

<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 42 = Kentucky 43 = Louisiana 44 = New Jersey 87 = Georgia 88 = California
3	Case Number	8	Encrypted SEER Case Number
11	Filler	1	Blank Space
	Non Cancer Patients – Patient ID		
1	HIC (9) (HICBIC)	11	Encrypted ID for Non Cancer Patients
12	BENEFICIARY IDENTIFICATION CODE (12) (BIC)	2	Relationship between individual and a primary Social Security Administration Beneficiary. (Refer to Appendix table BIC)
14	SSA STANDARD STATE CODE (14) (state_cd)	2	State of Beneficiary's residence, SSA Standard Code. (Refer to Appendix table STATE_CD)
16	SSA STANDARD COUNTY CODE (42) (cnty_cd)	3	County of Beneficiary's residence, SSA Standard Code.
19	MAILING CONTACT ZIP CODE (49) (bene_zip)	9	Beneficiary's mailing address zip code. *Special Permission Required.
28	CWF MEDICARE STATUS (53) (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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<u>COL</u>	<u>FIELD</u>	<u>LENGTH</u>	<u>NOTES</u>
30	NCH CLAIM TYPE CODE (7) (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' 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 (15) (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 (16) (thru_dtm, thru_dtd, thru_dty)	8	Last day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
48	FI NUMBER (46) (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 Outpatient, HHA, Hospice)
53	PROVIDER NUMBER (23) (provider)	6	ID of Medicare Provider certified to provide services to the Beneficiary. Encrypted Data. * Special Permission required to receive unencrypted data.

<u>COL</u>	<u>FIELD</u>	<u>LENGTH</u>	<u>NOTES</u>
59	CLAIM QUERY CODE (22) (query_cd)	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 (34) (fac_type)	1	Facility that provided care. (Refer to Appendix table FAC_TYPE).
61	CLAIM SERVICE CLASSIFICATION TYPE CODE (35) (typesrvc)	1	Classification of type of service provided to the Beneficiary. (Refer to Appendix table TYPESRVC).
62	CLAIM FREQUENCY CODE (36) (freq_cd)	1	Sequence of claim in the Beneficiary's current episode of care associated with a given facility. (Refer to Appendix table FREQ_CD).
63	CLAIM MEDICARE NON PAYMENT REASON CODE (62) (nopay_cd)	2	The reason that no Medicare payment is made for services on an institutional claim. (Refer to appendix table NOPAY_CD)
65	CLAIM PAYMENT AMOUNT (64) (pmt_amt)	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.
80	CLAIM TOTAL CHARGE AMOUNT (103) (tot_chrg)	15.2	Total charges for all services included on the institutional claim.
95	PRIMARY PAYER CODE (66) (prpay_cd)	1	Federal non-Medicaid program or other source with primary responsibility for payment of Beneficiary's medical bills. (Refer to appendix table PRPAY_CD)
96	PRIMARY PAYER CLAIM PAID AMOUNT (65) (prpayamt)	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.
111	FI CLAIM ACTION CODE (68) (actioncd)	1	Action requested by Intermediary to be taken on an Institutional claim. (Refer to Appendix table ACTIONCD).

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112	NCH PROVIDER STATE CODE (70) (prvstate)	2	SSA state code where provider facility is located. (Refer to appendix table STATE_CD).
114	ORGANIZATION NPI NUMBER (71) (orgnpinm)	10	The NPI assigned to the institutional provider. The NPI may not be available prior to 7/1/2007. Encrypted Data. * Special permission required to receive unencrypted data.
124	CLAIM ATTENDING PHYSICIAN UPIN NUMBER (73) (at_upin)	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. Encrypted Data. * Special permission required to receive unencrypted data.
130	CLAIM ATTENDING PHYSICIAN NPI NUMBER (74) (at_npi)	10	The NPI assigned to the attending physician. The NPI may not be available prior to 7/1/2007. Encrypted Data. * Special permission required to receive unencrypted data.
140	CLAIM OPERATING PHYSICIAN UPIN NUMBER (79) (op_upin)	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. Encrypted Data. * Special permission required to receive unencrypted data.
146	CLAIM OPERATING PHYSICIAN NPI NUMBER (80) (op_npi)	10	The NPI assigned to the operating physician. The NPI may not be available prior to 7/1/2007. Encrypted Data. * Special permission required to receive unencrypted data.
156	CLAIM OTHER PHYSICIAN UPIN NUMBER (85) (ot_upin)	6	On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim. Encrypted Data. * Special permission required to receive unencrypted data.
162	CLAIM OTHER PHYSICIAN NPI NUMBER (86) (ot_npi)	10	The NPI assigned to the other physician. The NPI may not be available prior to 7/1/2007. Encrypted Data. * Special permission required to receive unencrypted data.
172	PATIENT DISCHARGE STATUS CODE (98) (stus_cd)	2	Status of Beneficiary as of Service Through Date on a claim. (Refer to Appendix table STUS_CD).

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174	CLAIM PPS INDICATOR CODE (102) (pps_ind)	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.
175	CLAIM TOTAL LINE COUNT (28) (tot_line)	3	The total number of Revenue Center lines associated with the claim.
178	CLAIM SEGMENT LINE COUNT (29) (seg_line)	2	The count used to identify the number of lines on a record/segment.
180	CLAIM MCO PAID SWITCH (92) (mcopdsw)	1	A switch indicating whether or not a Managed Care Organization (MCO) has paid the provider for an institutional claim.
181	CLAIM TREATMENT AUTHORIZATION NUMBER (93) (authrzttn)	18	The number assigned by the medical reviewer and reported by the provider to identify the medical review (treatment authorization) action taken after review of the beneficiary's case.
199	CLAIM 1ST DIAGNOSIS E CODE (101) (e1dgnsacd)	7	The code used to identify the 1st external cause of injury, poisoning, or other adverse effect. This diagnosis E code is also stored as the 1st occurrence of the diagnosis E code trailer.
206	CLAIM SERVICE FACILITY ZIP CODE (108) (srvcfac)	9	The zip code used to identify the location of the facility where the service was performed.
215	OUTPATIENT REVENUE CENTER CODE COUNT (124) (oprevcnt)	2	The count of the number of revenue codes reported on an inpatient/SNF claim. The purpose of the count is to indicate how many revenue center trailers are present.
217	CLAIM OUTPATIENT SERVICE TYPE CODE (127) (opsrvtyp)	1	Code indicating type and priority of outpatient service.
218	CLAIM OUTPATIENT REFERRAL CODE (128) (op_rfrl)	1	The code indicating the means by which the beneficiary was referred for outpatient services.
219	REVENUE CENTER CODE (199) (center)	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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<u>COL</u>	<u>FIELD</u>	<u>LENGTH</u>	<u>NOTES</u>
223	REVENUE CENTER DATE (200) (cendm, cendd, cendy)	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
231	REVENUE CENTER 1ST ANSI CODE (201) (revan1)	5	The first code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).
236	REVENUE CENTER APC/HIPPS (205) (revhipps)	5	This field was created to house two pieces of data. The Ambulatory Payment Classification (APC) code and the HIPPS code.
241	HCPCS CODE (206) (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)
246	HCPCS INITIAL MODIFIER CODE (207) (mf1)	2	First modifier to the procedure code to enable a more specific procedure ID for the claim. (Carrier Information file)
248	HCPCS SECOND MODIFIER CODE (208) (mf2)	2	Second modifier to the procedure code to enable a more specific procedure ID. (Carrier Information file)
250	HCPCS THIRD MODIFIER CODE (209) (mf3)	2	A third modifier to the procedure code to make it more specific than the second modifier code to identify the procedures performed on the beneficiary for the claim.
252	REVENUE CENTER PAYMENT METHOD INDICATOR CODE (212) (pmtmthd)	2	The code used to identify how the service is priced for payment. This field is made up of two pieces of data, 1st position being the service indicator and the 2nd position being the payment indicator.
254	REVENUE CENTER DISCOUNT INDICATOR CODE (213) (dscntind)	1	The code used to identify those services that are packaged/bundled with another service.

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255	REVENUE CENTER PACKAGING INDICATOR CODE (214) (packgind)	1	The code used to identify those services that are packaged/bundled with another service.
256	REVENUE CENTER PRICING INDICATOR CODE (215) (pricing)	2	The code used to identify if there was a deviation from the standard method of calculating payment amount.
258	REVENUE CENTER NDC QUANTITY QUALIFIER CODE (218) (qtyqlfr)	2	The code used to indicate the unit of measurement for the drug that was administered.
260	REVENUE CENTER NDC QUANTITY (219) (ndcqty)	15.3	The quantity dispensed for the drug reflected on the revenue center line item.
275	REVENUE CENTER UNIT COUNT (220) (unit)	8	A quantitative measure (unit) of services provided to a beneficiary associated with accommodation and ancillary revenue centers described on an institutional claim.
283	REVENUE CENTER RATE AMOUNT (221) (rate)	15.2	Charges relating to unit cost associated with the revenue center code.
298	REVENUE CENTER CASH DEDUCTIBLE AMOUNT (223) (revdctbl)	15.2	The amount of cash deductible the beneficiary paid for the line item service.
313	REVENUE CENTER COINSURANCE/WAGE ADJUSTED COINSURANCE AMOUNT (224) (wageadj)	15.2	The amount of coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted.
328	REVENUE CENTER 1ST MEDICARE SECONDARY PAYER PAID AMOUNT (226) (rev_msp1)	15.2	The amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary).
343	REVENUE CENTER PROVIDER PAYMENT AMOUNT (228) (rprvdpmt)	15.2	The amount paid to the provider for the services reported on the line item.
358	REVENUE CENTER PATIENT RESPONSIBILITY PAYMENT AMOUNT (230) (ptntresp)	15.2	The amount paid by the beneficiary to the provider for the line item service.

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373	REVENUE CENTER TOTAL CHARGE AMOUNT (232) (charge)	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.
388	REVENUE CENTER PAYMENT AMOUNT (231) (pay)	15.2	Medicare payment amount for the specific revenue center.
403	REVENUE CENTER NON-COVERED CHARGE AMOUNT (233) (revncvr)	15.2	The charge amount related to a revenue center code for services that are not covered by Medicare.
418	REVENUE CENTER DEDUCTIBLE COINSURANCE CODE (234) (ded)	1	Code indicating whether the revenue center charges are subject to deductible and/or coinsurance. (Refer to Appendix table DED).
419	REVENUE CENTER STATUS INDICATOR CODE (236) (rstusind)	2	The code used to identify the status of the line item service. This field along with the payment method indicator field is used to identify how the service was priced for payment.
421	REVENUE CENTER DUPLICATE CLAIM CHECK INDICATOR CODE (237) (dup_chk)	1	The code used to identify an item or service that appeared to be a duplicate but has been reviewed by an FI or MAC and appropriately approved for payment.
422	YEAR OF CLAIMS FILE (year)	4	Year of the Claims file.
426	SEGMENT LINK NUMBER (25) (link_num)	10	A system generated by CMS number used to keep records/segments belonging to a specific claim together. Use in conjunction with the daily date in column 436 to identify a specific claim.
436	DAILY PROCESS DATE (24) (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
444	TOTAL SEGMENT COUNT (26) (tot_seg)	2	Total number of segments for each claim (corresponds to total number of original var-length recs for each claim. Max = 10)

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446	SEGMENT NUMBER (27) (seg_num)	2	Number of each segment (corresponds to the original var-length record for this claim. Values: 1 to 10)
448	RECORD COUNT (rec_count)	3	Counter for each claim.
451	BENEFICIARY PART B DEDUCTIBLE AMOUNT (130) (ptb_ded)	15.2	Beneficiary's liability for Part B cash deductible as determined by intermediary or Carrier.
466	BENEFICIARY PART B COINSURANCE AMOUNT (131) (ptb_coin)	15.2	Beneficiary's liability for Part B coinsurance as determined by intermediary.
481	NCH BENEFICIARY BLOOD DEDUCTIBLE LIABILITY AMOUNT (129) (blddedam)	15.2	The amount of money for which the intermediary determined the beneficiary is liable for the blood deductible.
496	CLAIM OUTPATIENT PROVIDER PAYMENT AMOUNT (134) (prvdrpmt)	15.2	The amount paid, from the Medicare trust fund, to the provider for the services reported on the outpatient claim.
511	NCH BLOOD PINTS FURNISHED QUANTITY (136) (bldfrnsh)	3	Number of whole pints of blood furnished to the beneficiary.
514	NCH BLOOD DEDUCTIBLE PINTS QUANTITY (139) (blddedpt)	3	The quantity of blood pints applied (blood deductible).
517	CLAIM OUTPATIENT TRANSACTION TYPE CODE (140) (trantype)	1	The code derived at CWF based on type of bill and provider number to identify the outpatient transaction type. (Refer to Appendix table TRANS_CD).
518	NCH EDIT TRAILER INDICATOR CODE (151) (editind1)	1	The code indicating the presence of an NCH edit trailer.
519	NCH EDIT CODE (152) (editcd1)	4	The code annotated to the claim indicating the CWFMA editing results so users will be aware of data deficiencies.

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The MCO variables repeat 2 times in columns 523 to 568:

523	MCO TRAILER INDICATOR CODE (158) (mcoind1)	1	The code indicating the presence of a Managed Care Organization (MCO) trailer.
524	MCO CONTRACT NUMBER (159) (mconum1)	5	This field represents the plan contract number of the Managed Care Organization (MCO).
529	MCO OPTION CODE (160) (mcoptn1)	1	The code indicating Managed Care Organization (MCO) lock-in enrollment status of the beneficiary.
530	MCO PERIOD EFFECTIVE DATE (161) (mcoedty1, mcoedtm1, mcoedtd1)	8	The date the beneficiary's enrollment in the Managed Care Organization (MCO) became effective. YYYYMMDD
538	MCO PERIOD TERMINATION DATE (162) (mcotdy1, mcotdtm1, mcotdtd1)	8	The date the beneficiary's enrollment in the Managed Care Organization (MCO) was terminated. YYYYMMDD
569	DIAGNOSIS CODES (171) (dgn_cd1-25)	25*7	ICD-9-CM codes of any coexisting conditions shown in medical record as affecting services provided. Up to 25 codes may be listed, each with 7 digits.
744	CLAIM DIAGNOSIS E CODE (175) (edgnsd1-6)	6*7	The diagnosis code identifying the beneficiary's principal or other diagnosis (including E code).

Claim Procedure fields repeat 13 times in columns 786 to 981:

786	CLAIM PROCEDURE CODES (179) (prcdr_cd1)	7	ICD-9-CM code that indicates the principal or other procedure performed during the period covered by the institutional claim.
793	CLAIM PROCEDURE PERFORMED DATES (180) (prcdrdtm1, prcdrdtd1, prcdrdty1)	8	On an institutional claim, the date on which the principal or other procedure was performed. MMDDYYYY
981	CLAIM RELATED CONDITION CODE (183) (rlt_cond1-5)	5*2	The code that indicates a condition relating to an institutional claim that may affect payer processing.

The Occurrence variables repeat 14 times in columns 991 to 1130:

991	CLAIM RELATED OCCURRENCE CODE (186) (ocrnc_cd1)	2	The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date.
993	CLAIM RELATED OCCURRENCE DATE (187) (ocrncdty1, ocrncdtm1, ocrncdtd1)	8	The date associated with a significant event related to an institutional claim that may affect payer processing. YYYYMMDD
1131	Filler	1	