Carrier Claims Data Dictionary

CCW Carrier Base Claim File:

NAME	TYPE	LENGTH
LDS Beneficiary Identifier	NUM	9

This field contains the key to link data for each beneficiary across all claim files.

SHORT NAME: DSYSRTKY
LONG NAME: DESY_SORT_KEY

LDS Claim Number	NUM	12

The unique number used to identify a unique claim.

SAS ALIAS: CLAIM_NO
STANDARD ALIAS: CLAIM_NO

NCH Near Line Record Identification Code	CHAR	1

A code defining the type of claim record being processed.

SHORT NAME: RIC_CD
LONG NAME: NCH_NEAR_LINE_REC_IDENT_CD

CODES:
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)

SOURCE:
NCH

NCH Claim Type Code CHAR 2

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

NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991).
NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.

SHORT NAME: CLM_TYPE
LONG NAME: NCH_CLM_TYPE_CD

DERIVATION:
FFS CLAIM TYPE CODES DERIVED FROM:
- NCH_NEAR_LINE_REC_IDENT_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

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
- (HDC processing -- AVAILABLE IN NMUD)
- FI_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD)
- FI_NUM
- CLM_FAC_TYPE_CD
- CLM_SRVC_CLSFCTN_TYPE_CD
- CLM_FREQ_CD

NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
- (AVAILABLE IN NMUD)
- CARR_NUM

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  CLM_DEMO_ID_NUM

OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (AVAILABLE IN NMUD)
  FI_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
DERIVED FROM:  (AVAILABLE IN NMUD)
  FI_NUM
  CLM_FAC_TYPE_CD
  CLM_SRVC_CLSFCTN_TYPE_CD
  CLM_FREQ_CD

DERIVATION RULES:

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

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

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

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

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

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

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

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

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

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

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1.   FI_NUM = 80881 AND
2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
     TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

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).
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SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
CONDITIONS ARE MET:
1. CARR_NUM = 80882 AND
2. CLM_DEMO_ID_NUM = 38

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

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

CODES:
NCH Claim Type Table

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

SOURCE:
NCH

Claim From Date DATE 8

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

NOTE: For Home Health PPS claims, the 'from'
date and the 'thru' date on the RAP (initial

claim) must always match.

8 DIGITS UNSIGNED

SHORT NAME: FROM_DT
LONG NAME: CLM_FROM_DT

EDIT-RULES:

YYYYMMDD

SOURCE:
CWF

Claim Through Date DATE 8

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.

If the year of the original Claim Through Date (THRU_DT) was future to the year of the Weekly Processing Date (WKLY_DT), the CCW Claim Through Date (THRU_DT) has been changed to 12/31/YYYY with YYYY representing the year of the Weekly Processing Date (WKLY_DT).

8 DIGITS UNSIGNED

SHORT NAME: THRU_DT
LONG NAME: CLM_THRU_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

Carrier Number CHAR 5

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

SHORT NAME: CARR_NUM
LONG NAME: CARR_NUM

CODES:

Carrier Number Table

00510 = Alabama BS (eff. 1983)
00511 = Georgia - Alabama BS (eff. 1998)
00512 = Mississippi - Alabama BS (eff. 2000)
00520 = Arkansas BS (eff. 1983)
00521 = New Mexico - Arkansas BS (eff. 1998)
00522 = Oklahoma - Arkansas BS (eff. 1998)
00523 = Missouri - Arkansas BS (eff. 1999)
00528 = Louisianna - Arkansas BS (eff. 1984)
00542 = California BS (eff. 1983; term. 1996)
00550 = Colorado BS (eff. 1983; term. 1994)
00570 = Delaware - Pennsylvania BS (eff. 1983; term. 1997)
00580 = District of Columbia - Pennsylvania BS (eff. 1983; term. 1997)
00590 = Florida BS (eff. 1983)
00591 = Connecticut - Florida BS (eff. 2000)
00621 = Illinois BS - HCSC (eff. 1983; term. 1998)
00623 = Michigan - Illinois Blue Shield (eff. 1995) (term. 1998)
00630 = Indiana - Administar (eff. 1983)
00635 = DMERC-B (Administar Federal, Inc.) (eff. 1993)
00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)
00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)
00650 = Kansas BS (eff. 1983)
00655 = Nebraska - Kansas BS (eff. 1988)
00660 = Kentucky - Administar (eff. 1983)
00690 = Maryland BS (eff. 1983; term. 1994)
00700 = Massachusetts BS (eff. 1983; term. 1997)
00710 = Michigan BS (eff. 1983; term. 1994)
00720 = Minnesota BS (eff. 1983; term. 1995)
00740 = Missouri - BS Kansas City (eff. 1983)
00751 = Montana BS (eff. 1983)
00770 = New Hampshire/Vermont Physician Services (eff. 1983; term. 1984)
00780 = New Hampshire/Vermont - Massachusetts BS (eff. 1985; term. 1997)
00801 = New York - Western BS (eff. 1983)
00803 = New York - Empire BS (eff. 1983)
00805 = New Jersey - Empire BS (eff. 3/99)
00811 = DMERC (A) - Western New York BS (eff. 2000)
00820 = North Dakota - North Dakota BS (eff. 1983)
00824 = Colorado - North Dakota BS (eff. 1995)
00825 = Wyoming - North Dakota BS (eff. 1990)
00826 = Iowa - North Dakota BS (eff. 1999)
00831 = Alaska - North Dakota BS (eff. 1998)
00832 = Arizona - North Dakota BS (eff. 1998)
00833 = Hawaii - North Dakota BS (eff. 1998)
00834 = Nevada - North Dakota BS (eff. 1998)
00835 = Oregon - North Dakota BS (eff. 1998)
00836 = Washington - North Dakota BS (eff. 1998)
00860 = New Jersey - Pennsylvania BS (eff. 1988; term. 1999)
00865 = Pennsylvania BS (eff. 1983)
00870 = Rhode Island BS (eff. 1983)
00880 = South Carolina BS (eff. 1983)

00882 = RRB - South Carolina PGBA (eff. 2000)
00885 = DMERC C - Palmetto (eff. 1993)
00900 = Texas BS (eff. 1983)
00901 = Maryland - Texas BS (eff. 1995)
00902 = Delaware - Texas BS (eff. 1998)
00903 = District of Columbia - Texas BS (eff. 1998)
00904 = Virginia - Texas BS (eff. 2000)
00910 = Utah BS (eff. 1983)
00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)
00952 = Illinois - Wisconsin Phy Svc (eff. 1999)
00953 = Michigan - Wisconsin Phy Svc (eff. 1999)
00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
00973 = Triple-S, Inc. - Puerto Rico (eff. 1983)
00974 = Triple-S, Inc. - Virgin Islands
01020 = Alaska - AETNA (eff. 1983; term. 1997)
01030 = Arizona - AETNA (eff. 1983; term. 1997)
01040 = Georgia - AETNA (eff. 1988; term. 1997)
01120 = Hawaii - AETNA (eff. 1983; term. 1997)
01290 = Nevada - AETNA (eff. 1983; term. 1997)
01360 = New Mexico - AETNA (eff. 1986; term. 1997)
01370 = Oklahoma - AETNA (eff. 1983; term. 1997)
01380 = Oregon - AETNA (eff. 1983; term. 1997
01390 = Washington - AETNA (eff. 1994; term. 1997)
02050 = California - TOLIC (eff. 1983) (term. 2000)
03070 = Connecticut General Life Insurance Co. (eff. 1983; term. 1985)
05130 = Idaho - Connecticut General (eff. 1983)
05320 = New Mexico - Equitable Insurance (eff. 1983; term. 1985)
05440 = Tennessee - Connecticut General (eff. 1983)
05530 = Wyoming - Equitable Insurance (eff. 1983) (term. 1989)
05535 = North Carolina - Connecticut General (eff. 1988)
05655 = DMERC-D - Connecticut General (eff. 1993)
10071 = Railroad Board Travelers (eff. 1983) (term. 2000)
10230 = Connecticut - Metra Health (eff. 1986) (term. 2000)
10240 = Minnesota - Metra Health (eff. 1983) (term. 2000)
10250 = Mississippi - Metra Health (eff. 1983) (term. 2000)
10490 = Virginia - Metra Health (eff. 1983) (term. 2000)
10555 = Travelers Insurance Co. (eff. 1993) (term. 2000)
11260 = Missouri - General American Life (eff. 1983; term. 1998)
14330 = New York - GHI (eff. 1983)
16360 = Ohio - Nationwide Insurance Co.
16510 = West Virginia - Nationwide Insurance Co.
21200 = Maine - BS of Massachusetts
31140 = California - National Heritage Ins.
31142 = Maine - National Heritage Ins.
31143 = Massachusetts - National Heritage Ins.
31144 = New Hampshire - National Heritage Ins.
31145 = Vermont - National Heritage Ins.
31146 = So. California - NHIC (eff. 2000)

SOURCE:
CWF

Carrier Claim Payment CHAR 1

Denial Code

The code on a noninstitutional claim indicating to whom payment was made or if the claim was denied.

SHORT NAME: PMTDNLCD
LONG NAME: CARR_CLM_PMT_DNL_CD

CODES:
Carrier Claim Payment Denial Table
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0 = Denied
1 = Physician/supplier
2 = Beneficiary
3 = Both physician/supplier and beneficiary
4 = Hospital (hospital based physicians)
5 = Both hospital and beneficiary
6 = Group practice prepayment plan
7 = Other entries (e.g. Employer, union)
8 = Federally funded
9 = PA service
A = Beneficiary under limitation of liability
B = Physician/supplier under limitation of liability
D = Denied due to demonstration involvement (eff. 5/97)
E = MSP cost avoided IRS/SSA/HCFA Data Match (eff. 7/3/00)
F = MSP cost avoided HMO Rate Cell (eff. 7/3/00)
G = MSP cost avoided Litigation Settlement (eff. 7/3/00)
H = MSP cost avoided Employer Voluntary Reporting (eff. 7/3/00)
J = MSP cost avoided Insurer Voluntary Reporting (eff. 7/3/00)
K = MSP cost avoided Initial Enrollment Questionnaire (eff. 7/3/00)
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided - (Contractor #88888) voluntary agreement (eff. 1/98)
T = MSP cost avoided - IEQ contractor (eff. 7/96) (obsolete 6/30/00)
U = MSP cost avoided - HMO rate cell adjustment (eff. 7/96) (obsolete 6/30/00)
V = MSP cost avoided - litigation settlement (eff. 7/96) (obsolete 6/30/00)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data match project (obsolete 6/30/00)

SOURCE:
CWF

Claim Payment Amount NUM 12

Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. **NOTE: In some

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

Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). After 4/1/03, the payment amount could also include a "new technology" add-on amount. It does NOT include the pass-thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any any other payer reimbursement.

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

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

Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center code =

'0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount.

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

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

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

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

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

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

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

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

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

SHORT NAME: PMT_AMT

LONG NAME: CLM_PMT_AMT

LENGTH: 9.2
SIGNED : Y

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

SOURCE: CWF

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

REFER TO :
PMT_AMT_EXCEDG_CHRG_AMT_LIM

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

Carrier Claim Primary Payer Paid Amount NUM 12

Effective with Version H, the amount of a
payment made on behalf of a Medicare bene-
ficiary by a primary payer other than Medicare,
that the provider is applying to covered
Medicare charges on a non-institutional claim.

NOTE: During the Version H conversion, this field
was populated with data throughout history (back to
service year 1991) by summing up the line item primary
payer amounts.

SHORT NAME: PRPAYAMT
LONG NAME: CARR_CLM_PRMRY_PYR_PD_AMT

LENGTH: 9.2
SIGNED : Y

SOURCE: CWF

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

Carrier Claim Referring UPIN Number — CHAR 6

The unique physician identification number (UPIN) of the physician who referred the beneficiary to the physician who performed the Part B services.

SHORT NAME: RFR_UPIN
LONG NAME: RFR_PHYSN_UPIN

SOURCE:
CWF

Carrier Claim Referring Physician NPI Number — CHAR 10

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

SHORT NAME: RFR_NPI
LONG NAME: RFR_PHYSN_NPI

SOURCE:
CWF

Carrier Claim Provider Assignment Indicator Switch — CHAR 1

A switch indicating whether or not the provider accepts assignment for the noninstitutional claim.

SHORT NAME: ASGMNTCD
LONG NAME: CARR_CLM_PRVDR_ASGNMT_IND_SW

LENGTH: 1

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

SOURCE: CWF

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

NCH Claim Provider Payment Amount — NUM 12

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

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

SHORT NAME: PROV_PMT
LONG NAME : NCH_CLM_PRVDR_PMT_AMT

LENGTH: 9.2
SIGNED: Y

SOURCE: NCH QA Process

NCH Claim Beneficiary Payment Amount NUM 12

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

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

SHORT NAME: BENE_PMT
LONG NAME: NCH_CLM_BENE_PMT_AMT

LENGTH: 9.2
SIGNED : Y

SOURCE: NCH QA Process

NCH Carrier Claim Submitted Charge Amount NUM 12

Effective with Version H, the total submitted charges on the claim (the sum of line item submitted charges).

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

SHORT NAME: SBMTCHRG
LONG NAME: NCH_CARR_CLM_SBMTD_CHRG_AMT

LENGTH: 9.2

SIGNED : Y

SOURCE: NCH QA Process

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

NCH Carrier Claim Allowed Charge Amount — NUM 12

Effective with Version H, the total allowed charges on the claim (the sum of line item allowed charges).

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

SHORT NAME: ALOWCHRG
LONG NAME: NCH_CARR_CLM_ALOWD_AMT

LENGTH: 9.2
SIGNED : Y

SOURCE: NCH QA Process

EDIT RULES :
$$$$$$$CC

Carrier Claim Cash Deductible Applied Amount — NUM 12

Effective with Version H, the amount of the cash deductible as submitted on the claim.

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

SHORT NAME: DEDAPPLY
LONG NAME: CARR_CLM_CASH_DDCTBL_APLD_AMT

LENGTH: 9.2
SIGNED : Y

SOURCE: CWF

Carrier Claim Referring PIN Number — CHAR 14

Carrier-assigned identification (profiling)

number of the physician who referred the beneficiary to the physician that performed the Part B services.

SHORT NAME: RFR_PRFL
LONG NAME: CARR_CLM_RFRNG_PIN_NUM

SOURCE:
CWF

Primary Claim Diagnosis Code CHAR 5

The ICD-9-CM based code identifying the beneficiary's principal diagnosis.

SHORT NAME: DGNSCD1
LONG NAME: ICD9_DGNS_CD1

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code II CHAR 5

The ICD-9-CM based code identifying the beneficiary's second diagnosis.

SHORT NAME: DGNSCD2
LONG NAME: ICD9_DGNS_CD2

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code III CHAR 5

The ICD-9-CM based code identifying the beneficiary's third diagnosis.

SHORT NAME: DGNSCD3
LONG NAME: ICD9_DGNS_CD3

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code IV CHAR 5

The ICD-9-CM based code identifying the beneficiary's fourth diagnosis.

SHORT NAME: DGNSCD4
LONG NAME: ICD9_DGNS_CD4

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code V CHAR 5

The ICD-9-CM based code identifying the beneficiary's fifth diagnosis. New variable effective in 2007.

SHORT NAME: DGNSCD5
LONG NAME: ICD9_DGNS_CD5

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code VI CHAR 5

The ICD-9-CM based code identifying the beneficiary's sixth diagnosis. New variable effective in 2007.

SHORT NAME: DGNSCD6
LONG NAME: ICD9_DGNS_CD6

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code VII CHAR 5

The ICD-9-CM based code identifying the beneficiary's seventh diagnosis. New variable effective in 2007.

SHORT NAME: DGNSCD7
LONG NAME: ICD9_DGNS_CD7

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code VIII CHAR 5

The ICD-9-CM based code identifying the beneficiary's eighth diagnosis. New variable effective in 2007.

SHORT NAME: DGNSCD8
LONG NAME: ICD9_DGNS_CD8

EDIT-RULES:
ICD-9-CM

DATE OF BIRTH FROM CLAIM NUM 1

Age Category Calculated from Date of Birth from Claim

1 DIGIT

SHORT NAME: DOB_DT
LONG NAME: DOB_DT

CODES:
0 = Unknown
1 = <65
2 = 65 Thru 69
3 = 70 Thru 74
4 = 75 Thru 79
5 = 80 Thru 84
6 = >84

LIMITATIONS:
DATE OF BIRTH WILL BE POPULATED FOR CLAIMS PROCESSED BETWEEN 1999-2004 AND CLAIMS PROCESSED AFTER FEBRUARY 2008. THESE FIELDS WILL LIKELY BE NULL FOR CLAIMS PROCESSED BETWEEN 2005-2007 (THESE FIELDS ARE MORE LIKELY TO BE POPULATED IN CLAIMS WITH SERVCIE DATES IN THE LATTER PART OF 2007-FORWARD).

GENDER CODE FROM CLAIM CHAR 1

THIS FIELD INDICATES THE SEX OF THE BENEFICIARY AS NOTED ON THE CLAIM.

SHORT NAME: GNDR_CD
LONG NAME: GNDR_CD

CODES:
0 = UNKNOWN
1 = MALE
2 = FEMALE

LIMITATIONS:
GENDER CODE WILL BE POPULATED FOR CLAIMS PROCESSED BETWEEN 1999-2004 AND CLAIMS PROCESSED AFTER FEBRUARY 2008. THESE FIELDS WILL LIKELY BE NULL FOR CLAIMS PROCESSED BETWEEN 2005-2007 (THESE FIELDS ARE MORE LIKELY TO BE POPULATED IN CLAIMS WITH SERVCIE DATES IN THE LATTER PART OF 2007-FORWARD).

RACE CODE FROM CLAIM CHAR 1

THE RACE OF A BENEFICIARY AS NOTED ON THE CLAIM.

SHORT NAME: RACE_CD
LONG NAME: BENE_RACE_CD

CODES:

0 = UNKNOWN
1 = WHITE
2 = BLACK
3 = OTHER
4 = ASIAN
5 = HISPANIC
6 = NORTH AMERICAN NATIVE

SQL-INFO:
CHAR(1) NOT NULL

LIMITATIONS:
RACE CODE WILL BE POPULATED FOR CLAIMS PROCESSED BETWEEN 1999-2004 AND CLAIMS PROCESSED AFTER FEBRUARY 2008. THESE FIELDS WILL LIKELY BE NULL FOR CLAIMS PROCESSED BETWEEN 2005-2007 (THESE FIELDS ARE MORE LIKELY TO BE POPULATED IN CLAIMS WITH SERVCIE DATES IN THE LATTER PART OF 2007-FORWARD).

COUNTY CODE FROM CLAIM (SSA) CHAR 3

THIS CODE SPECIFIES THE SSA CODE FOR THE COUNTY OF RESIDENCE OF THE BENEFICIARY AS NOTED ON THE CLAIM.EACH STATE HAS A SERIES OF CODES BEGINNING WITH '000' FOR EACH COUNTY WITHIN THAT STATE.CERTAIN CITIES WITHIN THAT STATE HAVE THEIR OWN CODE. COUNTY CODES MUST BE COMBINED WITH STATE CODES IN ORDER TO LOCATE THE SPECIFIC COUNTY. THE CODING SYSTEM IS THE SSA SYSTEM, NOT THE FEDERAL INFORMATION PROCESSING SYSTEM (FIPS).

SHORT NAME: CNTY_CD
LONG NAME: BENE_CNTY_CD

EDIT-RULES:
NUMERIC

LIMITATIONS:
SOME CODES MAY BE INVALID, UNKNOWN, OR '999'. (DIFFERENT FROM FIPS)

COUNTY CODE WILL BE POPULATED FOR CLAIMS PROCESSED BETWEEN 1999-2004 AND CLAIMS PROCESSED AFTER JANUARY 2009. THESE FIELDS WILL LIKELY BE NULL FOR CLAIMS PROCESSED BETWEEN 2005-2008 (THESE FIELDS ARE MORE LIKELY TO BE POPULATED IN CLAIMS WITH SERVICE DATES IN THE LATTER PART OF 2008-FORWARD).

STATE CODE FROM CLAIM (SSA) CHAR 2

THIS FIELD SPECIFIES THE STATE OF RESIDENCE OF THE BENEFICIARY AND IS BASED ON THE MAILING ADDRESS USED FOR CASH BENEFITS OR THE MAILING ADDRESS USED FOR OTHER PURPOSES AS NOTED ON THE CLAIM (FOR EXAMPLE,PREMIUM BILLING).THIS INFORMATION IS MAINTAINED FROM CHANGE OF ADDRESS NOTICES SENT IN BY THE BENEFICIARIES, AND IS APPENDED TO THE RECORD AT TIME OF PROCESSING IN CENTRAL OFFICE. THE CODING SYSTEM IS THE SSA SYSTEM, NOT THE FEDERAL INFORMATION PROCESSING STANDARD (FIPS).

SHORT NAME: STATE_CD
LONG NAME: BENE_STATE_CD

LIMITATIONS:
IN SOME CASES, THE CODE MAY NOT BE THE ACTUAL STATE OF RESIDENCE. (FOR EXAMPLE, IF THE BENEFICIARY HAS A REPRESENTATIVE PAYEE).

sTATE CODE WILL BE POPULATED FOR CLAIMS PROCESSED BETWEEN 1999-2004 AND CLAIMS PROCESSED AFTER JANUARY 2009. THESE FIELDS WILL LIKELY BE NULL FOR CLAIMS PROCESSED BETWEEN 2005-2008 (THESE FIELDS ARE MORE LIKELY TO BE POPULATED IN CLAIMS WITH SERVICE DATES IN THE LATTER PART OF 2008-FORWARD).

CWF Beneficiary Medicare Status Code CHAR 2

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

COBOL ALIAS: MSC
COMMON ALIAS: MSC
DB2 ALIAS: BENE_MDCR_STUS_CD
SAS ALIAS: MS_CD
STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD
SYSTEM ALIAS: LTMSC

TITLE ALIAS: MSC

DERIVATION:

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

5. Beneficiary Claim Number

DERIVATION:

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

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

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

CODES:

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

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

SOURCE:
CWF

NAME	TYPE	LENGTH
Claim Line Number	NUM	3

This number is assigned when a claim is processed in the Chronic Condition Warehouse. It distinguishes services that are submitted on the same claim.

SHORT NAME: LINE_NUM
LONG NAME: LINE_NUM

SOURCE:
CCW

Carrier Line Performing PIN Number — CHAR — 15

The profiling identification number (PIN) of the physician\supplier who performed the service for this line item on the carrier claim (non-DMERC).

SHORT NAME: PRF_PRFL
LONG NAME: CARR_PRFRNG_PIN_NUM

SOURCE:
CWF

Carrier Line Performing UPIN Number — CHAR — 6

The unique physician identification number (UPIN) of the physician who performed the service for this line item on the carrier claim (non-DMERC).

SHORT NAME: PRF_UPIN
LONG NAME: PRF_PHYSN_UPIN

SOURCE:
CWF

Carrier Line Performing NPI Number — CHAR — 10

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

SHORT NAME: PRFNPI
LONG NAME: PRF_PHYSN_NPI

SOURCE:
CWF

Carrier Line Performing Group NPI Number — CHAR — 10

A placeholder field (effective with Version H) for storing the NPI assigned to a group practice, where the performing physician is part of that group. If the physician is not part of a group, this field will be blank.

SHORT NAME: PRGRPNPI
LONG NAME: ORG_NPI_NUM

SOURCE:
CWF

Line NCH Provider State Code CHAR 2

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

SHORT NAME: PRVSTATE
LONG NAME: PRVDR_STATE_CD

SOURCE:
NCH

Line HCFA Provider Specialty Code CHAR 2

HCFA specialty code used for pricing the line item service on the noninstitutional claim.

SHORT NAME: HCFASPCL
LONG NAME: PRVDR_SPCLTY

SOURCE:
CWF

Line Provider Participating Indicator Code CHAR 1

Code indicating whether or not a provider is participating or accepting assignment for this line item service on the noninstitutional claim.

SHORT NAME: PRTCPTG
LONG NAME: PRTCPTNG_IND_CD

CODES:
Line Provider Participating Indicator Table
---
1 = Participating
2 = All or some covered and allowed expenses applied to deductible Participating
3 = Assignment accepted/non-participating
4 = Assignment not accepted/non-participating
5 = Assignment accepted but all or some covered and allowed expenses applied to deductible Non-participating.
6 = Assignment not accepted and all covered and allowed expenses applied to

deductible non-participating.
7 = Participating provider not accepting assignment.

SOURCE:
CWF

Carrier Line Reduced Payment Physician Assistant Code CHAR 1

Effective 1/92, the code on the carrier (non-DMERC) line item that identifies claims that have been paid a reduced fee schedule amount (65%, 75% or 85%) because a physician's assistant performed the services.

SHORT NAME: ASTNT_CD
LONG NAME: CARR_LINE_RDCD_PMT_PHYS_ASTN_C

CODES:
Carrier Line Part B Reduced Physician Assistant Table

BLANK = Adjustment situation (where CLM_DISP_CD equal 3)
0 = N/A
1 = 65%
A) Physician assistants assisting in surgery
B) Nurse midwives
2 = 75%
A) Physician assistants performing services in a hospital (other than assisting surgery)
B) Nurse practitioners and clinical nurse specialists performing services in rural areas
C) Clinical social worker services
3 = 85%
A) Physician assistant services for other than assisting surgery
B) Nurse practitioners services

SOURCE:
CWF

Line Service Count NUM 3

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

3 DIGITS SIGNED

SHORT NAME: SRVC_CNT

LONG NAME: LINE_SRVC_CNT

SOURCE:
CWF

Line HCFA Type Service Code CHAR 1

Code indicating the type of service, as defined in the HCFA Medicare Carrier Manual, for this line item on the non-institutional claim.

SHORT NAME: TYPSRVCB
LONG NAME: LINE_CMS_TYPE_SRVC_CD

EDIT-RULES:
The only type of service codes applicable to DMERC claims are: 1, 9, A, E, G, H, J, K, L, M, P, R, and S.

CODES:
HCFA Type of Service Table
---
1 = Medical care
2 = Surgery
3 = Consultation
4 = Diagnostic radiology
5 = Diagnostic laboratory
6 = Therapeutic radiology
7 = Anesthesia
8 = Assistant at surgery
9 = Other medical items or services
0 = Whole blood only eff 01/96, whole blood or packed red cells before 01/96
A = Used durable medical equipment (DME)
B = High risk screening mammography (obsolete 1/1/98)
C = Low risk screening mammography (obsolete 1/1/98)
D = Ambulance (eff 04/95)
E = Enteral/parenteral nutrients/supplies (eff 04/95)
F = Ambulatory surgical center (facility usage for surgical services)
G = Immunosuppressive drugs
H = Hospice services (discontinued 01/95)
I = Purchase of DME (installment basis) (discontinued 04/95)
J = Diabetic shoes (eff 04/95)
K = Hearing items and services (eff 04/95)
L = ESRD supplies (eff 04/95) (renal supplier in the home before 04/95)
M = Monthly capitation payment for dialysis
N = Kidney donor
P = Lump sum purchase of DME, prosthetics, orthotics
Q = Vision items or services
R = Rental of DME
S = Surgical dressings or other medical supplies (eff 04/95)
T = Psychological therapy (term. 12/31/97)

outpatient mental health limitation (eff. 1/1/98)
U = Occupational therapy
V = Pneumococcal/flu vaccine (eff 01/96),
Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),
Pneumococcal only before 04/95
W = Physical therapy
Y = Second opinion on elective surgery (obsoleted 1/97)
Z = Third opinion on elective surgery (obsoleted 1/97)

SOURCE:
CWF

Line Place Of Service Code CHAR 2

The code indicating the place of service, as defined in the Medicare Carrier Manual, for this line item on the noninstitutional claim.

SHORT NAME: PLCSRVC
LONG NAME: LINE_PLACE_OF_SRVC_CD

CODES:
Line Place Of Service Table

Prior To 1/92

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

Effective 1/92

11 = Office
12 = Home
21 = Inpatient hospital
22 = Outpatient hospital
23 = Emergency room - hospital
24 = Ambulatory surgical center
25 = Birthing center
26 = Military treatment facility
31 = Skilled nursing facility
32 = Nursing facility
33 = Custodial care facility
34 = Hospice
35 = Adult living care facilities (ALCF) (eff. NYD - added 12/3/97)

41 = Ambulance - land
42 = Ambulance - air or water
50 = Federally qualified health centers (eff. 10/1/93)
51 = Inpatient psychiatric facility
52 = Psychiatric facility partial hospitalization
53 = Community mental health center
54 = Intermediate care facility/mentally retarded
55 = Residential substance abuse treatment facility
56 = Psychiatric residential treatment center
60 = Mass immunizations center (eff. 9/1/97)
61 = Comprehensive inpatient rehabilitation facility
62 = Comprehensive outpatient rehabilitation facility
65 = End stage renal disease treatment facility
71 = State or local public health clinic
72 = Rural health clinic
81 = Independent laboratory
99 = Other unlisted facility

SOURCE:
CWF

Carrier Line Pricing Locality Code CHAR 2

Code denoting the carrier-specific locality used for pricing the service for this line item on the carrier claim (non-DMERC).

The Pricing Locality Code is assigned primarily for Carriers that have large geographic areas with different reimbursement rates. The locality code distinguishes these different geographic areas within a Carrier. Therefore, the Locality Code variable is only meaningful when used in conjunction with the Carrier number.

For example, Florida has three different locality codes: 03 for Fort Lauderdale; 04 for Miami; and 99 for the rest of Florida. Maine has two different locality codes: 03 for Southern Maine; and 99 for the rest of Maine. Because the locality codes are not unique across carriers or States, the Carrier number must be used in combination with the locality code in order to identify the correct pricing area.

SHORT NAME: LCLTY_CD
LONG NAME: CARR_LINE_PRCNG_LCLTY_CD

EDIT-RULES:
CARRIER INFORMATION FILE

SOURCE:
CWF

Line Last Expense Date DATE 8

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

8 DIGITS UNSIGNED

SHORT NAME: EXPNSDT2
LONG NAME: LINE_LAST_EXPNS_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

Line HCPCS Code CHAR 5

The Health Care Financing Administration (HCFA) 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:

SHORT NAME: HCPCS_CD
LONG NAME: HCPCS_CD

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

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

**** Note: ****
CPT-4 codes including both long and short descriptions shall be used in accordance with the 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.

Line HCPCS Initial Modifier Code CHAR 2

A first modifier to the HCPCS procedure code to enable a more specific procedure identification for the line item service on the noninstitutional claim.

SHORT NAME: MDFR_CD1
LONG NAME: HCPCS_1ST_MDFR_CD

EDIT-RULES:
CARRIER INFORMATION FILE

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

SOURCE:
CWF

Line HCPCS Second Modifier Code CHAR 2

A second modifier to the HCPCS procedure code to make it more specific than the first modifier code to identify the line item procedures for this claim.

SHORT NAME: MDFR_CD2
LONG NAME: HCPCS_2ND_MDFR_CD

EDIT-RULES:
CARRIER INFORMATION FILE

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

SOURCE:
CWF

Line NCH BETOS Code CHAR 3

Effective with Version H, the Berenson-Eggers type of service (BETOS) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services. This field is included as a line item on the noninstitutional claim.

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

For 2006 forward, refer to CMS web site for crosswalk of BETOS to HCPCS_CD.

SHORT NAME: BETOS
LONG NAME: BETOS_CD

DERIVATION:
DERIVED FROM:
- LINE_HCPCS_CD
- LINE_HCPCS_INITL_MDFR_CD
- LINE_HCPCS_2ND_MDFR_CD
- HCPCS MASTER FILE

DERIVATION RULES:
Match the HCPCS on the claim to the HCPCS on the HCPCS Master File to obtain the BETOS code.

SOURCE:
NCH

Line NCH Payment Amount NUM 12

Amount of payment made from the trust funds (after deductible and coinsurance amounts have been paid) for the line item service on the non-

institutional claim.

9.2 DIGITS SIGNED

SHORT NAME: LINEPMT
LONG NAME: LINE_NCH_PMT_AMT

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

SOURCE:
NCH

Line Beneficiary Payment Amount NUM 12

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

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

9.2 DIGITS SIGNED

SHORT NAME: LBENPMT
LONG NAME: LINE_BENE_PMT_AMT

SOURCE:
CWF

Line Provider Payment Amount NUM 12

Effective with Version H, the payment made to the provider for the line item service on the noninstitutional claim.

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

9.2 DIGITS SIGNED

SHORT NAME: LPRVPMT
LONG NAME: LINE_PRVDR_PMT_AMT

SOURCE:
CWF

Line Beneficiary Part B Deductible Amount NUM 12

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

9.2 DIGITS SIGNED

SHORT NAME: LDEDAMT
LONG NAME: LINE_BENE_PTB_DDCTBL_AMT

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

SOURCE:
CWF

Line Beneficiary Primary Payer Code CHAR 1

The code specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's medical bills relating to the line item service on the noninstitutional claim.

SHORT NAME: LPRPAYCD
LONG NAME: LINE_BENE_PRMRY_PYR_CD

CODES:
Beneficiary Primary Payer Table

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

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

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

T = MSP cost avoided - IEQ contractor (eff. 7/96 carrier claims only)
U = MSP cost avoided - HMO rate cell adjust- ment contractor (eff. 7/96 carrier claims only)
V = MSP cost avoided - litigation settlement contractor (eff. 7/96 carrier claims only)
X = MSP cost avoided override code (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)

Prior to 12/90

Y = Other secondary payer investigation shows Medicare as primary payer
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.)

SOURCE:
CWF,VA,DOL,SSA

Line Beneficiary Primary Payer Paid Amount NUM 12

The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges for to the line ITEM SERVICE ON THE NONINSTITUTIONAL.

9.2 DIGITS SIGNED

SHORT NAME: LPRPDAMT
LONG NAME: LINE_BENE_PRMRY_PYR_PD_AMT

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

SOURCE:
CWF

Line Coinsurance Amount NUM 12

Effective with Version H, the beneficiary coinsurance liability amount for this line item service on the noninstitutional claim.

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

9.2 DIGITS SIGNED

SHORT NAME: COINAMT
LONG NAME: LINE_COINSRNC_AMT

SOURCE:
CWF

Line Submitted Charge Amount NUM 12

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

9.2 DIGITS SIGNED

SHORT NAME: LSBMTCHG
LONG NAME: LINE_SBMTD_CHRG_AMT

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

SOURCE:
CWF

Line Allowed Charge Amount NUM 12

The amount of allowed charges for the line item service on the noninstitutional claim. This charge is used to compute pay to providers or reimbursement to beneficiaries. **NOTE: The allowed charge is determined by the lower of three charges: prevailing, customary or actual.

9.2 DIGITS SIGNED

SHORT NAME: LALOWCHG
LONG NAME: LINE_ALOWD_CHRG_AMT

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

SOURCE:
CWF

Line Processing Indicator Code CHAR 1

The code indicating the reason a line item on the noninstitutional claim was allowed or denied.

SHORT NAME: PRCNGIND
LONG NAME: LINE_PRCSG_IND_CD

CODES:
Line Processing Indicator Table

A = Allowed
B = Benefits exhausted
C = Noncovered care
D = Denied (existed prior to 1991; from BMAD)
I = Invalid data
L = CLIA (eff 9/92)
M = Multiple submittal--duplicate line item
N = Medically unnecessary
O = Other
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided (contractor #88888) - voluntary agreement (eff. 1/98)
R = Reprocessed--adjustments based on subsequent reprocessing of claim
S = Secondary payer
T = MSP cost avoided - IEQ contractor (eff. 7/76)
U = MSP cost avoided - HMO rate cell adjustment (eff. 7/96)
V = MSP cost avoided - litigation settlement (eff. 7/96)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data match project
Z = Bundled test, no payment (eff. 1/1/98)

SOURCE:
CWF

Line Payment 80%/100% Code CHAR 1

The code indicating that the amount shown in the payment field on the noninstitutional line item represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only.

SHORT NAME: PMTINDSW
LONG NAME: LINE_PMT_80_100_CD

CODES:
0 = 80%
1 = 100%

3 = 100% Limitation of liability only

SOURCE:
CWF

Line Service Deductible Indicator Switch — CHAR 1

Switch indicating whether or not the line item service on the noninstitutional claim is subject to a deductible.

SHORT NAME: DED_SW
LONG NAME: LINE_SERVICE_DEDUCTIBLE

CODES:
0 = Service subject to deductible
1 = Service not subject to deductible

SOURCE:
CWF

Carrier Line Miles/Time/Units/Services Count — NUM 5

The count of the total units associated with services needing unit reporting such as transportation, miles, anesthesia time units, number of services, volume of oxygen or blood units. This is a line item field on the carrier claim (non-DMERC) and is used for both allowed and denied services.

5 DIGITS SIGNED

SHORT NAME: MTUS_CNT
LONG NAME: CARR_LINE_MTUS_CNT

EDIT-RULES:
For CARR_LINE_MTUS_IND_CD equal to 2 (anesthesia time units) there is one implied decimal point.

SOURCE:
CWF

Carrier Line Miles/Time/Units/Services Indicator Code — CHAR 1

Code indicating the units associated with services needing unit reporting on the line item for the carrier claim (non-DMERC).

SHORT NAME: MTUS_IND
LONG NAME: CARR_LINE_MTUS_CD

CODES:
0 = Values reported as zero (no allowed activities)
1 = Transportation (ambulance) miles
2 = Anesthesia time units
3 = Services
4 = Oxygen units
5 = Units of blood
6 = Anesthesia base and time units (prior to 1991; from BMAD)

SOURCE:
CWF

Line Diagnosis Code CHAR 5

The ICD-9-CM code indicating the diagnosis supporting this line item procedure/service on the noninstitutional claim.

SHORT NAME: LINEDGNS
LONG NAME: LINE_ICD9_DGNS_CD

EDIT-RULES:
ICD-9-CM

SOURCE:
CWF

****