

<u>COL</u>	<u>FIELD</u>	<u>LENGTH</u>	<u>NOTES</u>
1	Patient ID (patient_id) SEER Cases (Patient ID)	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
	Non Cancer Patients – Patient ID		
1	HIC (HICBIC)	11	Encrypted ID for Non Cancer Patients
12	BENEFICIARY IDENTIFICATION CODE (BIC) (8)	2	Relationship between individual and a primary Social Security Administration Beneficiary. (Refer to Appendix table BIC)
14	SSA STANDARD STATE CODE (10) (state_cd)	2	State of Beneficiary's residence, SSA Standard Code. (Refer to Appendix table STATE_CD)
16	SSA STANDARD COUNTY CODE (30) (cnty_cd)	3	County of Beneficiary's residence, SSA Standard Code.
19	MAILING CONTACT ZIP CODE (37) (bene_zip)	9	Beneficiary's mailing address zip code. *Special Permission Required.
28	CWF 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

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30	CLAIM TYPE CODE (5) (clm_type)	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) (from_dtm, from_dtd, from_dty)	8	For Institutional or CWFB Claim, first day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
40	CLAIM THROUGH DATE (12) (thru_dtm, thru_dtd, thru_dty)	8	Last day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
48	FI NUMBER (34) (fi_num)	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)
54	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)
55	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

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56	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. Encrypted data. * Special permission required for unencrypted data.
62	CARRIER CLAIM REFERRING PHYSICIAN NPI NUMBER (54) (rfr_npi)	10	A placeholder field (effective with Version H) for storing the NPI assigned to the physician who referred beneficiary to physician that performed the Part B services.
72	LINE HCFA PROVIDER SPEC CODE (101) (hcfaspec)	2	HCFA Specialty code used for pricing the service for this line item on the CWFB claim. (Refer to appendix table HCFASPEC)
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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75	LINE PROCESSING INDICATOR CODE (131) (proindcd)	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) (pay80cd)	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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77	LINE SERVICE DEDUCTIBLE INDICATOR SWITCH (133) (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
78	LINE PAYMENT INDICATOR CODE (134) (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)
79	CARRIER MILES/TIME/UNITS/SERVICES COUNT (135) (mtuscnt)	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) (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 3 = Number of services 4 = Oxygen volume units 6 = Drug Dosage
88	LINE HCPCS CODE (108) (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)

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93	LINE HCPCS INITIAL MODIFIER CODE (109) (mfrcd1)	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) (mfrcd2)	2	Second modifier to enable a more specific procedure ID (Carrier Information File)
101	LINE SUBMITTED CHARGE AMOUNT (127) (submamnt)	15.2	The amount of submitted charges reported on the line item on the CWFB claim.
116	LINE ALLOWED CHARGE AMOUNT (128) (alowamt)	15.2	The amount of allowed charges reported on the line item on the CWFB claim.
131	LINE HCFA TYPE OF SERVICE CODE (104) (hcfatype)	1	Carrier's type of service code (usually different from HCFA's) used for pricing this service.
132	LINE PLACE OF SERVICE CODE (105) (plcsrvc)	2	Place of service for this procedure code. (Refer to appendix table PLCSRVC)
134	LINE FIRST EXPENSE DATE (106) (frexpenm, frexpend, frexpeny)	8	Beginning date of this service. (MMDDYYYY)
142	LINE LAST EXPENSE DATE (107) (lsexpenm, lsexpend, lsexpeny)	8	Ending date for this service.
150	LINE SERVICE COUNT (103) (srvc_cnt)	4	Count of the total number of services processed.
154	LINE DIAGNOSIS CODE (137) (linediag)	5	ICD – 9-CM code indicating diagnosis supporting this procedure/service.
159	LINE PAYMENT AMOUNT (117) (linepmt)	15.2	Amount of payment made to provider and/or beneficiary for the services covered
174	LINE BENEFICIARY PART B DEDUCTIBLE AMOUNT (120) (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.
189	LINE BENEFICIARY PRIMARY PAYER PAID AMOUNT (122) (lprpayat)	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.

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204	LINE BENEFICIARY PRIMARY PAYER CODE (121) (lprpaycd)	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 BENEFICIARY PAYMENT AMOUNT (126) (lbenpmt)	15.2	The payment (reimbursement) made to the beneficiary related to the line item service on the non-institutional claim.
220	LINE PROVIDER PAYMENT AMOUNT (127) (lprvpmt)	15.2	The payment made to the provider for the line item service on the non-institutional claim.
235	LINE COINSURANCE AMOUNT (131) (coinamt)	15.2	The beneficiary coinsurance liability amount for this line item service on the non-institutional claim.
250	CARRIER CLAIM CASH DEDUCTIBLE APPLIED AMOUNT (61) (dedapply)	15.2	The amount of the cash deductible as submitted on the claim.
265	CARRIER CLAIM PRIMARY PAYER PAID AMOUNT (51) (prpayamt)	15.2	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.
280	CLAIM PAYMENT AMOUNT (50) (pmt_amt)	15.2	Amount of payment made from the Medicare trust fund for the services covered by the claim record.
295	NCH CARRIER CLAIM ALLOWED CHARGE AMOUNT (60) (alowchrg)	15.2	The total allowed charges on the claim (the sum of line item allowed charges).
310	NCH CARRIER CLAIM SUBMITTED CHARGE AMOUNT (59) (sbmtchrg)	15.2	The total submitted charges on the claim (the sum of line item submitted charges).
325	NCH CLAIM PROVIDER PAYMENT AMOUNT (56) (prov_pmt)	15.2	The total payments made to the provider for this claim (sum of line item provider payment amounts).
340	LINE PRIMARY PAYER ALLOWED CHARGE AMOUNT (134) (prpyalow)	15.2	The primary payer allowed charge amount for the line item service on the non-institutional claim.

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355	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. (Blanked out)
369	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 physician assistant 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
370	CARRIER CLAIM HCPCS YEAR CODE (62) (hcpcs_yr)	1	The terminal digit of HCPCS version used to code the claim.
371	CARRIER LINE PERFORMING PIN NUMBER (100) (per_pin)	10	The profiling id number of the physician/supplier who performed the service. (Blanked out)
381	CARRIER LINE PERFORMING UPIN NUMBER (101) (perupin)	6	Unique identifier of physician performing the UPIN number procedure specified by the HCPCS code. Encrypted data. * Special permission required for unencrypted data.

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387	CARRIER LINE PERFORMING NPI NUMBER (102) (prf_npi)	10	A placeholder field (effective with Version H) for storing the NPI assigned to the performing provider.
397	CARRIER LINE PERFORMING GROUP NPI NUMBER (103) (prgrp_npi)	10	A placeholder field (effective with Version H) for storing the NPI assigned to a group practice, where the performing physician is part of that group. If the physician is not part of a group, this field will be blank.
407	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)
408	LINE NCH PROVIDER STATE CODE (106) (prvstate)	2	SSA State code where provider facility is located.
410	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. (Blanked out)
419	CARRIER CLAIM LINE COUNT (77) (clinecnt)	2	The count of the number of line items reported on the carrier claim.
421	SEGMENT LINK NUMBER (19) (link_num)	10	An IMS generated number used to keep records/segments belonging to a specific claim together.
431	DAILY PROCESS DATE (18) (daily_dtm,daily_dtd, daily_dty)	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
439	DESY SORT KEY (desy_sort_key)	9	Id that helps to identify a claim. (Blanked out)
448	Principle Diagnosis (pdgns_cd)	5	Beneficiaries principle diagnosis code.
453	CARRIER CLAIM DIAGNOSIS CODE COUNT (76) (cdgncnt)	1	The count of the number of diagnosis codes reported on the carrier claim.
454	CLAIM DIAGNOSIS CODES (92) (dgn_cd1-dgn_cd8)	5*8	Up to eight 5 digit ICD-9 diagnosis codes. For persons with less than eight codes the columns are blank filled.

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494	BETOS CODE (113) (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)
497	YEAR OF FILE (year)	4	Year of the file
501	RECORD COUNT (rec_count)	3	Record count for claim
504	Filler	1	

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