

<u>COL</u>	<u>FIELD</u>	<u>LENGTH</u>	<u>NOTES</u>
1	Patient ID <b>(patient_id)</b>  <b>SEER Cases (Patient ID)</b>	11	Use First 10 Characters only for SEER cases.
1	Registry	2	02 = Connecticut 20 = Detroit 21 = Hawaii 22 = Iowa 23 = New Mexico 25 = Seattle 26 = Utah 27 = Atlanta 37 = Rural Georgia 42 = Kentucky 43 = Louisiana 44 = New Jersey 88 = California
3	Case Number	8	Encrypted SEER Case Number
11	Filler	1	Blank Space
	<b>Non Cancer Patients – Patient ID</b>		
1	HIC <b>(HICBIC)</b>	11	Encrypted ID for Non Cancer Patients
12	BENEFICIARY IDENTIFICATION CODE <b>(BIC)</b> (8)	2	Relationship between individual and a primary Social Security Administration Beneficiary. (Refer to Appendix table BIC)
14	SSA STANDARD STATE CODE (10) <b>(state_cd)</b>	2	State of Beneficiary's residence, SSA Standard Code. (Refer to Appendix table STATE_CD)
16	SSA STANDARD COUNTY CODE (30) <b>(cnty_cd)</b>	3	County of Beneficiary's residence, SSA Standard Code.
19	MAILING CONTACT ZIP CODE (37) <b>(bene_zip)</b>	9	Beneficiary's mailing address zip code. *Special Permission Required.
28	CWF MEDICARE STATUS (41) <b>(ms_cd)</b>	2	Medicare entitlement reason 10 = Aged without ESRD 11 = Aged with ESRD 20 = Disabled without ESRD 21 = Disabled with ESRD 31 = ESRD only

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<u>COL</u>	<u>FIELD</u>	<u>LENGTH</u>	<u>NOTES</u>
30	CLAIM TYPE CODE (5) ( <b>clm_type</b> )	2	The code used to identify the type of Claim record being processed in NCH. 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' (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
32	CLAIM FROM DATE (11) ( <b>from_dtm, from_dtd, from_dty</b> )	8	For Institutional or CWFB Claim, first day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
40	CLAIM THROUGH DATE (12) ( <b>thru_dtm, thru_dtd, thru_dty</b> )	8	Last day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
48	FI NUMBER (34) ( <b>fi_num</b> )	5	Assigned by CMS to an Intermediary or Carrier authorized to process claims from Providers or Physician/Suppliers. (Refer to Appendix table FI_NUM for NCH & DME)

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<u>COL</u>	<u>FIELD</u>	<u>LENGTH</u>	<u>NOTES</u>
53	CARRIER CLAIM ENTRY CODE (25) ( <b>entry_cd</b> )	1	Generated by Carrier. 1 = *Original debt 3 = Full credit 5 = Replacement debit 9 = Accrete bill history only (Internal; effective 2/22/91) *if claim disposition code = 3, entry code = 1 means original debit was voided.
54	CARRIER CLAIM PAYMENT DENIAL CODE (48) ( <b>pmtdnlcd</b> )	1	Indicates to whom payment was made, or if a claim was denied. (Refer to Appendix table PMTDNLCD)
55	CARRIER CLAIM PROVIDER ASSIGNMENT INDICATOR SWITCH (55) ( <b>asgmtcd</b> )	1	Whether the provider accepts assignment for the INDICATOR SWITCH claim. A = Assigned claim N = Non-assigned claim
56	DMERC CLAIM ORDERING PHYSICIAN UPIN NUMBER (53) ( <b>ord_upin</b> )	6	Unique Physician Identification Number (UPIN) UPIN number of physician ordering the Part B services/DMEPOS item. <b>Encrypted data. *Special permission required for unencrypted data.</b>
62	DMERC CLAIM ORDERING PHYSICIAN NPI NUMBER (54) ( <b>ord_npi</b> )	10	A placeholder field (effective with Version H) for storing the NPI assigned to the physician ordering the Part B services/DMEPOS item.
72	LINE HCFA PROVIDER SPEC CODE (101) ( <b>hcfaspec</b> )	2	HCFA Specialty code used for pricing the service for this line item on the CWFB claim. (Refer to appendix table HCFASPEC)

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file documentation.

<u>COL</u>	<u>FIELD</u>	<u>LENGTH</u>	<u>NOTES</u>
74	LINE PROVIDER PART. INDICATOR CODE (102) (prtcptg)	1	Code indicating whether or not a provider is participating or accepting assignment for this line item on the Part B claim. 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-participation 6 = Assignment not accepted and all covered and allowed expenses applied to deductible non-participating 7 = Participating provider not accepting assignment

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<u>COL</u>	<u>FIELD</u>	<u>LENGTH</u>	<u>NOTES</u>
75	LINE PROCESSING INDICATOR CODE (131) ( <b>proindcd</b> )	1	<p>The code indicating the reason a line item on the CWFB claim was allowed or denied.</p> <p>A = Allowed            B = Benefits exhausted            C = Non-covered care            D = Denied (existed prior to 91 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            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 = Zero payment; allowed tests (eff 1/1/98)</p>
76	LINE PAYMENT 80/100% CODE (132) ( <b>pay80cd</b> )	1	<p>The code indicating that the amount shown in the payment field on the CWFB claim represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only.</p> <p>0 = 80%            1 = 100%            3 = 100% limitation of liability only</p>

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<u>COL</u>	<u>FIELD</u>	<u>LENGTH</u>	<u>NOTES</u>
77	LINE SERVICE DEDUCTIBLE INDICATOR SWITCH (133) ( <b>dedind</b> )	1	Switch indicating whether or not the service reflected on the line item on the CWFB claim is subject to deductible. 0 = Service subject to deductible 1 = Service not subject to deductible
78	LINE PAYMENT INDICATOR CODE (134) ( <b>payindcd</b> )	1	Code that indicates the payment screen used to determine the allowed charge for the line item on the CWFB claim. 1 = Actual charge 2 = Customary charge 3 = Prevailing charge 4 = Other 5 = Lab fee schedule 6 = Physician fee schedule (full fee schedule amt) 7 = Physician fee schedule (transition) 8 = Clinical psychologist fee schedule 9 = DME and prosthetics/orthotics fee schedule (eff 4/97)
79	CARRIER MILES/TIME/UNITS/SERVICES COUNT (135) ( <b>mtuscnt</b> )	8	The count of the total units associated with services needing unit reporting such as transportation, miles anesthesia time units, number of services, volume of oxygen or blood units. This is a line item on the CWFB claim and is used for both allowed and denied services.
87	CARRIER MILES/TIME/UNITS/SERVICES INDICATOR CODE (136) ( <b>mtusind</b> )	1	Code indicating the units associated with services needing unit reporting on the line item for the CWFB claim. 0 = Values reported as zero 3 = Number of services 4 = Oxygen volume units 6 = Drug Dosage
88	LINE HCPCS CODE (108) ( <b>hcpcs</b> )	5	Health Care Financing Administration Common Procedure Coding System (HCPCS) code. Procedures, supplies, products or services provided to Medicare Beneficiaries. (Refer to appendix table HCPCS)

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93	LINE HCPCS INITIAL MODIFIER CODE (109) <b>(mfrcd1)</b>	2	First modifier to the procedure code to enable a more specific procedure ID for the claim. (Carrier Information File)
95	LINE HCPCS SECOND MODIFIER CODE (110) <b>(mfrcd2)</b>	2	Second modifier to enable a more specific procedure ID (Carrier Information File)
97	DMERC LINE HCPCS THIRD MODIFIER CODE (111) <b>(mfrcd3)</b>	2	Third modifier to the HCPCS procedure code used to process the DMERC line item.
99	DMERC LINE HCPCS FOURTH MODIFIER CODE (112) <b>(mfrcd4)</b>	2	Fourth modifier to the HCPCS procedure code used to process the DMERC line item.
101	LINE SUBMITTED CHARGE AMOUNT (127) <b>(submamt)</b>	15.2	The amount of submitted charges reported on the line item on the CWFB claim.
116	LINE ALLOWED CHARGE AMOUNT (128) <b>(alowamt)</b>	15.2	The amount of allowed charges reported on the line item on the CWFB claim.
131	LINE HCFA TYPE OF SERVICE CODE (104) <b>(hcfatype)</b>	1	Carrier's type of service code (usually different from HCFA's) used for pricing this service.
132	LINE PLACE OF SERVICE CODE (105) <b>(plcsrvc)</b>	2	Place of service for this procedure code. (Refer to appendix table PLCSRVC)
134	LINE FIRST EXPENSE DATE (106) <b>(frexpenm, frexpend, frexpeny)</b>	8	Beginning date of this service. (MMDDYYYY)
142	LINE LAST EXPENSE DATE (107) <b>(lsexpenm, lsexpend, lsexpeny)</b>	8	Ending date for this service.
150	LINE SERVICE COUNT (103) <b>(srvc_cnt)</b>	4	Count of the total number of services processed.
154	LINE DIAGNOSIS CODE (137) <b>(linediag)</b>	5	ICD – 9-CM code indicating diagnosis supporting this procedure/service.
159	LINE PAYMENT AMOUNT (117) <b>(linepmt)</b>	15.2	Amount of payment made to provider and/or beneficiary for the services covered

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174	LINE BENEFICIARY PART B DEDUCTIBLE AMOUNT (120) ( <b>ldedamt</b> )	15.2	The amount of money for which the intermediary or carrier has determined that the beneficiary is liable for the Part B deductible on the CWFB claim.
189	LINE BENEFICIARY PRIMARY PAYER PAID AMOUNT (122) ( <b>lprpayat</b> )	15.2	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 CWFB claim.
204	LINE BENEFICIARY PRIMARY PAYER CODE (121) ( <b>lprpaycd</b> )	1	Specifies a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's medical bills. (Refer to appendix table PRPAY_CD)
205	LINE INTEREST AMOUNT (124) ( <b>lintamt</b> )	15.2	Amount of interest to be paid on this line item.
220	DMERC LINE SUPPLIER TYPE CODE (99) ( <b>sup_type</b> )	1	Code identifying the type of supplier furnishing the line item service on the DMERC claim. (Refer to Appendix table SUP_TYPE)
221	DMERC LINE SUPPLIER PROVIDER NUMBER (95) ( <b>suplrnum</b> )	10	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.
231	DMERC LINE ITEM SUPPLIER NPI NUMBER (96) ( <b>sup_npi</b> )	10	A placeholder field (effective with Version H) for storing the NPI assigned to the supplier of the Part B service/DMEPOS line item.
241	DMERC LINE PROVIDER STATE CODE (98) ( <b>prstate</b> )	2	Effective with Version G, the SSA standard state code (converted from the state postal abbreviation) representing the supplier's location, as reported on the DMERC line item. (Refer to Appendix table STATE_CD)

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243	BETOS CODE (113) ( <b>betos</b> )	3	Berenson-Eggers type of service (Betos) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services. (Refer to Appendix table BETOS)
246	LINE NATIONAL DRUG CODE (116) ( <b>ndc_cd</b> )	11	The National Drug Code identifies the oral anti-cancer drugs.
257	LINE ADDITIONAL CLAIM DOCUMENTATION INDICATOR CODE (139) ( <b>docindcd</b> )	1	Code indicating additional claim documentation was submitted 0 = No additional documentation 1 = Additional documentation submitted for non-DME EMC claim 2 = CMN/prescription/other documentation submitted which justifies medical necessity 3 = Prior authorization obtained and approved 4 = Prior authorization requested but not approved. 5 = CMN/prescription/other documentation submitted but did not justify medical necessity 6 = CMN/prescription/other documentation submitted and approved after prior authorization rejected 7 = Re-certification CMN/prescription/other documentation
258	CLAIM DIAGNOSIS CODES (92) ( <b>dgnscd1-dgnscd8</b> )	5*8	Up to eight 5 digit ICD-9 diagnosis codes. For persons with less than eight codes the columns are blank filled.
298	YEAR OF FILE ( <b>year</b> )	4	Year of the file
302	SEGMENT LINK NUMBER (19) ( <b>link_num</b> )	10	An IMS generated number used to keep records/segments belonging to a specific claim together.

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312	DAILY PROCESS DATE (18) ( <b>daily_dtm,daily_dtd, daily_dty</b> )	8	The date the claim record was processed by CMS's CWFMQA system. This date is used in conjunction with the segment link number to keep claims with Multiple records/segments together. MMDDYYYY
324	TOTAL LINE COUNT (22) ( <b>tot_line</b> )	3	The total number of line items associated with the claim.
327	RECORD COUNT ( <b>rec_count</b> )	3	Record count for claim
330	Filler	1	

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