CCW DMERC Base Claim File:

<table>
<thead>
<tr>
<th>NAME</th>
<th>TYPE</th>
<th>LENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDS Beneficiary Identifier</td>
<td>NUM</td>
<td>9</td>
</tr>
<tr>
<td>This field contains the key to link data for each beneficiary across all claim files.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHORT NAME: DSYSRTKY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LONG NAME: DESY_SORT_KEY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDS Claim Number</td>
<td>NUM</td>
<td>12</td>
</tr>
<tr>
<td>The unique number used to identify a unique claim.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: CLAIM_NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: CLAIM_NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCH Near Line Record Identification Code</td>
<td>CHAR</td>
<td>1</td>
</tr>
<tr>
<td>A code defining the type of claim record being processed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHORT NAME: RIC_CD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LONG NAME: NCH_NEAR_LINE_REC_IDENT_CD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CODES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCH Near-Line Record Identification Code Table</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CODE</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>Part B physician/supplier claim record (processed by local carriers; can include DMEPOS services)</td>
</tr>
<tr>
<td>V</td>
<td>Part A institutional claim record (inpatient (IP), skilled nursing facility (SNF), christian science (CS), home health agency (HHA), or hospice)</td>
</tr>
<tr>
<td>W</td>
<td>Part B institutional claim record (outpatient (OP), HHA)</td>
</tr>
<tr>
<td>U</td>
<td>Both Part A and B institutional home health agency (HHA) claim records -- due to HHPPS and HHA A/B split. (effective 10/00)</td>
</tr>
<tr>
<td>M</td>
<td>Part B DMEPOS claim record (processed</td>
</tr>
</tbody>
</table>
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 beneficiary (a.k.a. 'Statement Covers From Date').
NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

8 DIGITS UNSIGNED

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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00510</td>
<td>Alabama BS (eff. 1983)</td>
</tr>
<tr>
<td>00511</td>
<td>Georgia - Alabama BS (eff. 1998)</td>
</tr>
<tr>
<td>00512</td>
<td>Mississippi - Alabama BS (eff. 2000)</td>
</tr>
<tr>
<td>00520</td>
<td>Arkansas BS (eff. 1983)</td>
</tr>
<tr>
<td>00521</td>
<td>New Mexico - Arkansas BS (eff. 1998)</td>
</tr>
<tr>
<td>00522</td>
<td>Oklahoma - Arkansas BS (eff. 1998)</td>
</tr>
<tr>
<td>00523</td>
<td>Missouri - Arkansas BS (eff. 1999)</td>
</tr>
<tr>
<td>00528</td>
<td>Louisiana - Arkansas BS (eff. 1984)</td>
</tr>
<tr>
<td>00542</td>
<td>California BS (eff. 1983; term. 1996)</td>
</tr>
<tr>
<td>00550</td>
<td>Colorado BS (eff. 1983; term. 1994)</td>
</tr>
<tr>
<td>00570</td>
<td>Delaware - Pennsylvania BS (eff. 1983; term. 1997)</td>
</tr>
<tr>
<td>00580</td>
<td>District of Columbia - Pennsylvania BS (eff. 1983; term. 1997)</td>
</tr>
<tr>
<td>00590</td>
<td>Florida BS (eff. 1983)</td>
</tr>
<tr>
<td>00591</td>
<td>Connecticut - Florida BS (eff. 2000)</td>
</tr>
<tr>
<td>00621</td>
<td>Illinois BS - HCSC (eff. 1983; term. 1998)</td>
</tr>
<tr>
<td>00630</td>
<td>Indiana - Administar (eff. 1983)</td>
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<tr>
<td>00635</td>
<td>DMERC-B (Administar Federal, Inc.) (eff. 1993)</td>
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<tr>
<td>00640</td>
<td>Iowa - Wellmark, Inc. (eff. 1983; term. 1998)</td>
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<td>00645</td>
<td>Nebraska - Iowa BS (eff. 1985; term. 1987)</td>
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<td>00650</td>
<td>Kansas BS (eff. 1983)</td>
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<td>00655</td>
<td>Nebraska - Kansas BS (eff. 1988)</td>
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<td>00660</td>
<td>Kentucky - Administar (eff. 1983)</td>
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<tr>
<td>00690</td>
<td>Maryland BS (eff. 1983; term. 1994)</td>
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<tr>
<td>00700</td>
<td>Massachusetts BS (eff. 1983; term. 1997)</td>
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<tr>
<td>00710</td>
<td>Michigan BS (eff. 1983; term. 1994)</td>
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<tr>
<td>00720</td>
<td>Minnesota BS (eff. 1983; term. 1995)</td>
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<tr>
<td>00740</td>
<td>Missouri - BS Kansas City (eff. 1983)</td>
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<tr>
<td>00751</td>
<td>Montana BS (eff. 1983)</td>
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<tr>
<td>00770</td>
<td>New Hampshire/Vermont Physician Services (eff. 1983; term. 1984)</td>
</tr>
<tr>
<td>00780</td>
<td>New Hampshire/Vermont - Massachusetts BS (eff. 1985; term. 1997)</td>
</tr>
<tr>
<td>00801</td>
<td>New York - Western BS (eff. 1983)</td>
</tr>
<tr>
<td>00803</td>
<td>New York - Empire BS (eff. 1983)</td>
</tr>
<tr>
<td>00805</td>
<td>New Jersey - Empire BS (eff. 3/99)</td>
</tr>
<tr>
<td>00811</td>
<td>DMERC (A) - Western New York BS (eff. 2000)</td>
</tr>
<tr>
<td>00820</td>
<td>North Dakota - North Dakota BS (eff. 1983)</td>
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<td>00824</td>
<td>Colorado - North Dakota BS (eff. 1995)</td>
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<td>00825</td>
<td>Wyoming - North Dakota BS (eff. 1990)</td>
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<td>00826</td>
<td>Iowa - North Dakota BS (eff. 1999)</td>
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<td>00831</td>
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<td>Arizona - North Dakota BS (eff. 1998)</td>
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<td>00833</td>
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<td>00834</td>
<td>Nevada - North Dakota BS (eff. 1998)</td>
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<td>Oregon - North Dakota BS (eff. 1998)</td>
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<td>00836</td>
<td>Washington - North Dakota BS (eff. 1998)</td>
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<tr>
<td>00860</td>
<td>New Jersey - Pennsylvania BS (eff. 1988; term. 1999)</td>
</tr>
<tr>
<td>00865</td>
<td>Pennsylvania BS (eff. 1983)</td>
</tr>
</tbody>
</table>
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)
1985)
05130 = Idaho - Connecticut General (eff. 1983)
05320 = New Mexico - Equitable Insurance (eff. 1983; term. 1985)
05440 = Tennessee - Connecticut General (eff. 1983)
05535 = North Carolina - Connecticut General (eff. 1988)
05655 = DMERC-D - Connecticut General (eff. 1993)
10071 = Railroad Board Travelers (eff. 1983) (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
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

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 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. Also the noninstitutional claim records carried this field as a line item. Effective with Version H, this element is a claim level field across all claim types (and the line item field has been renamed.)

SOURCE: CWF  

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

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 beneficiary 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 :
$\text{###CC}$

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 line 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
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

SHORT NAME: DGNSCD5
LONG NAME: ICD9_DGNS_CD5

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code VI  CHAR  5

SHORT NAME: DGNSCD6
LONG NAME: ICD9_DGNS_CD6

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code VII  CHAR  5

SHORT NAME: DGNSCD7
LONG NAME: ICD9_DGNS_CD7

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code VIII    CHAR   5


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:

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:

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:

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)


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:


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:

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

CODES:

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

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_SFCLTY

SOURCE:
CWF

Line Provider Participating 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

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
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
Code

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 (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
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

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

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

***Prior to 12/90***
Y = Other secondary payer investigation shows Medicare as primary payer
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.)
Line Beneficiary Primary 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

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 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

<table>
<thead>
<tr>
<th>Line Submitted Charge</th>
<th>NUM 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Line Allowed Charge Amount</th>
<th>NUM 12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Line Processing Indicator</th>
<th>CHAR 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td></td>
</tr>
</tbody>
</table>

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

SHORT NAME: PRCNIND
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
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
DMERC Line Provider State CHAR 2

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:
CWF/NCH

DMERC Line HCPCS Third CHAR 2

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

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