

<u>COL</u>	<u>FIELD</u>	<u>LENGTH</u>	<u>NOTES</u>
1	NEAR-LINE RECORD IDENTIFICATION CODE (3) (ric_cd)	1	Claim Near-Line Record Identification Code O - Part B (CWFB) Physician/Supplier Claim Record 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) M - Part B (CWFB) DMEPOS claim record (Effective 10/93) U - Both Part A and B institutional HHA claim records - due to HHPPS and HHA A/B split. (eff. 10/00)
2	NEAR-LINE RECORD VERSION (2) (rec_lvl)	1	Record version of Near-Line file storing Institutional or CWFB claims data. Record format as of: A - January 1991 B - April 1991 C - May 1991 D - January 1992 E - March 1992 F - May 1992 G - October 1993 H - September 1998 I - July 2000
3	ID (regcase)	11	Use first 10 characters only for SEER Cases
3	SEER Cases REGISTRY	2	01 - San Francisco 02 - Connecticut 20 - Detroit 21 - Hawaii 22 - Iowa 23 - New Mexico 25 - Seattle 26 - Utah 27 - Atlanta 31 - San Jose 33 - Arizona Indians 35 - Los Angeles 37 - Rural Georgia

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			41 - Greater California 42 - Kentucky 43 - Louisiana 44 - New Jersey
5	CASE NUMBER	8	
13	FILLER	1	
	Non-cancer Patients		
3	HIC (hicbic)	11	
14	BENEFICIARY IDENTIFICATION CODE (BIC) (8) (bic)	2	Relationship between an individual and a primary Beneficiary. (Refer to Appendix table BIC)
16	SSA STANDARD STATE CODE (10) (state_cd)	2	State of Beneficiary's residence, SSA Standard Code. (Refer to Appendix table STATE_CD)
18	SSA STANDARD COUNTY CODE (30) (cnty_cd)	3	County of Beneficiary's residence, SSA Standard Code.
21	STATE SEGMENT CODE (9) (st_sgmt)	1	Segment of Near-Line file with Beneficiary's record for a specific service year. By ranges of county codes within the residence state.
22	MAILING CONTACT ZIP CODE (37) (bene_zip)	9	Beneficiary's mailing address zip code.
31	SEX (38) (sex)	1	Sex of a Beneficiary. 1 - Male 2 - Female 0 - Unknown
32	RACE (39) (race)	1	Race of a Beneficiary. 1 - White 2 - Black 3 - Other 4 - Asian 5 - Hispanic 6 - North American Native 0 - Unknown
33	BIRTH DATE (40)		

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	(dob_m, dob_d, dob_y)	8	Date of birth of Beneficiary: MMDDYYYY
41	CWF BENEFICIARY MEDICARE STATUS (41) (ms_cd)	2	Medicare entitlement reason. 10 - Aged without ESRD 11 - Aged with ESRD 20 - Disabled without ESRD 21 - Disabled with ESRD 31 - ESRD only
43	NCH WEEKLY CLAIM PROCESSING DATE (13) (wkly_dtm, wkly_dtd, wkly_dty)	8	Date Fiscal Intermediary completes processing and releases institutional claim to CWF host. MMDDYYYY
51	CLAIM FROM DATE (11) (from_dtm, from_dtd, from_dty)	8	For Institutional or CWFB Claim, firstday of Provider's or Physician/Supplier's billing statement. MMDDYYYY
59	CLAIM THROUGH DATE (12) (thru_dtm, thru_dtd, thru_dty)	8	Last day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
67	BENEFICIARY CWF LOCATION CODE (45) (cwfloccd)	1	Location where maintenance of Beneficiary's record, Common Working File (CWF), takes place. B - Mid-Atlantic C - Southwest D - Northeast E - Great Lakes F - Great Western G - Keystone H - Southeast I - South J - Pacific
68	CWF CLAIM ACCRETION DATE (14) (acrt_dtm, acrt_dtd, acrt_dty)	8	Date claim is posted to the master record and payment is authorized. MMDDYYYY
76	CWF CLAIM ACCRETION NUMBER (15) (acrtn_nm)	4	Assigned to claim when posted. Indicates position of the claim within that day's processing at the CWF host.
80	CLAIM DISPOSITION CODE (27)	2	Outcome of Institutional processing.

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	(disp_cd)		01- Debit Accepted 02- Debit Accepted (Automatic Adjustment) 03- Void (Cancel) Accepted 61- *Conversion code: debit accepted 62- *Conversion code: debit accepted(automatic adjustment) 63- *Conversion code: cancel accepted. *used only during conversion period: 1/1/91 - 2/21/91
82	CARRIER NUMBER (34) (fi_num)	5	Fiscal Intermediary/Carrier Identification Number. Assigned by HCFA to an Intermediary authorized to process claims from Providers or to a Carrier authorized to process claims from Physician/Suppliers. (Refer to Appendix Table FI_NUM for NCH)
87	CARRIER CLAIM CONTROL NUMBER (16) (carrcntl)	15	Fiscal Intermediary/Carrier Claim Control Number. Unique control number assigned to an Institutional or CWFB claim by an Intermediary or Carrier.
102	CARRIER CLAIM RECEIPT DATE (31) (rcpt_dtm, rcpt_dtd, rcpt_dty)	8	Date claim received from the Provider or Physician/Supplier. MMDDYYYY
110	CARRIER CLAIM SCHEDULED PAYMENT DATE (32) (schl_dtm, schl_dtd, schl_dty)	8	Scheduled date of payment to the Provider, Physician or Supplier, as appearing on the original Institutional or CWFB claim sent to the CWF host. This date is considered to be the date paid. MMDDYYYY
118	CARRIER CLAIM ENTRY CODE (25) (entry_cd)	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

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			debit was voided.
119	CARRIER CLAIM PAYMENT DENIAL CODE (48) (pmtdnlcd)	1	Indicates to whom payment was made, or if a claim was denied. (Refer to Appendix table PMTDNLCD)
120	CARRIER CLAIM REFERRING PIN NUMBER (66) (rfr_prfl)	14	Carrier-assigned ID number of physician who PROFILING NUMBER referred beneficiary to physician that performed Part B services.
134	CARRIER CLAIM PROVIDER ASSIGNMENT INDICATOR SWITCH(55) (asgmtcd)	1	Whether the provider accepts assignment for the INDICATOR SWITCH claim. A - Assigned claim N - Non-assigned claim
135	CARRIER CLAIM REFERRING UPIN NUMBER (53) (rfr_upin)	6	Unique Physician Identification Number (UPIN) UPIN NUMBER of physician who referred beneficiary to physician that performed the Part B services.
141	LINE HCFA PROVIDER SPEC CODE (108) (hcfaspec)	2	HCFA Specialty code used for pricing the service for this line item on the CWFB claim. (Refer to Appendix table HCFASPEC)
143	CARRIER LINE PROVIDER TYPE CODE (104) (prv_type)	1	Code identifying the type of provider furnishing the service for this line item on the Part B claim. (Refer to Appendix table PRV_TYPE)
144	LINE HCFA TYPE SERVICE CODE (113) (hcfatype)	1	Code indicating the type of service, as defined in the HCFA Medicare Carrier Manual, for this line item on the CWFB claim. (Refer to Appendix table HCFATYPE)
145	LINE PROVIDER PART. INDICATOR CODE (110) (prtctptg)	1	Code indicating whether or not a provider is participating or accepting assignment for this line item on the Part B claim.

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			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
146	LINE PROCESSING INDICATOR CODE (141) (proindcd)	1	The code indicating the reason a line item on the CWFB claim was allowed or denied. 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

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			Y - MSP cost avoided - IRS/SSA data match project Z - Zero payment; allowed tests (eff 1/1/98)
147	LINE PAYMENT 80/100% CODE (142) (pay80cd)	1	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. 0 - 80% 1 - 100% 3 - 100% limitation of liability only
148	LINE SERVICE DEDUCTIBLE INDICATOR SWITCH (143) (dedind)	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
149	LINE PAYMENT INDICATOR CODE(144) (payindcd)	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)
150	CARRIER MILES/TIME/UNITS/ SERVICES COUNT (145) (mtuscnt)	4	The count of the total units associated with services needing unit reporting such as transportation, miles, anesthesia time units, number of

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			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.
154	CARRIER MILES/TIME/UNITS/SERVICES INDICATOR CODE (146) (mtusind)	1	Code indicating the units associated with services needing unit reporting on the line item for the CWFB claim. 0 - Values reported as zero (no allowed activities) 1 - Transportation(ambulance) miles 2 - Anesthesia time units 3 - Services 4 - Oxygen units 5 - Units of blood 6 - Anesthesia base and time units (prior to 91; from BMAD)
155	LINE HCPCS CODE (119) (hcpcs)	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)
160	LINE HCPCS INITIAL MODIFIER CODE (120) (mfrcd1)	2	First modifier to the procedure code to enable a more specific procedure ID for the claim. (Carrier Information file)
162	LINE HCPCS SECOND MODIFIER CODE (121) (mfrcd2)	2	Second modifier to enable a more specific procedure ID. (Carrier Information file)
164	LINE SUBMITTED CHARGE AMOUNT (137) (submamt)	15.2	The amount of submitted charges reported on the line item on the CWFB claim.
179	LINE ALLOWED CHARGE AMOUNT (138) (alowamt)	15.2	The amount of allowed charges reported on the line item on the CWFB claim.
194	PROVIDER TAX NUMBER (105) (taxnum)	10	SSN of Employee ID of physician/supplier used to

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			identify to whom payment is made for the service included as a line item on the CWFB claim.
204	CARRIER LINE PRICING LOCALITY CODE (116) (lclty_cd)	2	Code denoting the carrier-specific locality used for pricing the service for this line item on the CWFB claim. (Carrier Information file)
206	CARRIER LINE PROVIDER SPEC CODE (109) (arrspec)	2	Carrier's specialty code for the provider (usually different from HCFA's) used for pricing the service for this line item on the CWFB claim. (Carrier Information file)
208	CARRIER LINE TYPE OF SERVICE (114) (carrtype)	2	Carrier's type of service code (usually different from HCFA's) used for pricing this service.
210	LINE PLACE OF SERVICE CODE (115) (plcsrv)	2	Place of service for this procedure code. (Refer to Appendix table PLCSRVC)
212	LINE FIRST EXPENSE DATE (117) (frexpenm, frexpend, frexpeny)	8	Beginning date for this service. MMDDYYYY
220	LINE LAST EXPENSE DATE (118) (lsexpenm, lsexpend, lsexpeny)	8	Ending date for this service. MMDDYYYY
228	CARRIER LINE PERFORMING PIN NUMBER (100) (per_pin)	10	The profiling id number of the physician/supplier who performed the service.
238	LINE SERVICE COUNT (112) (srvc_cnt)	4	Count of the total number of services processed.
242	LINE DIAGNOSIS CODE (147) (linediag)	5	ICD-9-CM code indicating diagnosis supporting this procedure/service.
247	CARRIER LINE CLINICAL LAB NUMBER (139) (lab_num)	10	The id number assigned to the clinical lab providing services.

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257	CARRIER LINE CLINICAL LAB CHARGE AMOUNT (140) (lab_amt)	15.2	Fee schedule charge amount applied for clinical lab services.
272	CARRIER LINE ANESTHESIA BASE UNIT COUNT (149) (anescnt)	4	The base number of units assigned to an anesthesia procedure for this line item.
276	LINE PAYMENT AMOUNT (125) (linepmt)	15.2	Amount of payment made to provider and/or beneficiary for the services covered
291	LINE BENEFICIARY PART B DEDUCTIBLE AMOUNT (128) (ldedamt)	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.
306	CARRIER LINE PSYCHIATRIC, OCCUPATIONAL THERAPY, PHYSICAL THERAPY LIMIT AMOUNT (132) (llmtamt)	15.2	For type of service psychiatric, occupational therapy or physical therapy, the amount of allowed charges applied toward the limit cap for this line item.
321	CARRIER LINE BLOOD DEDUCTIBLE PINTS QUANTITY (136) (blood)	4	The blood pints quantity (deductible) for the line item.
325	LINE BENEFICIARY PRIMARY PAYER PAID AMOUNT (130) (lprpayat)	15.2	Amount of a payment made on behalf of a medicare bene by a primary payer other than medicare, that the provider is applying to covered medicare charges on an CWFB claim.
340	LINE BENEFICIARY PRIMARY PAYER CODE (129) (lprpaycd)	1	Specifies a federal non-medicare program or other source that has primary responsibility for the payment of the medicare bene's medical bills.(Refer to Appendix table PRPAY_CD)
341	LINE INTEREST AMOUNT (133)	15.2	Amount of interest to be paid on

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	(lintamt)		this line item.
356	CARRIER LINE PERFORMING UPIN NUMBER(101) (perupin)	6	Unique identifier of physician performing the UPIN NUMBER procedure specified by the HCPCS code.
362	CARRIER LINE PERFORMING PROVIDER ZIP CODE (107) (prozip)	9	Zip code of the physician/supplier who performed the Part B service for this line item
371	CARRIER LINE REDUCED PAYMENT PHYSICIAN ASSISTANT CODE (111) (astnt_cd)	1	Code that identifies claims that have been paid a reduced fee schedule amount (65%, 75%, or 85%) because a phys assist. performed the services Blank - Adjustment situation 0 - N/A 1 - 65% A) Physician assistants assisting in surgery B) Nurse midwives 2 - 75% A) Physician assistants performing services in a hospital (other than assisting surgery) B) Nurse practitioners and clinical nurse specialists performing services in rural areas C) Clinical social worker services 3 - 85% A) Physician assistant services for other than assisting surgery B) Nurse practitioners services
372	CARRIER LINE CLIA ALERT INDICATOR CODE (150) (cliaind)	1	Physician/supplier line item added by CWF as the result of CLIA editing (eff 9/92 but not stored until 10/93) 0 - No alert 1 - 77X9 2 - 77XA 3 - 77X5 4 - 77X6

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			5 - 77X7
			6 - 77X8
			7 - 77XB
373	LINE ADDITIONAL CLAIM DOCUMENTATION INDICATOR CODE (151) (docindcd)	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
374	CARRIER LINE DURABLE MEDICAL EQUIP COVERAGE PERIOD START DATE (152) (dmestm, dmestd, dmesty)	8	The date durable medical equipment (DME) coverage period started. MMDDYYYY
382	LINE DURABLE MEDICAL EQUIP PURCHASE PRICE AMOUNT (153) (dmeamt)	15.2	Amount representing the lower of fee schedule for purchase of new or used DME, or actual charge.
397	CARRIER LINE DURABLE MEDICAL EQUIP MEDICAL NECESSITY MONTH COUNT (154) (dmeCNT)	4	The count determined by carrier showing the length of need (medical necessity) for DME in months from the start date through determined period of need.
401	CLAIM DIAGNOSIS CODES (97)	5*4	Up to four 5 digit ICD-9 diagnosis codes. For persons

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	(dgn_cd1-dgn_cd4)		with less than four codes the columns are blank filled.
421	BETOS CODE (122) (betos)	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)
424	YEAR OF FILE (year)	4	Year of the File.
428	SEGMENT LINK NUMBER (19) (link_num)	10	A system generated number used to keep records/segments belonging to a specific claim together.
438	TOTAL SEGMENT COUNT (20) (tot_seg)	2	Total number of segments for each claim. (corresponds to the total number of original variable-length records for each claim. Max = 10).
440	SEGMENT NUMBER (21) (seg_num)	2	Number of each segment. (corresponds to original variable-length record for this claim. Values 1 to 10).
442	TOTAL LINE COUNT (22) (tot_lin)	3	The total number of Revenue Center lines associated with the claim.
445	Filler	1	