01)
5014 = AVE Bridge Stent Sys-10/17/28 (eff. 1/01)
(obsolete 4/01)
5015 = AVE/X3 Bridge Sys, 40-100 (eff. 1/010
(obsolete 4/01)
5016 = Biliary stent single use cov (eff. 1/01)
(obsolete 4/01)
5017 = WallstentRP Bil--20/40/60/68mm (eff. 1/01)
(obsolete 4/01)
5018 = WallstentRP Bil--80/94mm (eff. 1/01)
(obsolete 4/01)
5019 = Flexima Bil Stent Sys (eff. 1/01)
(obsolete 4/01)
5020 = Smart Nitinol Stent--20mm (eff. 1/01)
(obsolete 4/01)
5021 = Smart Nitinol Stent--40/60mm (eff. 1/01)

(obsolete 4/01)
5022 = Smart Nitinol Stent--80mm (eff. 1/01)
(obsolete 4/01)
5023 = BX Velocity Stent--8/13mm (eff. 1/01)
(obsolete 4/01)
5024 = BX Velocity Stent 18mm (eff. 1/01)
(obsolete 4/01)
5025 = BX Velocity Stent 23 mm (eff. 1/01)
(obsolete 4/01)
5026 = BX Velocity Stent 28/33mm (eff. 1/01)
(obsolete 4/01)
5027 = BX Velocity Stent w/Hep--8/13mm (eff. 1/01)
(obsolete 4/01)
5028 = BX Velocity Stent w/Hep--18mm (eff. 1/01)
(obsolete 4/01)
5029 = BX Velocity Stent w/Hep--23mm (eff. 1/01)
(obsolete 4/01)
5030 = Stent, coronary, S660 9/12mm (eff. 1/01)
(obsolete 4/01)
5031 = Stent, coronary, S660 15/18mm (eff. 1/01)
(obsolete 4/01)
5032 = Stent, coronary, S660 24/30mm (eff. 1/01)
(obsolete 4/01)
5033 = Niroyal Stent Sys, 9mm (eff. 1/01)
(obsolete 4/01)
5034 = Niroyal Stent Sys, 12/15mm (eff. 1/01)
(obsolete 4/01)
5035 = Niroyal Stent Sys, 18mm (eff. 1/01)
(obsolete 4/01)
5036 = Niroyal Stent Sys, 25mm (eff. 1/01)
(obsolete 4/01)
5037 = Niroyal Stent Sys, 31mm (eff. 1/01)
(obsolete 4/01)
5038 = BX Velocity Stent w/Raptor (eff. 1/01)
(obsolete 4/01)
5039 = IntraCoil Periph Stent--40mm (eff. 1/01)
(obsolete 4/01)
5040 = IntraCoil Periph Stent--60mm (eff. 1/01)
(obsolete 4/01)
5041 = BeStent Over-the-Wire 24/30mm (eff. 1/01)
(obsolete 4/01)
5042 = BeStent Over-the-Wire 18mm (eff. 1/01)
(obsolete 4/01)
5043 = BeStent Over-the-Wire 15mm (eff. 1/01)
(obsolete 4/01)
5044 = BeStent Over-the-Wire 9/12mm (eff. 1/01)
(obsolete 4/01)
5045 = Multilink Tetra Cor Stent Sys (eff. 1/01)
(obsolete 4/01)
5046 = Radius 20mm cor stent (eff. 1/01)
(obsolete 4/01)
5047 = Niroyal Elite Cor Stent Sys (eff. 1/01)
(obsolete 4/01)
5048 = GR II Coronary Stent (eff. 1/01)

(obsolete 4/01)
5130 = Wilson-Cook Colonic Z-Stent (eff. 1/01)
(obsolete 4/01)
5131 = Bard Colorectal Stent-60mm (eff. 1/01)
(obsolete 4/01)
5132 = Bard Colorectal Stent-80mm (eff. 1/01)
(obsolete 4/01)
5133 = Bard Colorectal Stent-100mm (eff. 1/01)
(obsolete 4/01)
5134 = Enteral Wallstent-90mm (eff. 1/01)
(obsolete 4/01)
5279 = Contour/Percuflex Stent (eff. 1/01)
(obsolete 4/01)
5280 = Inlay Dbl Ureteral Stent (eff. 1/01)
(obsolete 4/01)
5281 = Wallgraft Trach Sys 70mm (eff. 1/01)
(obsolete 4/01)
5282 = Wallgraft Trach Sys 20/30/50 (eff. 1/01)
(obsolete 4/01)
5283 = Wallstent/RP TIPS--80mm (eff. 1/01)
(obsolete 4/01)
5284 = Wallstent TrachUltraFlex (eff. 1/01)
(obsolete 4/01)
5600 = Closure dev, VasoSeal ES (eff. 1/01)
(obsolete 4/01)
5601 = VasoSeal Model 1000 (eff. 1/01)
(obsolete 4/01)
6001 = Composix Mesh 8/21 in (eff. 1/01)
(obsolete 4/01)
6002 = Composix Mesh 32 in (eff. 1/01)
(obsolete 4/01)
6003 = Composix Mesh 48 in (eff. 1/01)
(obsolete 4/01)
6004 = Composix Mesh 80 in (eff. 1/01)
(obsolete 4/01)
6005 = Composix Mesh 140 in (eff. 1/01)
(obsolete 4/01)
6006 = Composix Mesh 144 in (eff. 1/01)
(obsolete 4/01)
6012 = Pelvicol Collagen 8/14 sq cm (eff. 1/01)
(obsolete 4/01)
6013 = Pelvicol Collagen 21/24/28 sq cm (eff. 1/01)
(obsolete 4/01)
6014 = Pelvicol Collagen 36 sq cm (eff. 1/01)
(obsolete 4/01)
6015 = Pelvicol Collagen 48 sq cm (eff. 1/01)
(obsolete 4/01)
6016 = Pelvicol Collagen 96 sq cm (eff. 1/01)
(obsolete 4/01)
6017 = Gore-Tex DualMesh 75/96 sq cm (eff. 1/01)
(obsolete 4/01)
6018 = Gore-Tex DualMesh 150 sq cm (eff. 1/01)
(obsolete 4/01)
6019 = Gore-Tex DualMesh 285 sq cm (eff. 1/01)

(obsolete 4/01)
6020 = Gore-Tex DualMesh 432 sq cm (eff. 1/01)
(obsolete 4/01)
6021 = Gore-Tex DualMesh 600 sq cm (eff. 1/01)
(obsolete 4/01)
6022 = Gore-Tex DualMesh 884 sq cm (eff. 1/01)
(obsolete 4/01)
6023 = Gore-TexPlus 1mm, 75/96 sq cm (eff. 1/01)
(obsolete 4/01)
6024 = Gore-TexPlus 1mm, 150 sq cm (eff. 1/01)
(obsolete 4/01)
6025 = Gore-TexPlus 1mm, 285 sq cm (eff. 1/01)
(obsolete 4/01)
6026 = Gore-TexPlus 1mm, 432 sq cm (eff. 1/01)
(obsolete 4/01)
6027 = Gore-TexPlus 1mm, 600 sq cm (eff. 1/01)
(obsolete 4/01)
6028 = Gore-TexPlus 1mm, 884 sq cm (eff. 1/01)
(obsolete 4/01)
6029 = Gore-TexPlus 2mm, 150 sq cm (eff. 1/01)
(obsolete 4/01)
6030 = Gore-TexPlus 2mm, 285 sq cm (eff. 1/01)
(obsolete 4/01)
6031 = Gore-TexPlus 2mm, 432 sq cm (eff. 1/01)
(obsolete 4/01)
6032 = Gore-TexPlus 2mm, 600 sq cm (eff. 1/01)
(obsolete 4/01)
6033 = Gore-TexPlus 2mm, 884 sq cm (eff. 1/01)
(obsolete 4/01)
6034 = Bard ePTFE: 150 sq cm-2mm
(obsolete 4/01)
6035 = Bard ePTFE: 150sqcm-1mm,75-2mm (eff. 1/01)
(obsolete 4/01)
6036 = Bard ePTFE: 50/75sqcm-1,2mm (eff. 1/01)
(obsolete 4/01)
6037 = Bard ePTFE: 300 sq cm-1,2mm (eff. 1/01)
(obsolete 4/01)
6038 = Bard ePTFE: 600 sq cm-1mm (eff. 1/01)
(obsolete 4/01)
6039 = Bard ePTFE: 884sq cm-1mm (eff. 1/01)
(obsolete 4/01)
6040 = Bard ePTFE: 600sq cm-2mm (eff. 1/01)
(obsolete 4/01)
6041 = Bard ePTFE: 884sq cm -2mm (eff. 1/01)
(obsolete 4/01)
6050 = Female Sling Sys w/wo Matrl (eff. 1/01)
(obsolete 4/01)
6051 = Stratasis Sling, 20/40 cm (eff. 1/01)
(obsolete 4/01)
6052 = Stratasis Sling, 60 cm (eff. 1/01)
(obsolete 4/01)
6053 = Surgisis Soft Graft (eff. 1/01)
(obsolete 4/01)
6054 = Surgisis Enhanced Graft (eff. 1/01)

(obsolete 4/01)
6055 = Surgisis Enhanced Tissue (eff. 1/01)
(obsolete 4/01)
6056 = Surgisis Soft Tissue Graft (eff. 1/01)
(obsolete 4/01)
6057 = Surgisis Hernia Graft (eff. 1/01)
(obsolete 4/01)
6058 = SurgiPro Hernia Plug, med/lg (eff. 1/01)
(obsolete 4/01)
6080 = Male Sling Sys w/wo Matrial (eff. 1/01)
(obsolete 4/01)
6200 = Exxcel Soft ePTFE vas graft (ef. 1/01)
(obsolete 4/01)
6201 = Impra Venaflo--10/20cm (eff. 1/01)
(obsolete 4/01)
6202 = Impra Venaflo--30/40 cm (eff. 1/01)
(obsolete 4/01)
6203 = Impra Venaflo--50 cm, vt45 (eff. 1/01)
(obsolete 4/01)
6204 = Impra Venaflo--stepped (eff. 1/01)
(obsolete 4/01)
6205 = Impra Carboflo--10cm (eff. 1/01)
(obsolete 4/01)
6206 = Impra Carboflo--20 cm (eff. 1/01)
(obsolete 4/01)
6207 = Impra Carboflo--30/35/40cm (eff. 1/01)
(obsolete 4/01)
6208 = Impra Carboflo--40/50cm (eff. 1/01)
(obsolete 4/01)
6209 = Impra Carboflo--ctrflex (eff. 1/01)
(obsolete 4/01)
6210 = Exxcel ePTFE vas graft (eff. 1/01)
(obsolete 4/01)
6300 = Vanguard III Endovas Graft (eff. 1/01)
(obsolete 4/01)
6500 = Preface Guiding Sheath (eff. 1/01)
(obsolete 4/01)
6501 = Soft Tip Sheaths (eff. 1/01)
(obsolete 4/01)
6502 = Perry Exchange Dilator (eff. 1/01)
(obsolete 4/01)
6525 = Spectranetics Laser Sheath (eff. 1/01)
(obsolete 4/01)
6600 = Micro Litho Flex Probes (eff. 1/01)
(obsolete 4/01)
6650 = Fast-Cath Guiding Introducer (eff. 1/01)
(obsolete 4/01)
6651 = Seal-Away Guding Introducer (eff. 1/01)
(obsolete 4/01)
6652 = Bard Excalibur Introducer (eff. 1/01)
(obsolete 4/01)
6700 = Focal Seal-L (eff. 1/01)
(obsolete 4/01)
7000 = Amifostine, 500 mg (eligible for pass-through

payments)
7001 = Amphotericin B lipid complex, 50 mg, Inj
(eligible for pass-through payments)
7002 = Clonidine, HCl, 1 MG (eligible for pass-
through payments) (obsolete 1/01)
7003 = Epoprostenol, 0.5 MG, inj (eligible for pass-
through payments)
7004 = Immune globulin intravenous human 5g, inj
(eligible for pass-through payments)
7005 = Gonadorelin hcI, 100 mcg (eligible for pass-
through payments)
7007 = Milrinone lacetate, per 5 ml, inj (not subject
to national coinsurance)
7010 = Morphine sulfate concentrate (preservative free)
per 10 mg (eligible for pass-through payments)
7011 = Oprelevekin, inj, 5 mg (eligible for pass-through
payments)
7012 = Pentamidine isethionate, 300 mg (eligible for
pass-through payments) (obsolete 1/01)
7014 = Fentanyl citrate, inj, up to 2 ml (eligible for
pass-through payments)
7015 = Busulfan, oral 2 mg (eligible for pass-through
payments)
7019 = Aprotinin, 10,000 kiu (eligible for pass-through
payments)
7021 = Baclofen, intrathecal, 50 mcg (eligible for pass-
through payments) (obsolete 1/01)
7022 = Elliotts B Solution, per ml (eligible for pass-
through payments)
7023 = Treatment for bladder calculi, I.e. Renacidin
per 500 ml (eligible for pass-through payments)
7024 = Corticorelin ovine triflutate, 0.1 mg
(eligible for pass-through payments)
7025 = Digoxin immune FAB (Ovine), 10 mg
(eligible for pass-through payments)
7026 = Ethanolamine oleate, 1000 ml
(eligible for pass-through payments)
7027 = Fomepizole, 1.5 G
(eligible for pass-through payments)
7028 = Fosphenytoin, 50 mg
(eligible for pass-through payments)
7029 = Glatiramer acetate, 25 mg
(eligible for pass-through payments)
7030 = Hemin, 1 mg
(eligible for pass-through payments)
7031 = Octreotide Acetate, 500 mcg
(eligible for pass-through payments)
7032 = Sermorelin acetate, 0.5 mg
(eligible for pass-through payments)
7033 = Somatrem, 5 mg
(eligible for pass-through payments)
7034 = Somatropin, 1 mg
(eligible for pass-through payments)
7035 = Teniposide, 50 mg

(eligible for pass-through payments)
7036 = Urokinase, inj, IV, 250,000 I.U.
(not subject to national coinsurance)
7037 = Urofollitropin, 75 I.U.
(eligible for pass-through payments)
7038 = Muromonab-CD3, 5 mg
(eligible for pass-through payments)
7039 = Pegademase bovine inj 25 I.U.
(eligible for pass-through payments)
7040 = Pentastarch 10% inj, 100 ml
(eligible for pass-through payments)
7041 = Tirofiban HCL, 0.5 mg
(not subject to national coinsurance)
7042 = Capecitabine, oral 150 mg
(eligible for pass-through payments)
7043 = Infliximab, 10 MG (eligible for pass-through payments)
7045 = Trimetrexate Glucoronate (eligible for pass-through payments)
7046 = Doxorubicin Hcl Liposome (eligible for pass-through payments)
7047 = Droperidol/fentanyl inj (eff. 1/01)
7048 = Alteplase, 1 mg (eff. 1/01)
7049 = Filgrastim 480 mcg injection (eff. 1/01)
7315 = Sodium hyaluronate, 20 mg (eff. 1/01)
8099 = Spectranetics Lead Lock Dev (eff. 1/01)
(obsolete 4/01)
8100 = Adhesion barrier, ADCON-L (eff. 1/01)
(obsolete 4/01)
8102 = SurgiVision Esoph Coil (eff. 1/01)
(obsolete 4/01)
9000 = Na chromate Cr51, per 0.25mCi (eff. 1/01)
9001 = Linezolid inj, 200mg (eff. 1/01)
9002 = Tenecteplase, 50mg/vial (eff. 1/01)
9003 = Palivizumab, per 50 mg (eff. 1/01)
9004 = Gemtuzumab ozogamicin inj, 5mg (eff. 1/01)
9005 = Reteplase inj, half-kit, 18.8 mg/vial (eff. 1/01)
9006 = Tacrolimus inj, per 5 mg (1 amp) (eff. 1/01)
9007 = Baclofen Intrathecal kit-1amp (eff. 1/01)
9008 = Baclofen Refill Kit--500mcg (eff. 1/01)
9009 = Baclofen Refill Kit--2000mcg (eff. 1/01)
9010 = Baclofen Refill Kit--4000mcg (eff. 1/01)
9011 = Caffeine Citrate, inj, 1ml (eff. 1/01)
9012 = Arsenic Trioxide, 1mg/kg (eff. 4/01)
9013 = Co 57 Cobaltous Cl, 1 ml (eff. 4/01)
9100 = Iodinated I-131 Albumin (eff. 1/01)
9102 = 51 Na chromate, 50mCi (eff. 1/01)
9103 = Na lothalamate I-125, 10uCi (eff. 1/01)
9104 = Anti-thymocyte globin, 25 mg (eff. 1/01)
9105 = Hep B immun glob, per 1 ml (eff. 1/01)
9106 = Sirolimus 1 mg/ml (eff. 1/01)
9107 = Tinzaparin sodium, 2ml vial (eff. 1/01)
9108 = Thyrotropin Alfa, 1.1 mg (eff. 1/01)
9109 = Tirofiban hydrachloride 6.25 mg (eff. 1/01)

9217 = Leuprolide acetate for depot suspension,
7.5 mg (eff. 1/01)
9500 = Platelets, irrad, ea unit (eff. 1/01)
9501 = Platelets, pheresis, ea unit (eff. 1/01)
9502 = Platelets, pher/irrad, ea unit (eff. 1/01)
9503 = Fresh frozen plasma, ea unit (eff. 1/01)
9504 = RBC, deglycerolized, ea unit (eff. 1/01)
9505 = RBC, irradiated, ea unit (eff. 1/01)
9998 = Enoxaparin (eff. 1/01)

REV_CNTR_CNSLDTD_BLG_TB Revenue Center Consolidated Billing Table

1 = Home Health Consolidated Billing Override Code
2 = SNF Consolidated Billing Override Code

REV_CNTR_DDCTBL_COINSRNC_TB Revenue Center Deductible Coinsurance Code

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

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

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

REV_CNTR_DSCNT_IND_TB Revenue Center Discount Indicator Table

DISCOUNTING FORMULAS
1 = 1.0
2 = (1.0+D(U-1))/U
3 = T/U
4 = (1+D)/U
5 = D

6 = TD/U
7 = D(1+D)/U
8 = 2.0/U

NOTE: VALUES D, U & T REPRESENT THE FOLLOWING:
D = Discounting fraction (currently 0.5)
U = Number of units
T = Terminated procedure discount (currently 0.5)

REV_CNTR_DUP_CLM_CHK_IND_TB Revenue Center Duplicate Claim Check Indcator Table

1 = Suspect duplicate review performed

REV_CNTR_NDC_QTY_QLFR_TB Revenue Center NDC Qualifier Code Table

Valid Values:
F2 = International Unit
GR = Gram
ML = Milliliter
UN = Unit

REV_CNTR_PACKG_IND_TB Revenue Center Packaging Indicator Table

0 = Not packaged
1 = Packaged service (service indicator N)
2 = Packaged as part of partial hospitalization per diem or daily mental health service per diem
3 = Artificial charges for surgical procedure (eff. 7/2004)

REV_CNTR_PMT_MTHD_IND_TB Revenue Center Payment Method Indicator Table

NOTE: Prior to 10/2005, this table contained the valid values for both the payment indicator and status indicator. Effective 10/2005, the payment indicator codes will remain in this table and the status indicator code values will be reflected in the new table: REV_CNTR_STUS_IND_TB. Both the payment indicator and status indicator values have been expanded to 2-btyes.

1 = Paid standard hospital OPPS amount (status indicators K, S,T,V,X)
2 = Services not paid under OPPS (status indicator A, or no HCPCS code and not

certain revenue center codes)
3 = Not paid (status indicator M,W,Y,E) or not paid under OPPS (status indicator B,C & Z)
4 = Paid at reasonable cost (status indicator F,L)
5 = Additional payment for drug or biological (status indicator G)
6 = Additional payment for device (status indicator H)
7 = Additional payment for new drug or new biological (status indicator J)
8 = Paid partial hospitalization per diem (status indicator P)
9 = No additional payment, payment included in line items with APCs (status indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy) or G0177 (partial hospitalization program services)
A2 = Surgical procedure on ASC list in CY 2007; payment based on OPPS payment relative weight
B5 = Alternative code may be available; no payment made
D5 = Deleted/discontinued code; no payment made
F4 = Corneal tissue acquisition, hepatitis B vaccine; paid at reasonable cost
G2 = Non-office based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight
H2 = Brachytherapy source paid separately when provided intregal to a surgical procedure on an ASC lists; payment based on OPPS rates
J7 = OPPS pass-through device paid when separately provided intregal to a surgical procedure on ASC list; payment contractor priced
J8 = Device-intensive procedure; paid at adjusted rate
K2 = Drugs and biologicals paid separately when provided intregal to a surgical procedure on ASC list; payment based on OPPS rate
K7 = Unclassified drugs and biologicals; payment contractor priced
L1 = Influenza vaccine; pneumoccocal vaccine. Packaged item/service, no separate payment made
L6 = New Technology Intarocular Lens (NTIOL); special payment
N1 = Package service/item; no separate payment made
P2 = Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RUVs payment based on OPPS relative payment weight.
P3 = Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RUVs payment based on MPFS nonfacility PE RUVs.
R2 = Office-based surgical procedure added to ASC list

in CY 2008 or later without MPFS non-facility PE RVUs payment based on OPPS relative payment weight.
Z2 = Radioloty or diagnostic service paid separately when provided intregal to a surgical procedure on an ASC list; payment based on OPPS relative payment weight.
Z3 = Radioloty or diagnostic service paid separately when provided intregal to a surgical procedure on an ASC list; payment based on MFPS nonfacility PE RVUs.

*********VALUES PRIOR TO 10/3/2005**********
**********Service Indicator**********
********** 1st position **********

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

**********Payment Indicator**********
********** 2nd position **********
1 = Paid standard hospital OPPS amount (service indicators S,T,V,X)
2 = Services not paid under OPPS (service indicator A, or no HCPCS code and not certain revenue center codes)
3 = Not paid (service indicators C & E)
4 = Acquisition cost paid (service indicator F)
5 = Additional payment for current drug or biological (service indicator G)
6 = Additional payment for device (service indicator H)
7 = Additional payment for new drug or new biological (service indicator J)
8 = Paid partial hospitalization per diem (service indicator P)
9 = No additional payment, payment included in line items with APCs (service indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes Q0082

(activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization training)

REV_CNTR_PRICNG_IND_TB Revenue Center Pricing Indicator Table

A = A valid HCPCS code not subject to a fee schedule payment. Reimbursement is calculated on provider submitted charges.

B = A valid HCPCS code subject to the fee schedule payment. for the provider billed charges. NOTE: There is an exception for Critical Access Hospitals (provider numbers XX1300-XX1399) with reimbursement method 'J' (all-inclusive method) and dates of service on or after 7/1/01. In these situations, reimbursement for professional services (revenue codes 96X, 97X, 98X) is always at the fee schedule amount of logic is not applicable.

C = Unlisted Rehabilitation Carrier Priced HCPCS

D = a valid radiology HCPCS code subject to the Radiology Pricer and the rate is reflected as zeroes on the HCPCS file and cost report. The Radiology Pricer treates this HCPCS as a non-covered service. Reimbursement is calculated on provider submitted charges.

E = A valid ASC HCPCS code subject to the ASC Pricer. The rate is reflected as zeroes on the HCPCS file. The ASC Pricer determines the ASC payment rate and is reported on the cost report.

F = A valid ESRD HCPCS code subject to the parameter rate. Reimbursement is the lesser of provider submitted charges or the fee schedule amount for non-dialysis HCPCS. Reimbursement is calculated on the provider file rates for dialysis HCPCS.

NOTE: The ESRD Pricing Indicator is used when processing the ESRD claim. The non-ESRD pricing indicator is used only for Inpatient claims as follows: valid Hemophilia HCPCS for inpatient claim only and code is summed to parameter rate.

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

H = A valid DME HCPCS, code is subject to a fee schedule. The rates are reflected under the DME segment. Reim-

bursement is calculated either on a fee schedule, provider submitted charges or the lesser of provider submitted, or the fee schedule depending on the category of DME.

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

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

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

L = A valid TENS HCPCS, rental period is six months or greater and must be reviewed by Medical Review. This code will be automatically set by the system.

M = A valid TENS HCPCS, Medical Review has approved the rental charge in excess of five months. This must be set by Medical Review. This must be set by Medical Review when approved for payment.

N = Paid based on the fee amount for non ESRD TOB's.
NOTE: Fee amount is paid regardless of charges.

Q = Manual pricing

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

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

T = Valid HCPCS. A fee amount is present. The amount payable should be the lower of the billed charge or fee amount. The system should compute the fee amount by multiplying the covered units times the rate. The fee amount is not subject to coinsurance and deductible or provider's reimbursement rate.

U = Valid ambulance HCPCS. A fee amount is present. The amount payable is a blended amount based on a percentage of the fee schedule and a percentage of the reasonable cost. The fee amount is subject to

coinsurance and deductible.

X = Unclassified drug as subject to manual pricing.

REV_CNTR_PRIOR_AUTHRZTN_TB Revenue Center Prior Authorization Indicator Table

A = Part A
B = Part B
D = DME
H = Home Health and Hospice
+ 3 digit number

REV_CNTR_PWK_TB Revenue Center Paperwork Table

P1 = one iteration is present
P2 = two iterations are present
P3 = three iterations are present
P4 = four iterations are present
P5 = five iterations are present
P6 = six iterations are present
P7 = seven iterations are present
P8 = eight iterations are present
P9 = nine iterations are present
P0 = ten iterations are present

REV_CNTR_STUS_IND_TB Revenue Center Status Indicator Table

A = Services not paid under OPPS; paid by MACs under a fee schedule or payment system other than OPPS
B = Non-allowed item or service for OPPS
C = Inpatient procedure; not paid under OPPS
D = Discontinued Codes - not paid under OPPS or any other Medicare payment system
E1 = Non-allowed item or service - not paid by Medicare when submitted on outpatient claims (any outpatient bill type)
E2 = Non-allowed item or service for which pricing information and claims data is not available - not paid by Medicare when submitted on outpatient claims (any outpatient bill type)
F = Corneal tissue acquisition and certain CRNA services and Hepatitis B vaccines
G = Drug/bilogical pass-through
H = Device pass-through
J1 = Hospital Part B services paid through a comprehensive APC -- Paid under OPPS; all covered Part B services on on the claim are packaged with the primary "J1" service

service for the claim, except services with OPPS status indicator of "F","G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; new technology services; self-administered drugs; all preventive services; and certain Part B inpatient services.

J2 = Hospital Part B services that may be paid through a comprehensize APC - Paid under OPPS; Addendum B displays APC assignments when services are separately payable

K = Non pass-through drug/biological, radiopharmaceutical agent, certain brachytherapy sources. Paid under OPPS; separate APC payment

L = Flu/PPV vaccines - Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance

M = Service not billable to MAC; Not paid under OPPS

N = Items and services packaged into APC rates Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment

P = Partial Hospitalization; Paid under OPPS; per diem APC payment

Q1 = STV - Packaged Codes - Paid under OPPS; Addendum B displays APC assignments when services are separately paybable

Q2 = T - Packaged Codes - Paid under OPPS; Addendum B displays APC assignments when services are separately paybable

Q3 = Codes that may be paid through a composite APC

Q4 = Conditionally packaged laboratory tests Paid under OPPS or CLFS

R = Blood and blood products; Paid under OPPS; separate APC payment

S = Significant procedure not subject to multiple procedure discounting - Paid under OPPS; separate APC payment

T = Significant procedure subject to multiple procedure discounting; Paid under OPPS; separate APC payment

U = Brachytherapy Sources - Paid under OPPS; separate APC payment

V = Medical visit to clinic or emergency department - Paid under OPPS; separate APC payment

W = Invalid HCPCS or invalid revenue code with blank HCPCS (terminated)

X = Ancillary service (terminated)

Y = Non-implantable DME, Therapeutic shoes

Z = Valid revenue with blank HCPCS and no other SI assigned (terminated)

REV_CNTR_TB Revenue Center Table

0001 = Total charge
0022 = SNF claim paid under PPS submitted as TOB 21X, effective for cost reporting periods beginning on or after 7/1/98 (dates of service after 6/30/98). NOTE: This code may appear multiple times on a claim to identify different HIPPS Rate Code/assessment periods.
0023 = Home Health services paid under PPS submitted as TOB 32X and 33X, effective 10/00. This code may appear multiple times on a claim to identify different HIPPS/Home Health Resource Groups (HRG).
0024 = Inpatient Rehabilitation Facility services paid under PPS submitted as TOB 11X, effective for cost reporting periods beginning on or after 1/1/2002 (dates of service after 12/31/01). This code may appear only once on a claim.
0100 = All inclusive rate-room and board plus ancillary
0101 = All inclusive rate-room and board
0110 = Private medical or general-general classification
0111 = Private medical or general-medical/surgical/GYN
0112 = Private medical or general-OB
0113 = Private medical or general-pediatric
0114 = Private medical or general-psychiatric
0115 = Private medical or general-hospice
0116 = Private medical or general-detoxification
0117 = Private medical or general-oncology
0118 = Private medical or general-rehabilitation
0119 = Private medical or general-other
0120 = Semi-private 2 bed (medical or general) general classification
0121 = Semi-private 2 bed (medical or general) medical/surgical/GYN
0122 = Semi-private 2 bed (medical or general)-OB
0123 = Semi-private 2 bed (medical or general)-pediatric
0124 = Semi-private 2 bed (medical or general)-psychiatric
0125 = Semi-private 2 bed (medical or general)-hospice
0126 = Semi-private 2 bed (medical or general) detoxification
0127 = Semi-private 2 bed (medical or general)-oncology
0128 = Semi-private 2 bed (medical or general) rehabilitation
0129 = Semi-private 2 bed (medical or general)-other
0130 = Semi-private 3 and 4 beds-general classification
0131 = Semi-private 3 and 4 beds-medical/surgical/GYN
0132 = Semi-private 3 and 4 beds-OB
0133 = Semi-private 3 and 4 beds-pediatric
0134 = Semi-private 3 and 4 beds-psychiatric
0135 = Semi-private 3 and 4 beds-hospice
0136 = Semi-private 3 and 4 beds-detoxification
0137 = Semi-private 3 and 4 beds-oncology
0138 = Semi_private 3 and 4 beds-rehabilitation
0139 = Semi-private 3 and 4 beds-other
0140 = Private (deluxe)-general classification
0141 = Private (deluxe)-medical/surgical/GYN

0142 = Private (deluxe)-OB
0143 = Private (deluxe)-pediatric
0144 = Private (deluxe)-psychiatric
0145 = Private (deluxe)-hospice
0146 = Private (deluxe)-detoxification
0147 = Private (deluxe)-oncology
0148 = Private (deluxe)-rehabilitation
0149 = Private (deluxe)-other
0150 = Room&Board ward (medical or general)
general classification
0151 = Room&Board ward (medical or general)
medical/surgical/GYN
0152 = Room&Board ward (medical or general)-OB
0153 = Room&Board ward (medical or general)-pediatric
0154 = Room&Board ward (medical or general)-psychiatric
0155 = Room&Board ward (medical or general)-hospice
0156 = Room&Board ward (medical or general)-detoxification
0157 = Room&Board ward (medical or general)-oncology
0158 = Room&Board ward (medical or general)-rehabilitation
0159 = Room&Board ward (medical or general)-other
0160 = Other Room&Board-general classification
0164 = Other Room&Board-sterile environment
0167 = Other Room&Board-self care
0169 = Other Room&Board-other
0170 = Nursery-general classification
0171 = Nursery-newborn
level I (routine)
0172 = Nursery-premature
newborn-level II (continuing care)
0173 = Nursery-newborn-level III (intermediate care)
(eff 10/96)
0174 = Nursery-newborn-level IV (intensive care)
(eff 10/96)
0175 = Nursery-neonatal ICU (obsolete eff 10/96)
0179 = Nursery-other
0180 = Leave of absence-general classification
0182 = Leave of absence-patient convenience charges
billable
0183 = Leave of absence-therapeutic leave
0184 = Leave of absence-ICF mentally retarded-any reason
(obsolete)
0185 = Leave of absence-nursing home (hospitalization)
0189 = Leave of absence-other leave of absence
0190 = Subacute care - general classification
(eff. 10/97)
0191 = Subacute care - level I (eff. 10/97)
0192 = Subacute care - level II (eff. 10/97)
0193 = Subacute care - level III (eff. 10/97)
0194 = Subacute care - level IV (eff. 10/97)
0199 = Subacute care - other (eff 10/97)
0200 = Intensive care-general classification
0201 = Intensive care-surgical
0202 = Intensive care-medical
0203 = Intensive care-pediatric

0204 = Intensive care-psychiatric
0206 = Intensive care-post ICU; redefined as
intermediate ICU (eff 10/96)
0207 = Intensive care-burn care
0208 = Intensive care-trauma
0209 = Intensive care-other intensive care
0210 = Coronary care-general classification
0211 = Coronary care-myocardial infraction
0212 = Coronary care-pulmonary care
0213 = Coronary care-heart transplant
0214 = Coronary care-post CCU; redefined as
intermediate CCU (eff 10/96)
0219 = Coronary care-other coronary care
0220 = Special charges-general classification
0221 = Special charges-admission charge
0222 = Special charges-technical support charge
0223 = Special charges-UR service charge
0224 = Special charges-late discharge, medically
necessary
0229 = Special charges-other special charges
0230 = Incremental nursing charge rate-general
classification
0231 = Incremental nursing charge rate-nursery
0232 = Incremental nursing charge rate-OB
0233 = Incremental nursing charge rate-ICU (include
transitional care)
0234 = Incremental nursing charge rate-CCU (include
transitional care)
0235 = Incremental nursing charge rate-hospice
0239 = Incremental nursing charge rate-other
0240 = All inclusive ancillary-general classification
0241 = All inclusive ancillary-basic
0242 = All inclusive ancillary-comprehensive
0243 = All inclusive ancillary-specialty
0249 = All inclusive ancillary-other inclusive ancillary
0250 = Pharmacy-general classification
0251 = Pharmacy-generic drugs
0252 = Pharmacy-nongeneric drugs
0253 = Pharmacy-take home drugs
0254 = Pharmacy-drugs incident to other diagnostic service-
subject to payment limit
0255 = Pharmacy-drugs incident to radiology-
subject to payment limit
0256 = Pharmacy-experimental drugs
0257 = Pharmacy-non-prescription
0258 = Pharmacy-IV solutions
0259 = Pharmacy-other pharmacy
0260 = IV therapy-general classification
0261 = IV therapy-infusion pump
0262 = IV therapy-pharmacy services (eff 10/94)
0263 = IV therapy-drug supply/delivery (eff 10/94)
0264 = IV therapy-supplies (eff 10/94)
0269 = IV therapy-other IV therapy
0270 = Medical/surgical supplies-general classification

(also see 062X)
0271 = Medical/surgical supplies-nonsterile supply
0272 = Medical/surgical supplies-sterile supply
0273 = Medical/surgical supplies-take home supplies
0274 = Medical/surgical supplies-prosthetic/orthotic devices
0275 = Medical/surgical supplies-pace maker
0276 = Medical/surgical supplies-intraocular lens
0277 = Medical/surgical supplies-oxygen-take home
0278 = Medical/surgical supplies-other implants
0279 = Medical/surgical supplies-other devices
0280 = Oncology-general classification
0289 = Oncology-other oncology
0290 = DME (other than renal)-general classification
0291 = DME (other than renal)-rental
0292 = DME (other than renal)-purchase of new DME
0293 = DME (other than renal)-purchase of used DME
0294 = DME (other than renal)-related to and listed as DME
0299 = DME (other than renal)-other
0300 = Laboratory-general classification
0301 = Laboratory-chemistry
0302 = Laboratory-immunology
0303 = Laboratory-renal patient (home)
0304 = Laboratory-non-routine dialysis
0305 = Laboratory-hematology
0306 = Laboratory-bacteriology & microbiology
0307 = Laboratory-urology
0309 = Laboratory-other laboratory
0310 = Laboratory pathological-general classification
0311 = Laboratory pathological-cytology
0312 = Laboratory pathological-histology
0314 = Laboratory pathological-biopsy
0319 = Laboratory pathological-other
0320 = Radiology diagnostic-general classification
0321 = Radiology diagnostic-angiocardiography
0322 = Radiology diagnostic-arthrography
0323 = Radiology diagnostic-arteriography
0324 = Radiology diagnostic-chest X-ray
0329 = Radiology diagnostic-other
0330 = Radiology therapeutic-general classification
0331 = Radiology therapeutic-chemotherapy injected
0332 = Radiology therapeutic-chemotherapy oral
0333 = Radiology therapeutic-radiation therapy
0335 = Radiology therapeutic-chemotherapy IV
0339 = Radiology therapeutic-other
0340 = Nuclear medicine-general classification
0341 = Nuclear medicine-diagnostic
0342 = Nuclear medicine-therapeutic
0343 = Nuclear medicine-diagnostic radiopharmaceuticals
0344 = Nuclear medicine-therapeutic radiopharmaceuticals
0349 = Nuclear medicine-other
0350 = Computed tomographic (CT) scan-general classification
0351 = CT scan-head scan

0352 = CT scan-body scan
0359 = CT scan-other CT scans
0360 = Operating room services-general classification
0361 = Operating room services-minor surgery
0362 = Operating room services-organ transplant, other than kidney
0367 = Operating room services-kidney transplant
0369 = Operating room services-other operating room services
0370 = Anesthesia-general classification
0371 = Anesthesia-incident to RAD and subject to the payment limit
0372 = Anesthesia-incident to other diagnostic service and subject to the payment limit
0374 = Anesthesia-acupuncture
0379 = Anesthesia-other anesthesia
0380 = Blood-general classification
0381 = Blood-packed red cells
0382 = Blood-whole blood
0383 = Blood-plasma
0384 = Blood-platelets
0385 = Blood-leukocytes
0386 = Blood-other components
0387 = Blood-other derivatives (cryopricipatates)
0389 = Blood-other blood
0390 = Blood storage and processing-general classification
0391 = Blood storage and processing-blood administration
0392 = Blood storage and processing - storage and processing
0399 = Blood storage and processing-other
0400 = Other imaging services-general classification
0401 = Other imaging services-diagnostic mammography
0402 = Other imaging services-ultrasound
0403 = Other imaging services-screening mammography (eff 1/1/91)
0404 = Other imaging services-positron emission tomography (eff 10/94)
0409 = Other imaging services-other
0410 = Respiratory services-general classification
0412 = Respiratory services-inhalation services
0413 = Respiratory services-hyperbaric oxygen therapy
0419 = Respiratory services-other
0420 = Physical therapy-general classification
0421 = Physical therapy-visit charge
0422 = Physical therapy-hourly charge
0423 = Physical therapy-group rate
0424 = Physical therapy-evaluation or re-evaluation
0429 = Physical therapy-other
0430 = Occupational therapy-general classification
0431 = Occupational therapy-visit charge
0432 = Occupational therapy-hourly charge
0433 = Occupational therapy-group rate

0434 = Occupational therapy-evaluation or re-evaluation
0439 = Occupational therapy-other (may include restorative therapy)
0440 = Speech language pathology-general classification
0441 = Speech language pathology-visit charge
0442 = Speech language pathology-hourly charge
0443 = Speech language pathology-group rate
0444 = Speech language pathology-evaluation or re-evaluation
0449 = Speech language pathology-other
0450 = Emergency room-general classification
0451 = Emergency room-emtala emergency medical screening services (eff 10/96)
0452 = Emergency room-ER beyond emtala screening (eff 10/96)
0456 = Emergency room-urgent care (eff 10/96)
0459 = Emergency room-other
0460 = Pulmonary function-general classification
0469 = Pulmonary function-other
0470 = Audiology-general classification
0471 = Audiology-diagnostic
0472 = Audiology-treatment
0479 = Audiology-other
0480 = Cardiology-general classification
0481 = Cardiology-cardiac cath lab
0482 = Cardiology-stress test
0483 = Cardiology-Echocardiology
0489 = Cardiology-other
0490 = Ambulatory surgical care-general classification
0499 = Ambulatory surgical care-other
0500 = Outpatient services-general classification
0509 = Outpatient services-other
0510 = Clinic-general classification
0511 = Clinic-chronic pain center
0512 = Clinic-dental center
0513 = Clinic-psychiatric
0514 = Clinic-OB-GYN
0515 = Clinic-pediatric
0516 = Clinic-urgent care clinic (eff 10/96)
0517 = Clinic-family practice clinic (eff 10/96)
0519 = Clinic-other
0520 = Free-standing clinic-general classification
0521 = Free-standing clinic-Clinic visit by a member to RHC/FQHC (eff. 7/1/06). Prior to 7/1/06 - Rural Health-Clinic
0522 = Free-standing clinic-Home visit by RHC/FQHC practitioner (eff. 7/1/06). Prior to 7/1/06 - Rural Health-Home
0523 = Free-standing clinic-family practice
0524 = Free-standing clinic - visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF. (eff. 7/1/06)
0525 = Free-standing clinic - visit by RHC/FQHC practitioner to a member in a SNF (not in

a covered Part A stay) or NF or ICF MR or other residential facility. (eff. 7/1/06)
0526 = Free-standing clinic-urgent care (eff 10/96)
0527 = Free-standing clinic-RHC/FQHC visiting nurse service(s) to a member's home when in a home health shortage area. (eff. 7/1/06)
0528 = Free-standing clinic-visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g. scene of accident). (eff. 7/1/06)
0529 = Free-standing clinic-other
0530 = Osteopathic services-general classification
0531 = Osteopathic services-osteopathic therapy
0539 = Osteopathic services-other
0540 = Ambulance-general classification
0541 = Ambulance-supplies
0542 = Ambulance-medical transport
0543 = Ambulance-heart mobile
0544 = Ambulance-oxygen
0545 = Ambulance-air ambulance
0546 = Ambulance-neo-natal ambulance
0547 = Ambulance-pharmacy
0548 = Ambulance-telephone transmission EKG
0549 = Ambulance-other
0550 = Skilled nursing-general classification
0551 = Skilled nursing-visit charge
0552 = Skilled nursing-hourly charge
0559 = Skilled nursing-other
0560 = Medical social services-general classification
0561 = Medical social services-visit charge
0562 = Medical social services-hourly charges
0569 = Medical social services-other
0570 = Home health aid (home health)-general classification
0571 = Home health aid (home health)-visit charge
0572 = Home health aid (home health)-hourly charge
0579 = Home health aid (home health)-other
0580 = Other visits (home health)-general classification (under HHPPS, not allowed as covered charges)
0581 = Other visits (home health)-visit charge (under HHPPS, not allowed as covered charges)
0582 = Other visits (home health)-hourly charge (under HHPPS, not allowed as covered charges)
0583 = Other visits (home health) - assessments (under HHPPS, not allow as covered charges)
0589 = Other visits (home health)-other (under HHPPS, not allowed as covered charges)
0590 = Units of service (home health)-general classification (under HHPPS, not allowed as covered charges)
0599 = Units of service (home health)-other (under HHPPS, not allowed as covered charges) (obsolete)
0600 = Oxygen/Home Health-general classification

0601 = Oxygen/Home Health-stat or port equip/supply or count
0602 = Oxygen/Home Health-stat/equip/under 1 LPM
0603 = Oxygen/Home Health-stat/equip/over 4 LPM
0604 = Oxygen/Home Health-stat/equip/portable add-on
0609 = Oxygen/Home Health - Other (Obsolete)
0610 = Magnetic resonance technology (MRT)-general classification
0611 = MRT/MRI-brain (including brainstem)
0612 = MRT/MRI-spinal cord (including spine)
0614 = MRT/MRI-other
0615 = MRT/MRA-Head and Neck
0616 = MRT/MRA-Lower Extremities
0618 = MRT/MRA-other
0619 = MRT/Other MRT
0620 = Reserved (Use 0270 for general classification)
0621 = Medical/surgical supplies-incident to radiology-subject to the payment limit - extension of 027X
0622 = Medical/surgical supplies-incident to other diagnostic service-subject to the payment limit - extension of 027X
0623 = Medical/surgical supplies-surgical dressings (eff 1/95) - extension of 027X
0624 = Medical/surgical supplies-medical investigational devices and procedures with FDA approved IDE's (eff 10/96) - extension of 027X
0630 = Reserved (eff. 1/98)
0631 = Drugs requiring specific identification-single drug source (eff 9/93)
0632 = Drugs requiring specific identification-multiple drug source (eff 9/93)
0633 = Drugs requiring specific identification-restrictive prescription (eff 9/93)
0634 = Drugs requiring specific identification-EPO under 10,000 units
0635 = Drugs requiring specific identification-EPO 10,000 units or more
0636 = Drugs requiring specific identification-detailed coding (eff 3/92)
0637 = Self-administered drugs administered in an emergency situation - not requiring detailed coding
0640 = Home IV therapy-general classification (eff 10/94)
0641 = Home IV therapy-nonroutine nursing (eff 10/94)
0642 = Home IV therapy-IV site care, central line (eff 10/94)
0643 = Home IV therapy-IV start/change peripheral line (eff 10/94)
0644 = Home IV therapy-nonroutine nursing, peripheral line (eff 10/94)
0645 = Home IV therapy-train patient/caregiver, central line (eff 10/94)

0646 = Home IV therapy-train disabled patient, central line (eff 10/94)
0647 = Home IV therapy-train patient/caregiver, peripheral line (eff 10/94)
0648 = Home IV therapy-train disabled patient, peripheral line (eff 10/94)
0649 = Home IV therapy-other IV therapy services (eff 10/94)
0650 = Hospice services-general classification
0651 = Hospice services-routine home care
0652 = Hospice services-continuous home care-1/2

0655 = Hospice services-inpatient care
0656 = Hospice services-general inpatient care (non-respite)
0657 = Hospice services-physician services
0658 = Hospice services-Hospice Room & Board - Nursing Facility
0659 = Hospice services-other
0660 = Respite care (HHA)-general classification (eff 9/93)
0661 = Respite care (HHA)-hourly charge/skilled nursing (eff 9/93)
0662 = Respite care (HHA)-hourly charge/home health aide/ homemaker (eff 9/93)
0663 = Respite care-daily respite care
0669 = Respite care-other respite care
0670 = OP special residence charges - general classification
0671 = OP special residence charges - hospital based
0672 = OP special residence charges - contracted
0679 = OP special residence charges - other special residence charges
0680 = Trauma Response-not used
0681 = Trauma response-Level I Trauma
0682 = Trauma response-Level II Trauma
0683 = Trauma response-Level III Trauma
0684 = Trauma response-Level IV Trauma
0689 = Trauma response-Other trauma response
0690 = Pre-hospice/Palliative Care Services - general (eff. 7/1/17)
0691 = Pre-hospice/Palliative Care Services - visit (eff. 7/1/17)
0692 = Pre-hospice/Palliative Care Services - hourly (eff. 7/1/17)
0693 = Pre-hospice/Palliative Care Services - evaluation (eff. 7/1/17)
0694 = Pre-hospice/Palliative Care Services - consultation & education (eff. 7/1/17)
0695 = Pre-hospice/Palliative Care Services - Inpatient (eff. 7/1/17)
0696 = Pre-hospice/Palliative Care Services - Physician (eff. 7/1/17)
0699 = Pre-hospice/Palliative Care Services - Other

(eff. 7/1/17)
0700 = Cast room-general classification
0709 = Cast room-other (obsolete)
0710 = Recovery room-general classification
0719 = Recovery room-other (obsolete)
0720 = Labor room/delivery-general classification
0721 = Labor room/delivery-labor
0722 = Labor room/delivery-delivery
0723 = Labor room/delivery-circumcision
0724 = Labor room/delivery-birthing center
0729 = Labor room/delivery-other
0730 = EKG/ECG-general classification
0731 = EKG/ECG-Holter moniter
0732 = EKG/ECG-telemetry (include fetal monitering until 9/93)
0739 = EKG/ECG-other
0740 = EEG-general classification
0749 = EEG (electroencephalogram)-other (Obsolete)
0750 = Gastro-intestinal services-general classification
0759 = Gastro-intestinal services-other (Obsolete)
0760 = Treatment or observation room-general classification
0761 = Treatment or observation room-treatment room (eff 9/93)
0762 = Treatment or observation room-observation room (eff 9/93)
0769 = Treatment or observation room-other
0770 = Preventative care services-general classification (eff 10/94)
0771 = Preventative care services-vaccine administration (eff 10/94)
0779 = Preventative care services-other (eff 10/94) (Obsolete)
0780 = Telemedicine - general classification (eff 10/97)
0789 = Telemedicine - telemedicine (eff 10/97) (Obsolete)
0790 = Extra-Corporeal Shock Wave Therapy (ESWT) - general classification - formerly Lithotripsy
0799 = Lithotripsy-other (Obsolete)
0800 = Inpatient renal dialysis-general classification
0801 = Inpatient renal dialysis-inpatient hemodialysis
0802 = Inpatient renal dialysis-inpatient peritoneal (non-CAPD)
0803 = Inpatient renal dialysis-inpatient CAPD
0804 = Inpatient renal dialysis-inpatient CCPD
0809 = Inpatient renal dialysis-other inpatient dialysis
0810 = Organ acquisition-general classification
0811 = Organ acquisition-living donor (eff 10/94); prior to 10/94, defined as living donor kidney
0812 = Organ acquisition-cadaver donor (eff 10/94); prior to 10/94, defined as cadaver donor kidney
0813 = Organ acquisition-unknown donor (eff 10/94) prior to 10/94, defined as unknown donor kidney
0814 = Organ acquisition - unsuccessful organ search-donor bank charges (eff 10/94); prior to 10/94,

defined as other kidney acquisition
0815 = Allogeneic Stem Cell Acquisition/Donor Services
0816 = Organ acquisition-other heart acquisition
(obsolete, eff 10/94)
0817 = Organ acquisition-donor-liver
(obsolete, eff 10/94)
0819 = Organ acquisition-other donor (eff 10/94);
prior to 10/94, defined as other
0820 = Hemodialysis OP or home dialysis-general
classification
0821 = Hemodialysis OP or home dialysis-hemodialysis-
composite or other rate
0822 = Hemodialysis OP or home dialysis-home supplies
0823 = Hemodialysis OP or home dialysis-home equipment
0824 = Hemodialysis OP or home dialysis-maintenance/100%
0825 = Hemodialysis OP or home dialysis-support services
0826 = Hemodialysis OP or home dialysis- Hemo short
(eff. 7/1/17)
0829 = Hemodialysis OP or home dialysis-other
0830 = Peritoneal dialysis OP or home-general
classification
0831 = Peritoneal dialysis OP or home-peritoneal-
composite or other rate
0832 = Peritoneal dialysis OP or home-home supplies
0833 = Peritoneal dialysis OP or home-home equipment
0834 = Peritoneal dialysis OP or home-maintenance/100%
0835 = Peritoneal dialysis OP or home-support services
0839 = Peritoneal dialysis OP or home-other
0840 = CAPD outpatient-general classification
0841 = CAPD outpatient-CAPD/composite or other rate
0842 = CAPD outpatient-home supplies
0843 = CAPD outpatient-home equipment
0844 = CAPD outpatient-maintenance/100%
0845 = CAPD outpatient-support services
0849 = CAPD outpatient-other
0850 = CCPD outpatient-general classification
0851 = CCPD outpatient-CCPD/composite or other rate
0852 = CCPD outpatient-home supplies
0853 = CCPD outpatient-home equipment
0854 = CCPD outpatient-maintenance/100%
0855 = CCPD outpatient-support services
0859 = CCPD outpatient-other
0860 = Magnetoencephalography (MEG) - general
classification
0861 = Magnetoencephalography (MEG) - MEG
0880 = Miscellaneous dialysis-general classification
0881 = Miscellaneous dialysis-ultrafiltration
0882 = Miscellaneous dialysis-home dialysis aide visit
(eff 9/93)
0889 = Miscellaneous dialysis-other
0890 = Other donor bank-general classification; changed to
reserved for national assignment (eff 4/94)
0891 = Other donor bank-bone; changed to
reserved for national assignment (eff 4/94)

0892 = Other donor bank-organ (other than kidney); changed to reserved for national assignment (eff 4/94) (term. 3/2020)
0892 = Special Processed Drugs - FDA Approved Gene Therapy (eff. 4/2020)
0893 = Other donor bank-skin; changed to reserved for national assignment (eff 4/94)
0899 = Other donor bank-other; changed to reserved for national assignment (eff 4/94)
0900 = Behavior Health Treatment/Services - general classification (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-general classification
0901 = Behavior Health Treatment/Services - electroshock treatment (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-electroshock treatment
0902 = Behavior Health Treatment/Services - milieu therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-milieu therapy
0903 = Behavior Health Treatment/Services - play therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-play therapy
0904 = Behavior Health Treatment/Services - activity therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-activity therapy
0905 = Behavior Health Treatment/Services - intensive outpatient services-psychiatric (eff. 10/2004)
0906 = Behavior Health Treatment/Services - intensive outpatient services-chemical dependency (eff. 10/2004)
0907 = Behavior Health Treatment/Services - community behavioral health program-day treatment (eff. 10/2004)
0909 = Reserved for National Use (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-other
0910 = Behavioral Health Treatment/Services-Reserved for National Assignment (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-general classification
0911 = Behavioral Health Treatment/Services-rehabilitation (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-rehabilitation
0912 = Behavioral Health Treatment/Services-partial hospitalization-less intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/ psychological services-less intensive
0913 = Behavioral Health Treatment/Services-partial hospitalization-intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/

psychological services-intensive
0914 = Behavioral Health Treatment/Services-individual therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-individual therapy
0915 = Behavioral Health Treatment/Services-group therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-group therapy
0916 = Behavioral Health Treatment/Services-family therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-family therapy
0917 = Behavioral Health Treatment/Services-bio feedback (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-bio feedback
0918 = Behavioral Health Treatment/Services-testing (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-testing
0919 = Behavioral Health Treatment/Services-other (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-other
0920 = Other diagnostic services-general classification
0921 = Other diagnostic services-peripheral vascular lab
0922 = Other diagnostic services-electromyelogram
0923 = Other diagnostic services-pap smear
0924 = Other diagnostic services-allergy test
0925 = Other diagnostic services-pregnancy test
0929 = Other diagnostic services-other
0931 = Medical Rehabilitation Day Program - Half Day
0932 = Medical Rehabilitation Day Program - Full Day
0940 = Other therapeutic services-general classification
0941 = Other therapeutic services-recreational therapy
0942 = Other therapeutic services-education/training (include diabetes diet training)
0943 = Other therapeutic services-cardiac rehabilitation
0944 = Other therapeutic services-drug rehabilitation
0945 = Other therapeutic services-alcohol rehabilitation
0946 = Other therapeutic services-routine complex medical equipment
0947 = Other therapeutic services-ancillary complex medical equipment (eff 3/92)
0948 = Other therapeutic services- pulmonary rehab
0949 = Other therapeutic services-other
0951 = Professional Fees-athletic training (extension of 094X)
0952 = Professional Fees-kinesiotherapy (extension of 094X)
0953 = Chemical Dependency (eff. 4/2013)
0960 = Professional fees-general classification
0961 = Professional fees-psychiatric
0962 = Professional fees-ophthalmology

0963 = Professional fees-anesthesiologist (MD)
0964 = Professional fees-anesthetist (CRNA)
0969 = Professional fees-other
NOTE: 097X is an extension of 096X
0971 = Professional fees-laboratory
0972 = Professional fees-radiology diagnostic
0973 = Professional fees-radiology therapeutic
0974 = Professional fees-nuclear medicine
0975 = Professional fees-operating room
0976 = Professional fees-respiratory therapy
0977 = Professional fees-physical therapy
0978 = Professional fees-occupational therapy
0979 = Professional fees-speech pathology
NOTE: 098X is an extension of 096X & 097X
0981 = Professional fees-emergency room
0982 = Professional fees-outpatient services
0983 = Professional fees-clinic
0984 = Professional fees-medical social services
0985 = Professional fees-EKG
0986 = Professional fees-EEG
0987 = Professional fees-hospital visit
0988 = Professional fees-consultation
0989 = Professional fees-private duty nurse
0990 = Patient convenience items-general classification
0991 = Patient convenience items-cafeteria/guest tray
0992 = Patient convenience items-private linen service
0993 = Patient convenience items-telephone/telecom
0994 = Patient convenience items-tv/radio
0995 = Patient convenience items-nonpatient room rentals
0996 = Patient convenience items-late discharge charge
0997 = Patient convenience items-admission kits
0998 = Patient convenience items-beauty shop/barber
0999 = Patient convenience items-other
1000 = Behavioral Health Accommodations - general classification
1001 = Behavioral Health Accommodations - residential treatment -Psychiatric
1002 = Behavioral Health Accommodations - residential treatment - chemical dependency
1003 = Behavioral Health Accommodations - supervised living
1004 = Behavioral Health Accommodations - halfway house
1005 = Behavioral Health Accommodations - group home
2100 = Alternative Therapy Services - general classification
2101 = Alternative Therapy Services - Acupuncture
2102 = Alternative Therapy Services - Acupressure
2103 = Alternative Therapy Services - massage

2104 = Alternative Therapy Services - reflexology
2105 = Alternative Therapy Services - biofeedback
2106 = Alternative Therapy Services - hypnosis
2109 = Alternative Therapy Services - other alternative therapy service
3100 = Adult Care - Reserved
3101 = Adult Care - adult day care, medical and social hourly
3102 = Adult Care - adult day care, social-hourly
3103 = Adult Care - adult day care, medical and social - daily
3104 = Adult Care - adult day care, social - daily
3105 = Adult Care - adult foster care daily
3109 = Adult Care - other adult care

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

9000 = RUGS-no MDS assessment available
9001 = Reduced physical functions-RUGS PA1/ADL index of 4-5
9002 = Reduced physical functions-RUGS PA2/ADL index of 4-5
9003 = Reduced physical functions-RUGS PB1/ADL index of 6-8
9004 = Reduced physical functions-RUGS PB2/ADL index of 6-8
9005 = Reduced physical functions-RUGS PC1/ADL index of 9-10
9006 = Reduced physical functions-RUGS PC2/ADL index of 9-10
9007 = Reduced physical functions-RUGS PD1/ADL index of 11-15
9008 = Reduced physical functions-RUGS PD2/ADL index of 11-15
9009 = Reduced physical functions-RUGS PE1/ADL index of 16-18
9010 = Reduced physical functions-RUGS PE2/ADL index of 16-18
9011 = Behavior only problems-RUGS BA1/ADL index of 4-5
9012 = Behavior only problems-RUGS BA2/ADL index of 4-5
9013 = Behavior only problems-RUGS BB1/ADL index of 6-10
9014 = Behavior only problems-RUGS BB2/ADL index of 6-10
9015 = Impaired cognition-

RUGS IA1/ADL index of 4-5
9016 = Impaired cognition-
RUGS IA2/ADL index of 4-5
9017 = Impaired cognition-
RUGS IB1/ADL index of 6-10
9018 = Impaired cognition-
RUGS IB2/ADL index of 6-10
9019 = Clinically complex-
RUGS CA1/ADL index of 4-5
9020 = Clinically complex-
RUGS CA2/ADL index of 4-5d
9021 = Clinically complex-
RUGS CB1/ADL index of 6-10
9022 = Clinically complex-
RUGS CB2/ADL index of 6-10d
9023 = Clinically complex-
RUGS CC1/ADL index of 11-16
9024 = Clinically complex-
RUGS CC2/ADL index of 11-16d
9025 = Clinically complex-
RUGS CD1/ADL index of 17-18
9026 = Clinically complex-
RUGS CD2/ADL index of 17-18d
9027 = Special care-
RUGS SSA/ADL index of 7-13
9028 = Special care-
RUGS SSB/ADL index of 14-16
9029 = Special care-
RUGS SSC/ADL index of 17-18
9030 = Extensive services-
RUGS SE1/1 procedure
9031 = Extensive services-
RUGS SE2/2 procedures
9032 = Extensive services-
RUGS SE3/3 procedures
9033 = Low rehabilitation-
RUGS RLA/ADL index of 4-11
9034 = Low rehabilitation-
RUGS RLB/ADL index of 12-18
9035 = Medium rehabilitation-
RUGS RMA/ADL index of 4-7
9036 = Medium rehabilitation-
RUGS RMB/ADL index of 8-15
9037 = Medium rehabilitation-
RUGS RMC/ADL index of 16-18
9038 = High rehabilitation-
RUGS RHA/ADL index of 4-7
9039 = High rehabilitation-
RUGS RHB/ADL index of 8-11
9040 = High rehabilitation-
RUGS RHC/ADL index of 12-14
9041 = High rehabilitation-
RUGS RHD/ADL index of 15-18
9042 = Very high rehabilitation-

RUGS RVA/ADL index of 4-7
9043 = Very high rehabilitation-
RUGS RVB/ADL index of 8-13
9044 = Very high rehabilitation-
RUGS RVC/ADL index of 14-18

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

9019 = Clinically complex-
RUGS CA1/ADL index of 11
9020 = Clinically complex-
RUGS CA2/ADL index of 11D
9021 = Clinically complex-
RUGS CB1/ADL index of 12-16
9022 = Clinically complex-
RUGS CB2/ADL index of 12-16D
9023 = Clinically complex-
RUGS CC1/ADL index of 17-18
9024 = Clinically complex-
RUGS CC2/ADL index of 17-18D
9025 = Special care-
RUGS SSA/ADL index of 14
9026 = Special care-
RUGS SSB/ADL index of 15-16
9027 = Special care-
RUGS SSC/ADL index of 17-18
9028 = Extensive services-
RUGS SE1/ADL index 7-18/1 procedure
9029 = Extensive services-
RUGS SE2/ADL index 7-18/2 procedures
9030 = Extensive services-
RUGS SE3/ADL index 7-18/3 procedures
9031 = Low rehabilitation-
RUGS RLA/ADL index of 4-13
9032 = Low rehabilitation-
RUGS RLB/ADL index of 14-18
9033 = Medium rehabilitation-
RUGS RMA/ADL index of 4-7
9034 = Medium rehabilitation-
RUGS RMB/ADL index of 8-14
9035 = Medium rehabilitation-
RUGS RMC/ADL index of 15-18
9036 = High rehabilitation-
RUGS RHA/ADL index of 4-7
9037 = High rehabilitation-
RUGS RHB/ADL index of 8-12
9038 = High rehabilitation-
RUGS RHC/ADL index of 13-18
9039 = Very High rehabilitation-
RUGS RVA/ADL index of 4-8
9040 = Very high rehabilitation-
RUGS RVB/ADL index of 9-15
9041 = Very high rehabilitation-

RUGS RVC/ADL index of 16
9042 = Very high rehabilitation-
RUGS RUA/ADL index of 4-8
9043 = Very high rehabilitation-
RUGS RUB/ADL index of 9-15
9044 = Ultra high rehabilitation-
RUGS RUC/ADL index of 16-18

REV_CNTR_THRPY_CAP_IND_CD_TB Revenue Center Therapy CAP Indicator Code Table

A = Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator will be used on institutional claims only).

B = Critical Access Hospital outpatient claims are subject to the therapy cap for this date of service (this indicator will be used on institutional claims only). Note: Currently, Critical Access Hospital claims are not subject to any therapy cap policies. Indicator B is created here to prepare for possible future legislation to include these claims.

C = The therapy cap exceptions process, as indicated by the submission of the KX modifier, no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

D = The $3700 threshold for review therapy services no longer applies for this date of service (this indicator will be used on both institutional and professional claims).

REV_CNTR_VLNTRY_SRVC_IND_TB Revenue Center Voluntary Service Indicator Table

V = A voluntary procedure code
Blank = A required procedure code

RP_IND_TB Claim Representative Payee (RP) Indicator Code Table

R = bypass representative payee
Space

RSDL_PMT_IND_TB Claim Residual Payment Indicator Code Table

X = Residual Payment

Space

QUERY: RIFQQ11, RIFQQ21 ON DB2T
*******END OF TOC APPENDIX FOR RECORD: FI_HHA_CLM_REC********

1
LIMITATIONS APPENDIX FOR RECORD: FI_HHA_CLM_REC, STATUS: PROD, VERSION: 21104
PRINTED: 04/26/2021, USER: F43D, DATA SOURCE: CA REPOSITORY ON DB2T

CHOICES_DEMO_LIM
FULL NAME: Choices Demonstration Limitation
DESCRIPTION :
A programming error created an 'INVALID' indication
in the demo text field for CHOICES claims.
BACKGROUND :
In 6/00, the CWFMQA front-end editing revealed that some
CHOICES demo claims were coming in with a valid 'H'
number in the fixed portion of the claims, but in the
first occurrence MCO trailer a numeric packed field
(value hex '0100000C') was moved to the MCO Contract
Number/Option Code fields. This created an invalid
period check of number/code to MCO effective date,
resulting in an INVALID indication in the demo info
text field.
CORRECTIVE ACTION :
The problem was forwarded to the CWF BSOG staff
for further investigation.
SOURCE:
CONTACT : OIS/EDG/DMUDD
CLM_ACNT_NUM_LIM
FULL NAME: Beneficiary Claim Account Number Limitation
DESCRIPTION :
RRB-issued numbers contain an overpunch in
the first position that may appear as a plus
zero or A-G. RRB-formatted numbers may
cause matching problems on non-IBM machines.
SOURCE:
CLM_HHA_CARE_STRT_DT_LIM
FULL NAME: Claim HHA Care Start Date Limitation
DESCRIPTION :
IT WAS BROUGHT TO OUR ATTENTION THAT THE HHA CARE START
DATE WAS NOT BEING POPULATED ON THE NCH CLAIMS SINCE
2008. AFTER FURTHER INVESTIGATION, IT WAS DISCOVERED
THERE WAS NEED TO CARRY MORE INFORMATION IN THE TREATMENT
AUTHORIZATION CODE FIELD (FIELD USED TO DERIVE THE HHA
CARE START DATE) SO CMS GAVE INSTRUCTIONS TO COMPRESS
THE DATE INTO 4 POSITIONS.
BACKGROUND :
PRIOR TO CY2008, THE HHA CARE START DATE WAS PULLED
FROM THE 1ST EIGHT POSITIONS OF THE TREATMENT AUTHOR-

IZATION CODE. AS OF CY2008, THE 1ST TWO POSITIONS REFLECT THE 2 DIGIT YEAR AND POSITIONS 3 & 4 REFLECT AN ALPHA CODE FOR THE MONTH/DAY DATE. POSITIONS 3 & 4 ARE DERIVED BY CONVERTING THE MM/DD TO 2 POSITION ALPHABETIC VALUES USING A HEXAVIGESIMAL CODING SYSTEM. BELOW IS AN EXAMPLE OF HOW THE DATE IS REFLECTED IN THE TREATMENT AUTHORIZATION CODE AS OF THE CY2008 CHANGE:

POSITION	DEFINITION	ACTUAL VALUE	RESULTING CODE
1 - 2	M0030 - 2 DIGIT YEAR	2007	07
3 - 4	M0030 - CODE FOR DATE	09/01	JK

AN EXAMPLE OF A TREATMENT AUTHORIZATION CODE THAT WOULD APPEAR ON THE CLAIM WOULD BE: 07JK08AA41GBMDCDLG.

SINCE THE TIME OF THIS CHANGE TO COMPRESS THE DATE, OUR FRONT-END SYSTEM WAS NOT MOVING A DATE INTO THE HHA CARE START DATE FIELD BECAUSE THE TREATMENT AUTHORIZATION CODE NO LONGER CARRIED A VALID 8 POSITION DATE. THE DATE IS THERE, IN THE 1ST 4 POSITIONS OF THE TREATMENT AUTHORIZATION CODE BUT IT MUST BE DECODED.

SUBSEQUENT ISSUE: AFTER IMPLEMENTING THE CODE CHANGE IN OUR FRONT-END SYSTEM TO DECODE THE DATE, A USER NOTICED THAT A SMALL VOLUME OF CLAIMS CARRIED INVALID MM/DD DATE INFORMATION. THE USER FOUND DATES OF 02/29/XXXX AND 04/31/XXXX. WE INVESTIGATED THE ISSUE AND FOUND TWO LOGIC DEFECTS:

(1) THE HEXAVEGIMAL TEST FOR THE SPECIFIC DATE OF MARCH 31 WAS INCORRECT; MONTH AND DATE 0331 (MARCH 31) WAS INCORRECTLY OUTPUT AS 0431 (APRIL 31).
(2) THE LEAP YEAR TEST WAS DEFECTIVE; THE MONTH AND DATE 0229 (FEBRUARY 29) THAT WAS OUTPUT RECEIVED AND TRANSLATED CORRECTLY, HOWEVER THE OUTPUT DATE SHOULD HAVE BEEN SET TO ZEROES BECAUSE THE SPECIFIC FEBRUARY 29, CALENDAR DATES REPORTED DID NOT OCCUR DURING A LEAP YEAR.

CORRECTIVE ACTION :
EFFECTIVE DECEMBER 17TH, CODE WAS IMPLEMENTED IN OUR FRONT END PROCESS TO CONVERT THE FOUR POSITIONS INTO A VALID DATE AND MOVE THAT DATE TO THE HHA CARE START DATE FIELD.

EFFECTIVE JANUARY 2013, A FIX WAS PUT IN TO CORRECT THE TWO LOGIC DEFECTS FOUND AFTER THE IMPLEMENTATION OF THE CORRECTIVE ACTION TO FIX THE FRONT END CODE TO CORRECTLY POPULATE THE DATE. THE TWO LOGIC DEFECTS ARE OUTLINED IN THE BACKGROUND SECTION.

SOURCE:
ADMINISTRATIVE DATA:

START DATE : 01/01/2008
END DATE : 12/17/2012
CONTACT : OIS/EDG/DDOM

CLM_TRANS_CD_LIM

FULL NAME: Claim Transaction Code Limitation
DESCRIPTION :
Claim Transaction Code missing from 1999 inpatient records and there was also a problem identified in the May and June 2000 data.
BACKGROUND :
Users of the data discovered taht the claim transaction code was missing values 2 & 3 for service year 1999 and for the months of May and June, 2000. This information was confirmed and OIS/BSOG was notified.
CORRECTIVE ACTION :
In July 2000 the problem was fixed and the claim transaction code contained the correct values.
SOURCE:
CONTACT : OIS/EDG/DMUDD

HHA_HCPCS_LIM

FULL NAME: Home Health HCPCS Limitation
DESCRIPTION :
It was determined that providers were not complying with the 15-minute increment billing instructions for using the 'G' HCPCS codes.
BACKGROUND :
The instructions state that providers are to use the newly created 'G' codes to identify services of the six home health disciplines during an HH episode of care. These 'G' codes (G0151, G0152, G0153, G0154, G0155, G0156) are subject to 15-minute interval billing. As a result the user can not trust the 'G' codes for visit counting. For a more accurate accounting of services the user should rely on the revenue center codes rather than the HCPCS.

Currently there is a check that if the 15-minute increment 'G' codes appear, the revenue center code must be the corresponding HH discipline; however, there is no check to see if the discipline revenue center code appears and that the HCPCS contains the corresponding 'G' code.
CORRECTIVE ACTION :
The Standard Systems has put a fix in to correct this problem.
SOURCE:
CONTACT : OIS/EDG/DMUDD

HHA_PPS_LUPA_IND_CD_LIM

FULL NAME: HHA PPS LUPA Indicator Code Limitation
DESCRIPTION :
LUPA indicator code blanked out.
BACKGROUND :
For Home Health PPS claims, the LUPA indicator was blanked out since the beginning of HHPPS (10/1/00).

CORRECTIVE ACTION :
CWFMQA put in a fix which was effective with claims with an NCH Weekly Process Date 3/16/01.
SOURCE:
ADMINISTRATIVE DATA:
START DATE : 10/01/00
END DATE : 03/16/01
CONTACT : OIS/EDG/DMUDD

HHA_RFRL_CD_LIM
FULL NAME: HHA Referral Code Limitation
DESCRIPTION :
HHA referral code was blanked out.
BACKGROUND :
For Home Health PPS claims, the HHA referral code was blanked out since the beginning of HHPPS (10/1/00).
CORRECTIVE ACTION :
CWFMQA put a fix in which will be effective with claims with an NCH Weekly Process Date 3/16/01.
SOURCE:
ADMINISTRATIVE DATA:
START DATE : 10/01/00
END DATE : 03/16/01
CONTACT : OIS/EDG/DMUDD

HHA_TOT_VISIT_CNT_LIM
FULL NAME: HHA Total Visit Count Limitation
DESCRIPTION :
NCH HHA recovered claims may be missing the claim-level total visit count.
BACKGROUND :
During the recovery of NCH dropped claims it was discovered that there is a possibility that some or all of the HHA claims may be missing the total visit count. There were 997,422 recovered HHA claims.

The field comes in from CWF but is also derivable from looking at revenue center trailer information, in combination with the Claim From Date. Beginning in 7/1/99, with HHA claims received with service dates 7/1/99 and after, the claims processing systems started counting visits based on the number of HHA visit revenue center lines. Prior to 7/1/99, the count was derived by adding up the units field associated with the HHA visit revenue centers.

To identify these claims, look for service year 1998 and 1999 HHA claims with revenue center codes 042X, 043X, 044X, 055X, 056X, 057X, 058X, 059X with missing total visit count. If the Claim From Date is less than 7/1/99, derive the total by adding up the Revenue Center Unit count for each of these visit revenue centers. If the Claim From Date is greater than 6/30/99, derive the total

by counting each visit revenue code line item as
1 visit.
CORRECTIVE ACTION :
During the history conversion to Version 'I' the
NCH and SAFs were patched to correct the problem.
Any service year prior to 2000 could be involved.
The patched record will be annotated with an NCH
Patch Code = 12.

The patched claims will have an NCH Weekly Process
Date of 12/10/99, 12/17/99, or 1/7/00.
SOURCE: NCH
CONTACT : OIS/EDG/DMUDD

MCO_PD_SW_LIM
FULL NAME: Claim MCO Paid Switch Limitation
DESCRIPTION :
The MCO paid switch made consistent with criteria
used to identify an inpatient encounter claim.
BACKGROUND :
During the NCH Version 'I' conversion, history was
populated with an NCH Claim Type Code that will
identify the record as an inpatient encounter claim.
When applying the CWF logic to identify an inpatient
encounter claim, it was discovered that when all
the criteria was met the MCO paid switch was some-
times a blank or '0' (reflecting that the MCO did
not pay the provider).
CORRECTIVE ACTION :
With the inception of the Version 'I' processing
(7/00), if all the criteria for identifying an
inpatient encounter claim is met but the MCO paid
switch is a blank or '0' it is changed to a '1'.

A patch code = '13' was applied to all claims back
to 7/1/97 service year thru date.
SOURCE:
CONTACT : OIS/EDG/DMUDD

MLTPL_REV_CNTR_0001_CD_LIM
FULL NAME: Multiple Revenue Center '0001' Code Limitation
DESCRIPTION :
Multiple total charge '0001' revenue center codes appearing
on outpatient, hospice and home health claim records.
BACKGROUND :
On outpatient, home health and hospice it appears that
more than one '0001' revenue center code is showing
up on the claims. The first total charge line adds
the revenue center codes above it correctly; the
problem exists below the first total charge line
where garbage may be present due to the FI Standard
System not clearing out fields before processing the
next claim. We believe the error began with the change-
over to a different claims processing contractor in
1/98.
CORRECTIVE ACTION :

CWF created an edit to reject mulitple '0001' revenue center codes, effective 6/28/99. EDG's CWFMQA process implemented an edit to drop any revenue center line items below the first total charge line. The NCH Nearline File, as well as the 1998 Standard Analytic Files (SAFs), have been patched/corrected to delete the multiple '0001' codes where present on any of the institutional claim types. Also, HCIS will be correcting the revenue center summaries during the next refresh.

The NCH_PATCH_CD field will reflect a value '10'.

SOURCE:

CONTACT : OIS/EDG/DMUDD

NCH_CLM_TYPE_CD_LIM

FULL NAME: NCH Claim Type Code Limitation

DESCRIPTION :

As of the implementation of Version 'J', the NCH claim type codes '62' and '64' were not correctly being set.

BACKGROUND :

With the implementation of Version'J', we added three new claim type codes ('62', '63' and '64') to identify Medicare Advantage claims.

It appears that the conversion code we used to convert all of our history files (claims prior to start of Version 'J') set the 62 and 64 correctly but that same code was not used in our normal monthly claims processing (claims received January 1, 2011 and after). The error was with the MCO-PD-SW logic used to derive the claim type code.

CORRECTIVE ACTION :

This anamoly was handled in two phases:

Phase 1 -- a fix was put into the NCH code to use the correct MCO-PD-SW logic. The fix was implemented prior to our October 2012 NCH monthly load. This fix corrected the claims received October 1st and forward.

Phase 2 -- History files (January 1, 2011 thru September 28, 2012) were corrected during our NCH Version 'K' conversion, which was implemented April 2013.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 01/01/2011

END DATE : 10/01/2012

NCH_DAILY_PROC_DT_LIM

FULL NAME: NCH Daily Process Date Limitation

DESCRIPTION :

The NCH Daily Process Date was mistakenly changed on all Version 'J' claims during the history conversion process.

BACKGROUND :

It was discovered during the process of modifying the conversion code used during Version 'J' processing that the NCH Daily Process Date was mistakenly changed in the Version 'J' conversion code. When preparing the specs for the Version 'J' conversion code, we were told to change the NCH Daily Process Date to reflect the date the history files were converted.

This change impacts the linkage of Part A claims that have multiple segments (claims with more than 45 revenue center lines) on the Version 'J' claim files. The NCH Daily Process Date is used in conjuction with the NCH Segment Link Number to keep records/segments belonging to a specific claim together.

There is the possibility that two different claims could now have the same NCH Daily Process Date and NCH Segment Link Number. This could cause users of the data to match claim records/segments together that should not be paired. We believe the chances of this occurring to be minimal.

CORRECTIVE ACTION :

Because the Version 'I' files were converted and the date changed, we have no way of going back and retrieving the original NCH Daily Process Date so no fix/patch will be applied.

SOURCE:

CONTACT : OIS/EDG/DDOM

PMT_AMT_EXCEDG_CHRG_AMT_LIM

FULL NAME: Claim Payment Amount Exceeding Total Charge Amount Limitation

DESCRIPTION :

Approximately 75 Inpatient claims had a reimbursement amount exceed $500,000 which was at least 25 times the total charge amount. There were also claims where the reimbursement was less than $500,000 but greater than the total charges.

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

SQL_INFO: NUMBER(11,2)

BACKGROUND :

In November of 1999, it was brought to the attention of the HDUG that large reimbursement amounts were being paid in Pennsylvania. There were 75 inpatient claims provided where the reimbursement amount was over $500,000 and at least 25 times the total charge amount. These claims were processed between 9/29/98

and 10/1/98. There were also claims identified with reimbursement less than $500,000 but greater than total charge. It was later discovered that the source of the problem was an error in entering an MSA; the decimal point was off by 2 positions.

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

CORRECTIVE ACTION :

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

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

SOURCE:

CONTACT : OIS/EDG/DMUDD

REV_CNTR_IDE_NDC_UPC_LIM

FULL NAME: Revenue Center IDE, NDC, UPC Limitation

DESCRIPTION :

Missing data in the REV_CNTR_IDE_NDC_UPC_NUM field.

BACKGROUND :

Prior to Version 'I', this field housed only the 7-position exemption number assigned by the FDA to an investigational device after a manufacturer has been approved to conduct a clinical trial on that device. With Version 'I', this field expanded to 24 positions to accommodate the future receipt of the National Drug Code and the Uniform Product Code. The CWFMQA editing process was moving the IDE to the expanded field, but then incorrectly blanked it out (positions 8-24 should be blank).

CORRECTIVE ACTION :

CWFMQA fixed the code and the problem was corrected with claims processed with NCH weekly process date 9/15/00.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 06/09/00

END DATE : 09/08/00

CONTACT : OIS/EDG/DMUDD

REV_CNTR_RNDRNG_SPCLTY_CD_LIM

FULL NAME: Revenue Center Rendering Specialty Code Limitation

DESCRIPTION :

It was discovered that the specialty code at the line level on Outpatient claims was erroneous due to the

truncation of the the revenue center rendering physician NPI number.

BACKGROUND :

In March 2013, it was discovered that since January 2013 FISS was sending CWF/NCH truncated revenue center rendering physician NPI numbers. Because the NPI was being truncated this also caused erroneous data in the specialty code field. This issue only impacts outpatient claims.

After further investigation, it was determined that the correct outpatient copybook was not being used with the implementation of the January release.

CORRECTIVE ACTION :

The fix for this anomaly is being handled in two phases:

Phase 1 -- a fix was put in the FISS system on 4/22/2013 to correct the issue going forward.

Phase 2 -- the second fix will be to send debit/credit adjustmentss to correct the data in the NCH/SAF.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 01/01/2013

END DATE : 04/22/2013

CONTACT : OIS/EDG/DDOM

REV_CNTR_TOT_CHRG_AMT_LIM

FULL NAME: Revenue Center Total Charge Amount Limitation

DESCRIPTION :

Revenue center total charge amount field being populated on segments 2-10 of the Version 'I' record.

BACKGROUND :

Under Version 'I', a decision was made that any amount, count and quantity field would be zeroed out to eliminate the risk of overstating values during an accumulation.

CORRECTIVE ACTION :

The CWFMQA front-end process was modified to zero out the total charge amount field in segments 2-10.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 07/01/00

END DATE : 02/02/01

CONTACT : OIS/EDG/DMUDD

REV_RNDRNG_PHYSN_NPI_NUM_LIM

FULL NAME: Revenue Center Rendering Physician NPI Number Limitation

DESCRIPTION :

It was discovered that the NPI at the line level on Outpatient claims was being truncated since January 2013.

BACKGROUND :

In March 2013, it was discovered that since January 2013 FISS was sending CWF/NCH truncated revenue center ren-

dering physician NPI numbers (REV-CNTR-RNDRNG-PHYSN-NPI-NUM). The NPIs were coming in as 8 bytes instead of 10 bytes. Because the NPI is truncated it is also causing erroneous data in the specialty code (REV-CNTR-RNDRNG-SPCLTY-CD) field. The issue only impacts outpatient claims.

After further investigation, it was determined that the correct outpatient copybook was not being used with the implementation of the January release.

CORRECTIVE ACTION :

The fix for this anamoly is being handled in two phases:

Phase 1 -- a fix was put in the FISS system on 4/22/13 to correct the issue going forward.

Phase 2 -- A second fix will be to send in debit/credit adjustments to correct the data in the NCH/SAF.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 01/01/2013
END DATE : 04/22/2013
CONTACT : OIS/EDG/DDOM

TOT_CHRG_AMT_LIM

FULL NAME: Claim Total Charge Amount Limitation

DESCRIPTION :

The total charge amount field in the fixed portion was truncated on outpatient, hospice and home health claims.

BACKGROUND :

For outpatient, hospice and home health claims, the total charge amount field in the fixed portion was truncated (the cents were dropped off; the decimal point was moved, making cents out of dollars) in the CWFMQA process beginning with data received from CWF 1/4/99 through 5/14/99. The problem occurred when CWF increased the size of the field.

CORRECTIVE ACTION :

The CWFMQA front-end was fixed. The Nearline was patched during the quarterly merge in 7/99 for service years 1998 and 1999. The NCH_PACTCH_CD field will be populated with a value '11'. The 1998 and 1999 SAFs were corrected when finalized in 7/99.

The patch involved moving the total charge amount in the revenue center trailer to the total charge amount field in the fixed portion, for records with NCH Daily Process Date 1/4/99 - 5/14/99.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 01/04/99
END DATE : 05/14/99
CONTACT : OIS/EDG/DMUDD

QUERY: RIFQQ41 ON DB2T
*******END OF LIMITATION APPENDIX FOR RECORD: FI_HHA_CLM_REC*******