

<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 (36) <b>(cnty_cd)</b>	3	County of Beneficiary's residence, SSA Standard Code.
19	MAILING CONTACT ZIP CODE (43) <b>(bene_zip)</b>	9	Beneficiary's mailing address zip code. *Special Permission Required.
28	CWF MEDICARE STATUS (47) <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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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' 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
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 (40) ( <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 HHA)
53	PROVIDER NUMBER (19) ( <b>provider</b> )	6	ID of Medicare Provider certified to provide services to the Beneficiary. <b>Encrypted Data.</b> <b>* Special Permission required to receive unencrypted data.</b>

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<u>COL</u>	<u>FIELD</u>	<u>LENGTH</u>	<u>NOTES</u>
59	CLAIM QUERY CODE (18) <b>(query_cd)</b>	1	Payment type of claim being processed. 0 = Credit adjustment 1 = Interim bill 2 = Home Health Agency benefits exhausted (obsolete 7/98) 3 = Final bill 4 = Discharge notice (obsolete 7/98) 5 = Debit adjustment
60	CLAIM FACILITY TYPE CODE (28) <b>(fac_type)</b>	1	Facility that provided care. 1 = Hospital 2 = Skilled Nursing Facility (SNF) 3 = Home Health Association (HHA) 4 = Religious Nonmedical (Hospital) (eff. 8/1/00); prior to 8/00 referenced Christian Science (CS) 5 = Religious Nonmedical Extended Care (eff. 8/1/00); prior to 8/00 referenced CS extended care 6 = Intermediate Care 7 = Clinic (Requires special information Service Classification Code) 8 = Special Facility or ASC Surgery (Requires special information in Service Classification Code) 9 = Reserved

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61	CLAIM SERVICE CLASSIFICATION TYPE CODE (29) ( <b>typesrvc</b> )	1	<p>Classification of type of service provided to the Beneficiary.</p> <p><b>For facility type code 1-6 and 9</b></p> <p>1 = Inpatient(including Part A)  2 = Inpatient(Part B only) or Home Health visits under Part B.  3 = Outpatient (HHA-A also)  4 = Other(Part B)  5 = Intermediate care - level 1  6 = Intermediate care - level 2  7 = Intermediate care - level 3  8 = Swing beds  9 = Reserved for national assignment.</p> <p><b>For facility type code 7</b></p> <p>1 = Rural health  2 = Hospital based of independent renal dialysis facility  3 = Independent provider based federally qualified health center(eff 10/91)  4 = Other Rehabilitation Facility (ORF) and Community Mental Health Center (CMHC)(eff 10/91 3/97); ORF only(eff 4/97)  5 = Comprehensive Rehabilitation Center (CORF)  6 = Community Mental Health Center (CMHC) (eff 4/97)  7&amp;8 = Reserved for national assignment  9 = Other</p> <p><b>For facility type code 8</b></p> <p>1 = Hospice (non-hospital based)  2 = Hospice (hospital based)  3 = Ambulatory surgical center  4 = Freestanding birthing center  5 = Critical Access Hospital (eff. 10/99) formerly Rural primary care hospital (eff 10/94)  6-8 = Reserved for national use  9 = Other</p>

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62	CLAIM FREQUENCY CODE (30) ( <b>freq_cd</b> )	1	<p>Sequence of claim in the Beneficiary's current episode of care associated with a given facility.</p> <p>0 = Non-payment/zero claims  1 = Admit thru discharge claim  2 = Interim - first claim  3 = Interim - continuing claim  4 = Interim - last claim  5 = Late charge(s) only claim  6 = Adjustment of prior claim  7 = Replacement of prior claim (eff 10/93, provider debit)  8 = Void/cancel prior claim (eff 10/93, provider cancel)  9 = Final claim – used in an HHPPS episode to indicate the claim should be processed like debit/credit adjustment to RAP (initial claim) (eff. 10/00)</p> <p>A = Admission notice - used when hospice is submitting the HCFA-1450 as an admission notice - hospice NOE only  B = Hospice termination/revocation notice – hospice NOE only (eff 9/93)  C = Hospice change of provider notice - hospice NOE only (eff 9/93)  D = Hospice election void/cancel - hospice NOE only (eff 9/93)  E = Hospice change of ownership - hospice NOE only (eff 1/97)  F = Beneficiary initiated adjustment (eff 10/93)  G = CWF generated adjustment (eff 10/93)  H = CMS generated adjustment (eff 10/93)  I = Misc adjustment claim (other than PRO or provider) - used to identify a debit adjustment initiated by CMS or an intermediary(eff 10/93)  J = Other adjustment request (eff 10/93)  K = OIG initiated adjustment (eff 10/93)  M = MSP adjustment (eff 10/93)  P = Adjustment required by peer review organization (PRO)  X = Special adjustment processing used for QA editing(eff 8/92)  Z = Hospital Encounter Data alternate submission used for MCO enrollee hospital discharges 7/1/97-12/31/98</p>

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63	CLAIM MEDICARE NON PAYMENT REASON CODE (54) ( <b>nopay_cd</b> )	1	The reason that no Medicare payment is made for services on an institutional claim. Refer to appendix table CLM_MDCR_NPMT_RSN_TB.
64	CLAIM PAYMENT AMOUNT (56) ( <b>pmt_amt</b> )	15.2	Made to Provider and/or Beneficiary from trust fund (after deductible and coinsurance amounts) for services covered by Institutional claim (does not include pass-through per diem or organ acquisition), or for Physician/Supplier claim. Does not include automatic adjustments.
79	CLAIM TOTAL CHARGE AMOUNT (91) ( <b>tot_chrg</b> )	15.2	Total charges for all services included on the institutional claim.
94	PRIMARY PAYER CODE (58) ( <b>prpay_cd</b> )	1	Federal non-Medicaid program or other source with primary responsibility for payment of Beneficiary's medical bills. (Refer to appendix table PRPAY_CD)
95	PRIMARY PAYER CLAIM PAID AMOUNT (57) ( <b>prpayamt</b> )	15.2	Made on behalf of Beneficiary by a primary payer other than Medicare. Provider is applying to covered Medicare charges on Institutional or CWFB claim.
110	FI CLAIM ACTION CODE (60) ( <b>actioncd</b> )	1	Action requested by Intermediary to be taken on an Institutional claim. 1 = Original debit action (includes non-adjustment RTI correction items) - all regular bills. 2 = Cancel by credit adjustment - only in credit/debit pairs. 3 = Secondary debit adjustment - only in credit/debit pairs. 4 = Cancel only adjustment. 5 = Force action code 3. 6 = Force action code 2. 8 = Benefits refused (For inpatient bills, 'R' Nonpayment Code must also be present). 9 = Payment requested (Bills that replace previously-submitted benefits-refused bills, action code 8. Debit/credit pair is not required. Inpatient bills should have 'P' Nonpayment Code).
111	NCH PROVIDER STATE CODE (62) ( <b>prvstate</b> )	2	SSA state code where provider facility is located. Refer to appendix GEO_SSA_STATE_TB.

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113	ORGANIZATION NPI NUMBER (63) ( <b>orgnpinm</b> )	10	The NPI assigned to the institutional provider.
123	CLAIM ATTENDING PHYSICIAN UPIN NUMBER (64) ( <b>at_upin</b> )	6	Institutional claim's state license number or other identifier (like UPIN, required since 1/92) of Physician expected to certify medical necessity of services rendered and/or has primary responsibility for Beneficiary's medical care and treatment. <b>Encrypted Data. * Special permission required to receive unencrypted data.</b>
129	CLAIM ATTENDING PHYSICIAN NPI NUMBER (65) ( <b>at_npi</b> )	10	The NPI assigned to the attending physician.
139	CLAIM OPERATING PHYSICIAN UPIN NUMBER (69) ( <b>op_upin</b> )	6	The unique physician ID number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgical procedure. <b>Encrypted Data. * Special permission required to receive unencrypted data.</b>
145	CLAIM OPERATING PHYSICIAN NPI NUMBER (70) ( <b>op_npi</b> )	10	The NPI assigned to the operating physician.
155	CLAIM OTHER PHYSICIAN UPIN NUMBER (74) ( <b>ot_upin</b> )	6	On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim. <b>Encrypted Data. * Special permission required to receive unencrypted data.</b>
161	CLAIM OTHER PHYSICIAN NPI NUMBER (75) ( <b>ot_npi</b> )	10	The NPI assigned to the other physician.

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171	PATIENT DISCHARGE STATUS CODE (87) ( <b>stus_cd</b> )	2	Status of Beneficiary as of Service Through Date on a claim. 01 = Discharge to home/self care 02 = Discharge/transferred to other short term general hospital for inpatient care. 03 = Discharged/transferred to skilled SNF. 04 = Discharged/transferred to intermediate care facility. 05 = Discharged/transferred to another type of institution. 06 = Discharged/transferred to home care of organized home health service organization. 07 = Left against medical advice or discontinued care. 08 = Discharged/transferred to home under care of home IV drug therapy provider. 09 = Admitted as an inpatient to this hospital. 20 = Expired. 30 = Still patient. 40 = Expired at home. 41 = Expired in medical facility. 42 = Expired - place unknown. 50 = Hospice - home. 51 = Hospice - medical facility. 61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed. 71 = Discharged/transferred/referred to another institution for outpatient services. 72 = Discharged/transferred/referred to this institution for outpatient services.
173	CLAIM PPS INDICATOR CODE (90) ( <b>pps_ind</b> )	1	The code indicating whether or not the (1) claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee.
174	CLAIM TOTAL LINE COUNT (24) ( <b>hsrevcnt</b> )	3	The total number of Revenue Center lines associated with the claim.
177	REVENUE CENTER CODE (147) ( <b>center</b> )	4	Cost center (division or unit within a hospital) for which a separate charge is billed (type of accommodation or ancillary). Assigned by provider. (Refer to appendix table CEN)

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181	REVENUE CENTER DATE (148) <b>(cen_dtm,cen_dtd,cen_dty)</b>	8	The date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with the from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS. MMDDYYYY
189	HCPCS CODE (154) <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)
194	HCPCS INITIAL MODIFIER CODE (155) <b>(mf1)</b>	2	First modifier to the procedure code to enable a more specific procedure ID for the claim. (Carrier Information file)
196	HCPCS SECOND MODIFIER CODE (156) <b>(mf2)</b>	2	Second modifier to the procedure code to enable a more specific procedure ID. (Carrier Information file)
198	REVENUE CENTER UNIT COUNT (167) <b>(unit)</b>	8	A quantitative measure (unit) of services provided to a beneficiary associated with accommodation and ancillary revenue centers described on an institutional claim.
206	REVENUE CENTER RATE AMOUNT (168) <b>(rate)</b>	15.2	Charges relating to unit cost associated with the revenue center code.
221	REVENUE CENTER TOTAL CHARGE AMOUNT (180) <b>(charge)</b>	15.2	Total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided.
236	REVENUE CENTER PAYMENT AMOUNT (179) <b>(pay)</b>	15.2	Medicare payment amount for the specific revenue center.

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251	REVENUE CENTER DEDUCTIBLE COINSURANCE CODE (182) <b>(ded)</b>	1	Code indicating whether the revenue center charges are subject to deductible and/or coinsurance. 0 = Charges are subject to deductible and Coinsurance 1 = Charges are not subject to deductible 2 = Charges are not subject to coinsurance 3 = Charges are not subject to deductible or Coinsurance 4 = No charge or units associated with this revenue center code <b>For revenue center code 0001; the following MSP override values may be present:</b> M = Override code; EGHP services involved (eff 12/90 for non- institutional claims; 10/93 for institutional claims) N = Override code; non-EGHP services involved (eff 12/90 for non-institutional claims; 10/93 for institutional claims) X = Override code: MSP cost avoided (eff 12/90 for non-institutional claims; 10/93 for institutional claims)
252	YEAR OF FILE <b>(year)</b>	4	Year of the file
256	SEGMENT LINK NUMBER (21) <b>(link_num)</b>	10	A system generated number used to keep records/segments belonging to a specific claim together. Use in conjunction with the daily date in column 266 to identify a specific claim.
266	DAILY PROCESS DATE (20) <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
274	TOTAL SEGMENT COUNT (22) <b>(tot_seg)</b>	2	Total number of segments for each claim. (corresponds to total number of original var-length recs for each claim. Max = 10)
276	SEGMENT NUMBER (23) <b>(seg_num)</b>	2	Number of each segment. (corresponds to the original var-length record for this claim. Values: 1 to 10)
278	RECORD COUNT <b>(rec_count)</b>	3	Counter for each claim.

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281	CLAIM UTILIZATION DAY COUNT (110) ( <b>util_day</b> )	4	On an institutional claim, the number of covered days of care that are chargeable to Medicare facility utilization that includes full days, coinsurance days and lifetime reserve days.
285	CLAIM HOSPICE START DATE (107) ( <b>hspstrtm</b> , <b>hspstrtd</b> , <b>hspstrty</b> )	8	On an institutional claim, the date the beneficiary was admitted to the hospice.
293	NCH BENEFICIARY MEDICARE BENEFITS EXHAUSTED DATE (108) ( <b>exhs_dtm</b> , <b>exhs_dtd</b> , <b>exhs_dty</b> )	8	The last date for which the beneficiary has Medicare coverage. This is completed only where benefits were exhausted before the date of discharge and during the billing period covered by this institutional claim.
301	BENEFICIARY'S HOSPICE PERIOD COUNT (111) ( <b>hospcprd</b> )	1	The count of the number of hospice period trailers present for the beneficiary's record. Prior to BBA a beneficiary was entitled to a maximum of 4 hospice benefit periods that may be elected in lieu of standard Part A hospital benefits. The BBA changed the hospice benefit to the following: 2 initial 90 day periods followed by an unlimited number of 60 day periods (effective 8/5/97).
302	CLAIM DIAGNOSIS CODES (131) ( <b>dgn_cd1 -dgn_cd10</b> )	10*5	ICD-9-CM codes of any coexisting conditions shown in medical record as affecting services provided. Up to 10 codes may be listed, each with 5 digits.
352	Filler	1	

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