DME Claims Data Dictionary

CCW DMERC 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   CHAR   1
 Identification Code

     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
  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
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).

        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)
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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
      --------------------------------
      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   NUM   12
Payer Paid Amount

    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 Provider        CHAR       1
Assignment Indicator Switch

     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                  NUM      12
Payment Amount

     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              NUM      12
Payment Amount

     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   NUM   12
Submitted Charge Amount

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   NUM   12
Allowed Charge Amount

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              NUM      12
Deductible Applied Amount

    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


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

DMERC Claim Ordering   CHAR   6
Physician UPIN Number

       Effective with Version G, the unique physician
       identification number (UPIN) of the physician
       ordering the Part B services/DMEPOS item.

       SHORT NAME: RFR_UPIN
       LONG NAME: RFR_PHYSN_UPIN

       SOURCE:
       CWF

DMERC Claim Ordering   CHAR   10
Physician NPI Number

       A placeholder field (effective with Version H)
       for storing the NPI assigned to the physician
       ordering the Part B services/DMEPOS item.

       SHORT NAME: RFR_NPI
       LONG NAME: RFR_PHYSN_NPI

       SOURCE:
       CWF

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   CHAR   2
Status Code

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

CCW DMERC Line File:

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

Line HCFA Provider   CHAR   2

Specialty Code

      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   CHAR   1
Indicator Code

      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

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
```

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   CHAR   2
Code

    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     CHAR        2
Code

        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   NUM   12
Amount

Effective with Version H, the payment (reim-
bursement) made to the beneficiary related
to the line item service on the noninstitu-
tional 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              NUM      12
Amount

     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            NUM      12
Deductible Amount

     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           CHAR      1
Payer Code

     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          NUM     12
Payer Paid Amount


     The amount of a payment made on behalf of a
     Medicare beneficiary by a primary payer other
     than Medicare, that the provider is applying
     to covered Medicare charges 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 Primary Payer Allowed       NUM     12
Charge Amount


     Effective with Version H, the primary payer
     allowed charge amount 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: PRPYALOW
LONG NAME: LINE_PRMRY_ALOWD_CHRG_AMT

SOURCE:
CWF

Line Submitted Charge   NUM   12
Amount

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   CHAR   1
Code

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          CHAR     1
Indicator Switch

     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

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

Line DME Purchase Price          NUM      12
Amount

     Effective 5/92, the amount representing the
     lower of fee schedule for purchase of new or
     used DME, or actual charge.  In case of rental
     DME, this amount represents the purchase cap;
     rental payments can only be made until the
     cap is met.  This line item field is applicable
     to non-institutional claims involving DME,
     prosthetic, orthotic and supply items,
     immunosuppressive drugs, pen, ESRD and oxygen
     items referred to as DMEPOS.

     9.2 DIGITS SIGNED

     SHORT NAME: DME_PURC
     LONG NAME: LINE_DME_PRCHS_PRICE_AMT

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

```
SOURCE:
CWF


DMERC Line Supplier                CHAR      10
Provider Number

     Effective with Version G, billing number assigned
     to the supplier of the Part B service/DMEPOS by the
     National Supplier Clearinghouse, as reported on the
     line item for the DMERC claim.

     SHORT NAME: SUPLRNUM
     LONG NAME: PRVDR_NUM

     SOURCE:
     CWF


DMERC Line Item Supplier           CHAR      10
NPI Number

     A placeholder field (effective with Version H)
     for storing the NPI assigned to the supplier
     of the Part B service/DMEPOS line item.

     SHORT NAME: SUP_NPI
     LONG NAME: PRVDR_NPI

     SOURCE:
     CWF


DMERC Line Pricing State           CHAR      2
Code

     The two position state SSA code
     representing the pricing location of the service
     reported on the DMERC line item.
     This is usually the beneficiary state of
     residence.

     Note: the BENE_RSDNC_SSA_STD_STATE_CD reported
     in the fixed portion of the DMERC claim record
     may differ from this field.  This can happen
     when the beneficiary is in another state when
     the service is rendered (other than the
     primary residence state), or the beneficiary
     has moved to another state and the CWF master
     record has not yet been changed.

     SHORT NAME: PRCNG_ST
     LONG NAME: DMERC_LINE_PRCNG_STATE_CD
```

```
    SOURCE:
    CWF/NCH


DMERC Line Provider State        CHAR      2
Code

    The two position state SSA code
    representing the supplier's location, as reported
    on the DMERC line item.

    NOTE: Although created for Version 'G', this
    field was blank until 1/95 when the supplier
    state code was added to the DME claim record as
    a required field.

    SHORT NAME: PRVSTATE
    LONG NAME: PRVDR_STATE_CD

    SOURCE:
    WF/NCH


DMERC Line HCPCS Third           CHAR      2
Modifier Code

    Effective with Version G, a third modifier to the
    HCPCS procedure code used to process the DMERC line
    item.

    SHORT NAME: MDFR_CD3
    LONG NAME: HCPCS_3RD_MDFR_CD

    SOURCE:
    CWF


DMERC Line HCPCS Fourth          CHAR      2
Modifier Code

    Effective with Version G, a fourth modifier to the
    HCPCS procedure code used to process the DMERC
    line item.

    SHORT NAME: MDFR_CD4
    LONG NAME: HCPCS_4TH_MDFR_CD

    SOURCE:
    CWF


DMERC Line Screen Savings        NUM      12
Amount
```

Effective with Version G, the amount of savings
attributable to the coverage screen for this DMERC
line item.

9.2 DIGITS SIGNED

SHORT NAME: SCRNSVGS
LONG NAME: DMERC_LINE_SCRN_SVGS_AMT

SOURCE:
CWF

DMERC Line   NUM   7
Miles/Time/Units/Services
Count

Effective with Version G, the count of the
total units associated with the DMERC line item
service needing unit reporting, including number
of services, volume of oxygen and drug dose.

7 DIGITS SIGNED

SHORT NAME: DME_UNIT
LONG NAME: DMERC_LINE_MTUS_CNT

SOURCE:
CWF

DMERC Line   CHAR   1
Miles/Time/Units/Services
Indicator Code

Effective with Version G, the code indicating the
type of units reported for the DMERC line item.

SHORT NAME: UNIT_IND
LONG NAME: DMERC_LINE_MTUS_CD

CODES:
0 = Values reported as zero
3 = Number of services
4 = Oxygen volume units
6 = Drug dosage

SOURCE:
CWF

Line National Drug Code   CHAR   11

Effective 1/1/94 on the DMERC claim, the National

Drug Code identifying the oral anti-cancer drugs.

Effective with Version H, this line item field was
added as a placeholder on the carrier claim.

DB2 ALIAS: LINE_NATL_DRUG_CD
SAS ALIAS: NDC_CD{x}
STANDARD ALIAS: LINE_NATL_DRUG_CD
TITLE ALIAS: NDC_CD

SOURCE:
CWF