

Appendix for SEER-Medicare 1/2009 Claims Files

(BENE_IDENT_CD)

Social Security Administration:

A = Primary claimant
 B = Aged wife, age 62 or over (1st claimant)
 B1 = Aged husband, age 62 or over (1st claimant)
 B2 = Young wife, with a child in her care (1st claimant)
 B3 = Aged wife (2nd claimant)
 B4 = Aged husband (2nd claimant)
 B5 = Young wife (2nd claimant)
 B6 = Divorced wife, age 62 or over (1st claimant)
 B7 = Young wife (3rd claimant)
 B8 = Aged wife (3rd claimant)
 B9 = Divorced wife (2nd claimant)
 BA = Aged wife (4th claimant)
 BD = Aged wife (5th claimant)
 BG = Aged husband (3rd claimant)
 BH = Aged husband (4th claimant)
 BJ = Aged husband (5th claimant)
 BK = Young wife (4th claimant)
 BL = Young wife (5th claimant)
 BN = Divorced wife (3rd claimant)
 BP = Divorced wife (4th claimant)
 BQ = Divorced wife (5th claimant)
 BR = Divorced husband (1st claimant)
 BT = Divorced husband (2nd claimant)
 BW = Young husband (2nd claimant)
 BY = Young husband (1st claimant)
 C1-C9,CA-CZ = Child (includes minor, student or disabled child)
 D = Aged widow, 60 or over (1st claimant)
 D1 = Aged widower, age 60 or over (1st claimant)
 D2 = Aged widow (2nd claimant)
 D3 = Aged widower (2nd claimant)
 D4 = Widow (remarried after attainment of age 60) (1st claimant)
 D5 = Widower (remarried after attainment of age 60) (1st claimant)
 D6 = Surviving divorced wife, age 60 or over (1st claimant)
 D7 = Surviving divorced wife (2nd claimant)
 D8 = Aged widow (3rd claimant)
 D9 = Remarried widow (2nd claimant)
 DA = Remarried widow (3rd claimant)
 DD = Aged widow (4th claimant)
 DG = Aged widow (5th claimant)
 DH = Aged widower (3rd claimant)
 DJ = Aged widower (4th claimant)
 DK = Aged widower (5th claimant)
 DL = Remarried widow (4th claimant)
 DM = Surviving divorced husband (2nd claimant)
 DN = Remarried widow (5th claimant)
 DP = Remarried widower (2nd claimant)
 DQ = Remarried widower (3rd claimant)
 DR = Remarried widower (4th claimant)
 DS = Surviving divorced husband (3rd claimant)
 DT = Remarried widower (5th claimant)
 DV = Surviving divorced wife (3rd claimant)
 DW = Surviving divorced wife (4th claimant)
 DX = Surviving divorced husband (4th claimant)
 DY = Surviving divorced wife (5th claimant)
 DZ = Surviving divorced husband (5th claimant)
 E = Mother (widow) (1st claimant)
 E1 = Surviving divorced mother (1st claimant)
 E2 = Mother (widow) (2nd claimant)
 E3 = Surviving divorced mother (2nd claimant)

BIC

Beneficiary Identification Code (BIC) Table

(BENE_IDENT_CD)

- E4 = Father (widower) (1st claimant)
- E5 = Surviving divorced father (widower) (1st claimant)
- E6 = Father (widower) (2nd claimant)
- E7 = Mother (widow) (3rd claimant)
- E8 = Mother (widow) (4th claimant)
- E9 = Surviving divorced father (widower) (2nd claimant)
- EA = Mother (widow) (5th claimant)
- EB = Surviving divorced mother (3rd claimant)
- EC = Surviving divorced mother (4th claimant)
- ED = Surviving divorced mother (5th claimant)
- EF = Father (widower) (3rd claimant)
- EG = Father (widower) (4th claimant)
- EH = Father (widower) (5th claimant)
- EJ = Surviving divorced father (3rd claimant)
- EK = Surviving divorced father (4th claimant)
- EM = Surviving divorced father (5th claimant)
- F1 = Father
- F2 = Mother
- F3 = Stepfather
- F4 = Stepmother
- F5 = Adopting father
- F6 = Adopting mother
- F7 = Second alleged father
- F8 = Second alleged mother
- J1 = Primary prouty entitled to HIB (less than 3 Q.C.) (general fund)
- J2 = Primary prouty entitled to HIB (over 2 Q.C.) (RSI trust fund)
- J3 = Primary prouty not entitled to HIB (less than 3 Q.C.) (general fund)
- J4 = Primary prouty not entitled to HIB (over 2 Q.C.) (RSI trust fund)
- K1 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)
- K2 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)
- K3 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)
- K4 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)
- K5 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)
- K6 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)
- K7 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)
- K8 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)
- K9 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)
- KA = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)
- KB = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)
- KC = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)
- KD = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (4th claimant)
- KE = Prouty wife entitled to HIB (over 2 Q.C.) (4th claimant)
- KF = Prouty wife not entitled to HIB (less than 3 Q.C.) (4th claimant)
- KG = Prouty wife not entitled to HIB (over

 (BENE_IDENT_CD)

2 Q.C.) (4th claimant)
 KH = Prouty wife entitled to HIB (less than
 3 Q.C.) (5th claimant)
 KJ = Prouty wife entitled to HIB (over 2
 Q.C.) (5th claimant)
 KL = Prouty wife not entitled to HIB (less
 than 3 Q.C.) (5th claimant)
 KM = Prouty wife not entitled to HIB (over
 2 Q.C.) (5th claimant)
 M = Uninsured-not qualified for deemed HIB
 M1 = Uninsured-qualified but refused HIB
 T = Uninsured-entitled to HIB under deemed
 or renal provisions
 TA = MQGE (primary claimant)
 TB = MQGE aged spouse (first claimant)
 TC = MQGE disabled adult child (first claimant)
 TD = MQGE aged widow(er) (first claimant)
 TE = MQGE young widow(er) (first claimant)
 TF = MQGE parent (male)
 TG = MQGE aged spouse (second claimant)
 TH = MQGE aged spouse (third claimant)
 TJ = MQGE aged spouse (fourth claimant)
 TK = MQGE aged spouse (fifth claimant)
 TL = MQGE aged widow(er) (second claimant)
 TM = MQGE aged widow(er) (third claimant)
 TN = MQGE aged widow(er) (fourth claimant)
 TP = MQGE aged widow(er) (fifth claimant)
 TQ = MQGE parent (female)
 TR = MQGE young widow(er) (second claimant)
 TS = MQGE young widow(er) (third claimant)
 TT = MQGE young widow(er) (fourth claimant)
 TU = MQGE young widow(er) (fifth claimant)
 TV = MQGE disabled widow(er) fifth claimant
 TW = MQGE disabled widow(er) first claimant
 TX = MQGE disabled widow(er) second claimant
 TY = MQGE disabled widow(er) third claimant
 TZ = MQGE disabled widow(er) fourth claimant
 T2-T9 = Disabled child (second to ninth
 claimant)
 W = Disabled widow, age 50 or over (1st
 claimant)
 W1 = Disabled widower, age 50 or over (1st
 claimant)
 W2 = Disabled widow (2nd claimant)
 W3 = Disabled widower (2nd claimant)
 W4 = Disabled widow (3rd claimant)
 W5 = Disabled widower (3rd claimant)
 W6 = Disabled surviving divorced wife (1st
 claimant)
 W7 = Disabled surviving divorced wife (2nd
 claimant)
 W8 = Disabled surviving divorced wife (3rd
 claimant)
 W9 = Disabled widow (4th claimant)
 WB = Disabled widower (4th claimant)
 WC = Disabled surviving divorced wife (4th
 claimant)
 WF = Disabled widow (5th claimant)
 WG = Disabled widower (5th claimant)
 WJ = Disabled surviving divorced wife (5th
 claimant)
 WR = Disabled surviving divorced husband
 (1st claimant)
 WT = Disabled surviving divorced husband
 (2nd claimant)

Railroad Retirement Board:

NOTE:

Employee: a Medicare beneficiary who is
 still working or a worker who
 died before retirement
 Annuitant: a person who retired under the
 railroad retirement act on or
 after 03/01/37
 Pensioner: a person who retired prior to
 03/01/37 and was included in the
 railroad retirement act

BIC

Beneficiary Identification Code (BIC) Table

(BENE_IDENT_CD)

- 10 = Retirement - employee or annuitant
- 80 = RR pensioner (age or disability)
- 14 = Spouse of RR employee or annuitant (husband or wife)
- 84 = Spouse of RR pensioner
- 43 = Child of RR employee
- 13 = Child of RR annuitant
- 17 = Disabled adult child of RR annuitant
- 46 = Widow/widower of RR employee
- 16 = Widow/widower of RR annuitant
- 86 = Widow/widower of RR pensioner
- 43 = Widow of employee with a child in her care
- 13 = Widow of annuitant with a child in her care
- 83 = Widow of pensioner with a child in her care
- 45 = Parent of employee
- 15 = Parent of annuitant
- 85 = Parent of pensioner
- 11 = Survivor joint annuitant (reduced benefits taken to insure benefits for surviving spouse)

PRPAY_CD

Beneficiary Primary Payer Table

(BENE_PRMRY_PYR_CD)

- A = Working aged bene/spouse with employer group health plan (EGHP)
- B = End stage renal disease (ESRD) beneficiary in the 18 month coordination period with an employer group health plan
- C = Conditional payment by Medicare; future reimbursement expected
- D = Automobile no-fault (eff. 4/97; Prior to 3/94, also included any liability insurance)
- E = Workers' compensation
- F = Public Health Service or other federal agency (other than Dept. of Veterans Affairs)
- G = Working disabled bene (under age 65 with LGHP)
- H = Black Lung
- I = Dept. of Veterans Affairs
- J = Any liability insurance (eff. 3/94 - 3/97)
- L = Any liability insurance (eff. 4/97) (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)
- M = Override code: EGHP services involved (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)
- N = Override code: non-EGHP services involved (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)
- BLANK = Medicare is primary payer (not sure of effective date: in use 1/91, if not earlier)
- T = MSP cost avoided - IEQ contractor (eff. 7/96 carrier claims only)
- U = MSP cost avoided - HMO rate cell adjustment contractor (eff. 7/96 carrier claims only)
- V = MSP cost avoided - litigation settlement contractor (eff. 7/96 carrier claims only)
- X = MSP cost avoided override code (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)

PRPAY_CD

Beneficiary Primary Payer Table

(BENE_PRMRY_PYR_CD)

Prior to 12/90

Y = Other secondary payer investigation shows Medicare as primary payer

Z = Medicare is primary payer

NOTE: Values C, M, N, Y, Z and BLANK indicate Medicare is primary payer. (values Z and Y were used prior to 12/90. BLANK was suppose to be effective after 12/90, but may have been used prior to that date.)

PMTDNLCD

Carrier Claim Payment Denial Table

(CARR_CLM_PMT_DNL_CD)

- 0 = Denied
1 = Physician/supplier
2 = Beneficiary
3 = Both physician/supplier and beneficiary
4 = Hospital (hospital based physicians)
5 = Both hospital and beneficiary
6 = Group practice prepayment plan
7 = Other entries (e.g. Employer, union)
8 = Federally funded
9 = PA service
A = Beneficiary under limitation of liability
B = Physician/supplier under limitation of liability
D = Denied due to demonstration involvement (eff. 5/97)
E = MSP cost avoided IRS/SSA/HCFA Data Match (eff. 7/3/00)
F = MSP cost avoided HMO Rate Cell (eff. 7/3/00)
G = MSP cost avoided Litigation Settlement (eff. 7/3/00)
H = MSP cost avoided Employer Voluntary Reporting (eff. 7/3/00)
J = MSP cost avoided Insurer Voluntary Reporting (eff. 7/3/00)
K = MSP cost avoided Initial Enrollment Questionnaire (eff. 7/3/00)
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided - (Contractor #88888) voluntary agreement (eff. 1/98)
T = MSP cost avoided - IEQ contractor (eff. 7/96) (obsolete 6/30/00)
U = MSP cost avoided - HMO rate cell adjustment (eff. 7/96) (obsolete 6/30/00)
V = MSP cost avoided - litigation settlement (eff. 7/96) (obsolete 6/30/00)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data match project (obsolete 6/30/00)

PRV_TYPE

Carrier Line Provider Type Table

(CARR_LINE_PRVDR_TYPE_CD)

For Physician/Supplier (RIC O) Claims:

- 0 = Clinics, groups, associations, partnerships, or other entities
1 = Physicians or suppliers reporting as solo practitioners
2 = Suppliers (other than sole proprietorship)
3 = Institutional provider
4 = Independent laboratories
5 = Clinics (multiple specialties)
6 = Groups (single specialty)
7 = Other entities

PRV_TYPE

Carrier Line Provider Type Table

(CARR_LINE_PRVDR_TYPE_CD)

For DMERC (RIC M) Claims - PRIOR TO VERSION H:

- 0 = Clinics, groups, associations, partnerships, or other entities for whom the carrier's own ID number has been assigned.
- 1 = Physicians or suppliers billing as solo practitioners for whom SSN's are shown in the physician ID code field.
- 2 = Physicians or suppliers billing as solo practitioners for whom the carrier's own physician ID code is shown.
- 3 = Suppliers (other than sole proprietorship) for whom EI numbers are used in coding the ID field.
- 4 = Suppliers (other than sole proprietorship) for whom the carrier's own code has been shown.
- 5 = Institutional providers and independent laboratories for whom EI numbers are used in coding the ID field.
- 6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.
- 7 = Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field.
- 8 = Other entities for whom EI numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.

ASTNT_CD

Carrier Line Part B Reduced Physician Assistant Table

(CARR_LINE_RDCD_PHYSN_ASTNT_CD)

- BLANK = Adjustment situation (where CLM_DISP_CD equal 3)
- 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

FI_NUM (IN NCH, DME)

Carrier Number Table

(CARR_NUM_CD)

- 00510 = Alabama BS (eff. 1983)
- 00511 = Georgia - Alabama BS (eff. 1998)
- 00512 = Mississippi - Alabama BS (eff. 2000)
- 00520 = Arkansas BS (eff. 1983)
- 00521 = New Mexico - Arkansas BS (eff. 1998)
- 00522 = Oklahoma - Arkansas BS (eff. 1998)
- 00523 = Missouri - Arkansas BS (eff. 1999)
- 00528 = Louisiana - Arkansas BS (eff. 1984)
- 00542 = California BS (eff. 1983; term. 1996)
- 00550 = Colorado BS (eff. 1983; term. 1994)
- 00570 = Delaware - Pennsylvania BS (eff. 1983; term. 1997)
- 00580 = District of Columbia - Pennsylvania BS (eff. 1983; term. 1997)
- 00590 = Florida BS (eff. 1983)
- 00591 = Connecticut - Florida BS (eff. 2000)

FI_NUM (IN NCH, DME)

Carrier Number Table

(CARR_NUM_CD)

00621 = Illinois BS - HCSC (eff. 1983; term. 1998)
00623 = Michigan - Illinois Blue Shield (eff. 1995)
(term. 1998)
00630 = Indiana - Administar (eff. 1983)
00635 = DMERC-B (Administar Federal, Inc.)
(eff. 1993)
00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)
00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)
00650 = Kansas BS (eff. 1983)
00655 = Nebraska - Kansas BS (eff. 1988)
00660 = Kentucky - Administar (eff. 1983)
00690 = Maryland BS (eff. 1983; term. 1994)
00700 = Massachusetts BS (eff. 1983; term. 1997)
00710 = Michigan BS (eff. 1983; term. 1994)
00720 = Minnesota BS (eff. 1983; term. 1995)
00740 = Missouri - BS Kansas City (eff. 1983)
00751 = Montana BS (eff. 1983)
00770 = New Hampshire/Vermont Physician Services
(eff. 1983; term. 1984)
00780 = New Hampshire/Vermont - Massachusetts BS
(eff. 1985; term. 1997)
00801 = New York - Western BS (eff. 1983)
00803 = New York - Empire BS (eff. 1983)
00805 = New Jersey - Empire BS (eff. 3/99)
00811 = DMERC (A) - Western New York BS (eff. 2000)
00820 = North Dakota - North Dakota BS (eff. 1983)
00824 = Colorado - North Dakota BS (eff. 1995)
00825 = Wyoming - North Dakota BS (eff. 1990)
00826 = Iowa - North Dakota BS (eff. 1999)
00831 = Alaska - North Dakota BS (eff. 1998)
00832 = Arizona - North Dakota BS (eff. 1998)
00833 = Hawaii - North Dakota BS (eff. 1998)
00834 = Nevada - North Dakota BS (eff. 1998)
00835 = Oregon - North Dakota BS (eff. 1998)
00836 = Washington - North Dakota BS (eff. 1998)
00860 = New Jersey - Pennsylvania BS (eff. 1988;
term. 1999)
00865 = Pennsylvania BS (eff. 1983)
00870 = Rhode Island BS (eff. 1983)
00880 = South Carolina BS (eff. 1983)
00882 = RRB - South Carolina PGBA (eff. 2000)
00885 = DMERC C - Palmetto (eff. 1993)
00900 = Texas BS (eff. 1983)
00901 = Maryland - Texas BS (eff. 1995)
00902 = Delaware - Texas BS (eff. 1998)
00903 = District of Columbia - Texas BS (eff. 1998)
00904 = Virginia - Texas BS (eff. 2000)
00910 = Utah BS (eff. 1983)
00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)
00952 = Illinois - Wisconsin Phy Svc (eff. 1999)
00953 = Michigan - Wisconsin Phy Svc (eff. 1999)
00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
00973 = Triple-S, Inc. - Puerto Rico (eff. 1983)
00974 = Triple-S, Inc. - Virgin Islands
01020 = Alaska - AETNA (eff. 1983; term. 1997)
01030 = Arizona - AETNA (eff. 1983; term. 1997)
01040 = Georgia - AETNA (eff. 1988; term. 1997)
01120 = Hawaii - AETNA (eff. 1983; term. 1997)
01290 = Nevada - AETNA (eff. 1983; term. 1997)
01360 = New Mexico - AETNA (eff. 1986; term. 1997)
01370 = Oklahoma - AETNA (eff. 1983; term. 1997)
01380 = Oregon - AETNA (eff. 1983; term. 1997)
01390 = Washington - AETNA (eff. 1994; term. 1997)
02050 = California - TOLIC (eff. 1983)
(term. 2000)
03070 = Connecticut General Life Insurance Co.
(eff. 1983; term. 1985)
05130 = Idaho - Connecticut General (eff. 1983)
05320 = New Mexico - Equitable Insurance
(eff. 1983; term. 1985)
05440 = Tennessee - Connecticut General (eff. 1983)
05530 = Wyoming - Equitable Insurance (eff. 1983)
(term. 1989)
05535 = North Carolina - Connecticut General
(eff. 1988)
05655 = DMERC-D - Connecticut General (eff. 1993)

(CARR_NUM_CD)

10071 = Railroad Board Travelers (eff. 1983)
(term. 2000)
10230 = Connecticut - Metra Health (eff. 1986)
(term. 2000)
10240 = Minnesota - Metra Health (eff. 1983)
(term. 2000)
10250 = Mississippi - Metra Health (eff. 1983)
(term. 2000)
10490 = Virginia - Metra Health (eff. 1983)
(term. 2000)
10555 = Travelers Insurance Co. (eff. 1993)
(term. 2000)
11260 = Missouri - General American Life
(eff. 1983; term. 1998)
14330 = New York - GHI (eff. 1983)
16360 = Ohio - Nationwide Insurance Co.
16510 = West Virginia - Nationwide Insurance Co.
21200 = Maine - BS of Massachusetts
31140 = California - National Heritage Ins.
31142 = Maine - National Heritage Ins.
31143 = Massachusetts - National Heritage Ins.
31144 = New Hampshire - National Heritage Ins.
31145 = Vermont - National Heritage Ins.
31146 = So. California - NHIC (eff. 2000)

DISP_CD

Claim Disposition Table

(CLM_DISP_CD)

01 = Debit accepted
02 = Debit accepted (automatic adjustment)
applicable through 4/4/93
03 = 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

FAC_TYPE

Claim Facility Type Table

(CLM_FAC_TYPE_CD)

1 = Hospital
2 = Skilled nursing facility (SNF)
3 = Home health agency (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
6 = Intermediate care
7 = Clinic or hospital-based renal dialysis facility
8 = Special facility or ASC surgery
9 = Reserved

FREQ_CD

Claim Frequency Table

(CLM_FREQ_CD)

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 HH PPS
episode to indicate the claim
should be processed like debit/
credit adjustment to RAP (initial
claim) (eff. 10/00)

FREQ_CD

Claim Frequency Table

(CLM_FREQ_CD)

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 = HCFA generated adjustment (eff 10/93)
I = Misc adjustment claim (other than PRO or provider) - used to identify a debit adjustment initiated by HCFA or an intermediary - eff 10/93, used to identify intermediary initiated adjustment only
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 (TOB '11Z') used for MCO enrollee hospital discharges 7/1/97-12/31/98; not stored in NCH. Exception: Problem in startup months may have resulted in this abbreviated UB-92 being erroneously stored in NCH.

TYPESRVC

Claim Service Classification Type Table

(CLM_SRVC_CLSFCTN_TYPE_CD)

For facility type code 1 thru 6, and 9
1 = Inpatient (including Part A)
2 = Hospital based or Inpatient (Part B only) or home health visits under Part B
3 = Outpatient (HHA-A also)
4 = Other (Part B)
5 = Intermediate care - level I
6 = Intermediate care - level II
7 = Subacute Inpatient (formerly Intermediate care - level III)
8 = Swing beds (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)
9 = Reserved for national assignment

For facility type code 7
1 = Rural health
2 = Hospital based or independent renal dialysis facility
3 = Free-standing 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)
7-8 = Reserved for national assignment
9 = Other

For facility type code 8
1 = Hospice (non-hospital based)
2 = Hospice (hospital based)
Claim Service Classification Type Table

TYPESRVC

(CLM_SRVC_CLSFCTN_TYPE_CD)

- 3 = Ambulatory surgical center in hospital outpatient department
- 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

TRANS_CD

Claim Transaction Table

(CLM_TRANS_CD)

- 0 = Religious NonMedical Health Care Institutions (RNHCI) bill (prior to 8/00, Christian Science bill), SNF bill, or state buy-in
- 1 = Psychiatric hospital facility bill or dummy psychiatric
- 2 = Tuberculosis hospital facility bill
- 3 = General care hospital facility bill or dummy LRD
- 4 = Regular SNF bill
- 5 = Home health agency bill (HHA)
- 6 = Outpatient hospital bill
- C = CORF bill - type of OP bill in the HHA bill format (obsoleted 7/98)
- H = Hospice bill

Last Two digits in the HIC

Category Equatable Beneficiary Identification Code (BIC) Table

(CTGRY_EQTBL_BENE_IDENT_CD)

- | NCH BIC | SSA Categories |
|---------|--|
| A | = A;J1;J2;J3;J4;M;M1;T;TA |
| B | = B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6;TB(F);TD(F);TE(F);TW(F) |
| B1 | = B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M);TD(M);TE(M);TW(M) |
| B3 | = B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2
W7;TG(F);TL(F);TR(F);TX(F) |
| B4 | = B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG(M)
TL(M);TR(M);TX(M) |
| B8 | = B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4
W8;TH(F);TM(F);TS(F);TY(F) |
| BA | = BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9
WC;TJ(F);TN(F);TT(F);TZ(F) |
| BD | = BD;BL;BQ;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WF
WJ;TK(F);TP(F);TU(F);TV(F) |
| BG | = BG;DH;DQ;DS;EF;EJ;W5;TH(M);TM(M);TS(M);TY(M) |
| BH | = BH;DJ;DR;DX;EG;EK;WB;TJ(M);TN(M);TT(M);TZ(M) |
| BJ | = BJ;DK;DT;DZ;EH;EM;WG;TK(M);TP(M);TU(M);TV(M) |
| C1 | = C1;TC |
| C2 | = C2;T2 |
| C3 | = C3;T3 |
| C4 | = C4;T4 |
| C5 | = C5;T5 |
| C6 | = C6;T6 |
| C7 | = C7;T7 |
| C8 | = C8;T8 |
| C9 | = C9;T9 |
| F1 | = F1;TF |
| F2 | = F2;TQ |
| F3-F8 | = Equatable only to itself (e.g., F3 IS equatable to F3) |
| CA-CZ | = Equatable only to itself. (e.g., CA is only equatable to CA) |

RRB Categories

- 10 = 10
- 11 = 11
- 13 = 13;17
- 14 = 14;16
- 15 = 15
- 43 = 43
- 45 = 45
- 46 = 46
- 80 = 80
- 83 = 83
- 84 = 84;86
- 85 = 85

ACTIONCD

Fiscal Intermediary Claim Action Table

(FI_CLM_ACTN_CD)

- 1 = Original debit action (includes non-adjustment RTI correction items) - it will always be a 1 in regular bills.
- 2 = Cancel by credit adjustment - used only in credit/debit pairs (under HHPPS, updates the RAP).
- 3 = Secondary debit adjustment - used only in credit/debit pairs (under HHPPS, would be the final claim or an adjustment on a LUPA).
- 4 = Cancel only adjustment (under HHPPS, RAP/final claim/LUPA).
- 5 = Force action code 3
- 6 = Force action code 2
- 8 = Benefits refused (for inpatient bills, an 'R' nonpayment code must also be present)
- 9 = Payment requested (used on bills that replace previously-submitted benefits-refused bills, action code 8. In such cases a debit/credit pair is not required. For inpatient bills, a 'P' should be entered in the nonpayment code.)

FI_NUM(In Output.,HHA,Hosp)

Fiscal Intermediary Number Table

(FI_NUM_CD)

- 00010 = Alabama BC
- 00020 = Arkansas BC
- 00030 = Arizona BC
- 00040 = California BC (term. 12/00)
- 00050 = New Mexico BC/CO
- 00060 = Connecticut BC
- 00070 = Delaware BC - terminated 2/98
- 00080 = Florida BC
- 00090 = Florida BC
- 00101 = Georgia BC
- 00121 = Illinois - HCSC
- 00123 = Michigan - HCSC
- 00130 = Indiana BC/Administar Federal
- 00131 = Illinois - Administar
- 00140 = Iowa - Wellmark (term. 6/2000)
- 00150 = Kansas BC
- 00160 = Kentucky/Administar
- 00180 = Maine BC
- 00181 = Maine BC - Massachusetts
- 00190 = Maryland BC
- 00200 = Massachusetts BC - terminated 7/97
- 00210 = Michigan BC - terminated 9/94
- 00220 = Minnesota BC
- 00230 = Mississippi BC
- 00231 = Mississippi BC/LA
- 00232 = Mississippi BC
- 00241 = Missouri BC - terminated 9/92
- 00250 = Montana BC
- 00260 = Nebraska BC
- 00270 = New Hampshire/VT BC
- 00280 = New Jersey BC (term. 8/2000)
- 00290 = New Mexico BC - terminated 11/95
- 00308 = Empire BC
- 00310 = North Carolina BC
- 00320 = North Dakota BC
- 00332 = Community Mutual Ins Co; Ohio-Administar
- 00340 = Oklahoma BC
- 00350 = Oregon BC
- 00351 = Oregon BC/ID.
- 00355 = Oregon-CWF
- 00362 = Independence BC - terminated 8/97
- 00363 = Veritus, Inc (PITTS)
- 00370 = Rhode Island BC
- 00380 = South Carolina BC
- 00390 = Tennessee BC
- 00400 = Texas BC
- 00410 = Utah BC
- 00423 = Virginia BC; Trigon

FI_NUM(In Output.,HHA,Hosp)

Fiscal Intermediary Number Table

(FI_NUM_CD)

00430 = Washington/Alaska BC
 00450 = Wisconsin BC
 00452 = Michigan - Wisconsin BC
 00454 = United Government Services -
 Wisconsin BC (eff. 12/00)
 00460 = Wyoming BC
 00468 = N Carolina BC/CPRTIVA
 00993 = BC/BS Assoc.
 17120 = Hawaii Medical Service
 50333 = Travelers; Connecticut United Healthcare
 (terminated - date unknown)
 51051 = Aetna California - terminated 6/97
 51070 = Aetna Connecticut - terminated 6/97
 51100 = Aetna Florida - terminated 6/97
 51140 = Aetna Illinois - terminated 6/97
 51390 = Aetna Pennsylvania - terminated 6/97
 52280 = Mutual of Omaha
 57400 = Cooperative, San Juan, PR
 61000 = Aetna

CANCELCD

Claim Cancel Reason Code Table

(FI_RQST_CLM_CNCL_RSN_CD)

 C = Coverage Transfer
 D = Duplicate Billing
 H = Other or blank
 L = Combining two beneficiary master records
 P = Plan Transfer
 S = Scramble
 *****For Action Code 4 *****
 *****Effective with HHPSS - 10/00*****
 A = RAP/Final claim/LUPA is cancelled by Interme-
 diary. Does not delete episode. Do not set
 cancellation indicator.
 B = RAP/Final claim/LUPA is cancelled by Interme-
 diary. Does not delete episode. Set
 cancellation indicator to 1.
 E = RAP/Final claim/LUPA is cancelled by Interme-
 diary. Remove episode.
 F = RAP/Final claim/LUPA is cancelled by Provider.
 Remove episode.

STATE_CD

State Table

(GEO_SSA_STATE_CD)

 01 = Alabama
 02 = Alaska
 03 = Arizona
 04 = Arkansas
 05 = California
 06 = Colorado
 07 = Connecticut
 08 = Delaware
 09 = District of Columbia
 10 = Florida
 11 = Georgia
 12 = Hawaii
 13 = Idaho
 14 = Illinois
 15 = Indiana
 16 = Iowa
 17 = Kansas
 18 = Kentucky
 19 = Louisiana
 20 = Maine
 21 = Maryland
 22 = Massachusetts
 23 = Michigan
 24 = Minnesota
 25 = Mississippi
 26 = Missouri
 27 = Montana
 28 = Nebraska
 29 = Nevada
 30 = New Hampshire
 31 = New Jersey
 32 = New Mexico

STATE_CD

State Table

(GEO_SSA_STATE_CD)

- 33 = New York
- 34 = North Carolina
- 35 = North Dakota
- 36 = Ohio
- 37 = Oklahoma
- 38 = Oregon
- 39 = Pennsylvania
- 40 = Puerto Rico
- 41 = Rhode Island
- 42 = South Carolina
- 43 = South Dakota
- 44 = Tennessee
- 45 = Texas
- 46 = Utah
- 47 = Vermont
- 48 = Virgin Islands
- 49 = Virginia
- 50 = Washington
- 51 = West Virginia
- 52 = Wisconsin
- 53 = Wyoming
- 54 = Africa
- 55 = Asia
- 56 = Canada & Islands
- 57 = Central America and West Indies
- 58 = Europe
- 59 = Mexico
- 60 = Oceania
- 61 = Philippines
- 62 = South America
- 63 = U.S. Possessions
- 64 = American Samoa
- 65 = Guam
- 66 = Saipan
- 97 = Northern Marianas
- 98 = Guam
- 99 = With 000 county code is American Samoa;
otherwise unknown

HCFA SPEC

HCFA Provider Specialty Table

(HCFA_PRVDR_SPCLTY_CD)

Prior to 5/92

- 01 = General practice
- 02 = General surgery
- 03 = Allergy (revised 10/91 to mean allergy/
immunology)
- 04 = Otolaryngology, laryngology, rhinology
revised 10/91 to mean otolaryngology)
- 05 = Anesthesiology
- 06 = Cardiovascular disease (revised 10/91
to mean cardiology)
- 07 = Dermatology
- 08 = Family practice
- 09 = Gynecology--osteopaths only (deleted
10/91; changed to '16')
- 10 = Gastroenterology
- 11 = Internal medicine
- 12 = Manipulative therapy (osteopaths only)
(revised 10/91 to mean osteopathic
manipulative therapy)
- 13 = Neurology
- 14 = Neurological surgery (revised 10/91 to
mean neurosurgery)
- 15 = Obstetrics--osteopaths only (deleted
10/91; changed to '16')
- 16 = OB-gynecology
- 17 = Ophthalmology, otology, laryngology
rhinology--osteopaths only (deleted
10/91; changed to '18' if physicians
practice is more than 50% ophthalmology
or to '04' if physician's practice is
more than 50% otolaryngology. If
practice is 50/50, choose specialty
with greater allowed charges.

HCFA SPEC

HCFA Provider Specialty Table

- 18 = Ophthalmology
- 19 = Oral surgery (dentists only)
- 20 = Orthopedic surgery
- 21 = Pathologic anatomy, clinical pathology-osteopaths only (deleted 10/91; changed to '22')
- 22 = Pathology
- 23 = Peripheral vascular disease or surgery (deleted 10/91; changed to '76')
- 24 = Plastic surgery (revised to mean plastic and reconstructive surgery).
- 25 = Physical medicine and rehabilitation
- 26 = Psychiatry
- 27 = Psychiatry, neurology (osteopaths only) (deleted 10/91; changed to '86')
- 28 = Proctology (revised 10/91 to mean colorectal surgery).
- 29 = Pulmonary disease
- 30 = Radiology (revised 10/91 to mean diagnostic radiology)
- 31 = Roentgenology, radiology (osteopaths) (deleted 10/91; changed to '30')
- 32 = Radiation therapy--osteopaths (deleted 10/91; changed to '92')
- 33 = Thoracic surgery
- 34 = Urology
- 35 = Chiropractor, licensed (revised 10/91 to mean chiropractic)
- 36 = Nuclear medicine
- 37 = Pediatrics (revised 10/91 to mean pediatric medicine)
- 38 = Geriatrics (revised 10/91 to mean geriatric medicine)
- 39 = Nephrology
- 40 = Hand surgery
- 41 = Optometrist - services related to condition of aphakia (revised 10/91 to mean optometrist)
- 42 = Certified nurse midwife (added 7/88)
- 43 = Certified registered nurse anesthetist (revised 10/91 to mean CRNA, anesthesia assistant)
- 44 = Infectious disease
- 46 = Endocrinology (added 10/91)
- 48 = Podiatry - surgery chiropody (revised 10/91 to mean podiatry)
- 49 = Miscellaneous (include ASCS)
- 51 = Medical supply company with C.O. certification (certified orthotist - certified by American Board for Certification in Prosthetics and Orthotics).
- 52 = Medical supply company with C.P. certification (certified prosthetist - certified by American Board for Certification in Prosthetics and Orthotics).
- 53 = Medical supply company with C.P.O. certification (certified prosthetist - orthotist - certified by American Board for Certification in Prosthetics and Orthotics).
- 54 = Medical supply company not included in 51, 52, or 53.
- 55 = Individual certified orthotist
- 56 = Individual certified prosthetist
- 57 = Individual certified prosthetist - orthotist
- 58 = Individuals not included in 55,56 or 57
- 59 = Ambulance service supplier (e.g. private ambulance companies, funeral homes, etc.)
- 60 = Public health or welfare agencies (federal, state, and local)
- 61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities)

- 62 = Psychologist--billing independently
- 63 = Portable X-ray supplier--billing independently (revised 10/91 to mean portable X-ray supplier)
- 64 = Audiologist (billing independently)
- 65 = Physical therapist (independent practice)
- 66 = Rheumatology (added 10/91)
- 67 = Occupational therapist--independent practice
- 68 = Clinical psychologist
- 69 = Independent laboratory--billing independently (revised 10/91 to mean independent clinical laboratory -- billing independently)
- 70 = Clinic or other group practice, except Group Practice Prepayment Plan (GPPP)
- 71 = Group Practice Prepayment Plan - diagnostic X-ray (do not use after 1/92)
- 72 = Group Practice Prepayment Plan - diagnostic laboratory (do not use after 1/92)
- 73 = Group Practice Prepayment Plan - physiotherapy (do not use after 1/92)
- 74 = Group Practice Prepayment Plan - occupational therapy (do not use after 1/92)
- 75 = Group Practice Prepayment Plan - other medical care (do not use after 1/92)
- 76 = Peripheral vascular disease (added 10/91)
- 77 = Vascular surgery (added 10/91)
- 78 = Cardiac surgery (added 10/91)
- 79 = Addiction medicine (added 10/91)
- 80 = Clinical social worker (1991)
- 81 = Critical care-intensivists (added 10/91)
- 82 = Ophthalmology, cataracts specialty (added 10/91; used only until 5/92)
- 83 = Hematology/oncology (added 10/91)
- 84 = Preventive medicine (added 10/91)
- 85 = Maxillofacial surgery (added 10/91)
- 86 = Neuropsychiatry (added 10/91)
- 87 = All other (e.g. drug and department stores) (revised 10/91 to mean all other suppliers)
- 88 = Unknown (revised 10/91 to mean physician assistant)
- 90 = Medical oncology (added 10/91)
- 91 = Surgical oncology (added 10/91)
- 92 = Radiation oncology (added 10/91)
- 93 = Emergency medicine (added 10/91)
- 94 = Interventional radiology (added 10/91)
- 95 = Independent physiological laboratory (added 10/91)
- 96 = Unknown physician specialty (added 10/91)
- 99 = Unknown--incl. social worker's psychiatric services (revised 10/91 to mean unknown supplier/provider)

Effective 5/92

- 00 = Carrier wide
- 01 = General practice
- 02 = General surgery
- 03 = Allergy/immunology
- 04 = Otolaryngology
- 05 = Anesthesiology
- 06 = Cardiology
- 07 = Dermatology
- 08 = Family practice
- 09 = Gynecology (osteopaths only) (discontinued 5/92 use code 16)
- 10 = Gastroenterology
- 11 = Internal medicine
- 12 = Osteopathic manipulative therapy
- 13 = Neurology
- 14 = Neurosurgery

15 = Obstetrics (osteopaths only)
 (discontinued 5/92 use code 16)
 16 = Obstetrics/gynecology
 17 = Ophthalmology, otology, laryngology,
 rhinology (osteopaths only)
 (discontinued 5/92 use codes 18 or 04
 depending on percentage of practice)
 18 = Ophthalmology
 19 = Oral surgery (dentists only)
 20 = Orthopedic surgery
 21 = Pathologic anatomy, clinical
 pathology (osteopaths only)
 (discontinued 5/92 use code 22)
 22 = Pathology
 23 = Peripheral vascular disease, medical
 or surgical (osteopaths only)
 (discontinued 5/92 use code 76)
 24 = Plastic and reconstructive surgery
 25 = Physical medicine and rehabilitation
 26 = Psychiatry
 27 = Psychiatry, neurology (osteopaths
 only) (discontinued 5/92 use code 86)
 28 = Colorectal surgery (formerly
 proctology)
 29 = Pulmonary disease
 30 = Diagnostic radiology
 31 = Roentgenology, radiology (osteopaths
 only) (discontinued 5/92 use code 30)
 32 = Radiation therapy (osteopaths only)
 (discontinued 5/92 use code 92)
 33 = Thoracic surgery
 34 = Urology
 35 = Chiropractic
 36 = Nuclear medicine
 37 = Pediatric medicine
 38 = Geriatric medicine
 39 = Nephrology
 40 = Hand surgery
 41 = Optometry (revised 10/93 to
 mean optometrist)
 42 = Certified nurse midwife (eff 1/87)
 43 = Crna, anesthesia assistant
 (eff 1/87)
 44 = Infectious disease
 45 = Mammography screening center
 46 = Endocrinology (eff 5/92)
 47 = Independent Diagnostic Testing Facility
 (IDTF) (eff. 6/98)
 48 = Podiatry
 49 = Ambulatory surgical center
 (formerly miscellaneous)
 50 = Nurse practitioner
 51 = Medical supply company with
 certified orthotist (certified by
 American Board for Certification in
 Prosthetics And Orthotics)
 52 = Medical supply company with
 certified prosthetist
 (certified by American Board for
 Certification In Prosthetics And
 Orthotics)
 53 = Medical supply company with
 certified prosthetist-orthotist
 (certified by American Board for
 Certification in Prosthetics
 and Orthotics)
 54 = Medical supply company not included
 in 51, 52, or 53. (Revised 10/93
 to mean medical supply company for DMERC)
 55 = Individual certified orthotist
 56 = Individual certified prosthetist
 57 = Individual certified prosthetist-
 orthotist
 58 = Individuals not included in 55, 56,
 or 57 (revised 10/93 to mean medical
 supply company with registered pharmacist)

HCFASPEC

HCFA Provider Specialty Table

 (HCFA_PRVDR_SPCLTY_CD)

59 = Ambulance service supplier, e.G., private ambulance companies, funeral homes, etc.

60 = Public health or welfare agencies (federal, state, and local)

61 = Voluntary health or charitable agencies (e.G., National Cancer Society, National Heart Association, Catholic Charities)

62 = Psychologist (billing independently)

63 = Portable X-ray supplier

64 = Audiologist (billing independently)

65 = Physical therapist (independently practicing)

66 = Rheumatology (eff 5/92)
Note: during 93/94 DMERC also used this to mean medical supply company with respiratory therapist

67 = Occupational therapist (independently practicing)

68 = Clinical psychologist

69 = Clinical laboratory (billing independently)

70 = Multispecialty clinic or group practice

71 = Diagnostic X-ray (GPPP) (not to be assigned after 5/92)

72 = Diagnostic laboratory (GPPP) (not to be assigned after 5/92)

73 = Physiotherapy (GPPP) (not to be assigned after 5/92)

74 = Occupational therapy (GPPP) (not to be assigned after 5/92)

75 = Other medical care (GPPP) (not to be assigned after 5/92)

76 = Peripheral vascular disease (eff 5/92)

77 = Vascular surgery (eff 5/92)

78 = Cardiac surgery (eff 5/92)

79 = Addiction medicine (eff 5/92)

80 = Licensed clinical social worker

81 = Critical care (intensivists) (eff 5/92)

82 = Hematology (eff 5/92)

83 = Hematology/oncology (eff 5/92)

84 = Preventive medicine (eff 5/92)

85 = Maxillofacial surgery (eff 5/92)

86 = Neuropsychiatry (eff 5/92)

87 = All other suppliers (e.g. drug and department stores) (note: DMERC used 87 to mean department store from 10/93 through 9/94; recoded eff 10/94 to A7; NCH cross-walked DMERC reported 87 to A7.

88 = Unknown supplier/provider specialty (note: DMERC used 87 to mean grocery store from 10/93 - 9/94; recoded eff 10/94 to A8; NCH cross-walked DMERC reported 88 to A8.

89 = Certified clinical nurse specialist

90 = Medical oncology (eff 5/92)

91 = Surgical oncology (eff 5/92)

92 = Radiation oncology (eff 5/92)

93 = Emergency medicine (eff 5/92)

94 = Interventional radiology (eff 5/92)

95 = Independent physiological laboratory (eff 5/92)

96 = Optician (eff 10/93)

97 = Physician assistant (eff 5/92)

98 = Gynecologist/oncologist (eff 10/94)

99 = Unknown physician specialty

A0 = Hospital (eff 10/93) (DMERCs only)

A1 = SNF (eff 10/93) (DMERCs only)

A2 = Intermediate care nursing facility (eff 10/93) (DMERCs only)

A3 = Nursing facility, other (eff 10/93) (DMERCs only)

HCFASPEC

HCFA Provider Specialty Table

(HCFA_PRVDR_SPCLTY_CD)

- A4 = HHA (eff 10/93) (DMERCs only)
- A5 = Pharmacy (eff 10/93) (DMERCs only)
- A6 = Medical supply company with respiratory therapist (eff 10/93) (DMERCs only)
- A7 = Department store (for DMERC use: eff 10/94, but cross-walked from code 87 eff 10/93)
- A8 = Grocery store (for DMERC use: eff 10/94, but cross-walked from code 88 eff 10/93)

HC FATYPE

(HCFA_TYPE_SRVC_CD)

HCFA Type of Service Table

- 1 = Medical care
- 2 = Surgery
- 3 = Consultation
- 4 = Diagnostic radiology
- 5 = Diagnostic laboratory
- 6 = Therapeutic radiology
- 7 = Anesthesia
- 8 = Assistant at surgery
- 9 = Other medical items or services
- 0 = Whole blood only eff 01/96,
whole blood or packed red cells before 01/96
- A = Used durable medical equipment (DME)
- B = High risk screening mammography
(obsolete 1/1/98)
- C = Low risk screening mammography
(obsolete 1/1/98)
- D = Ambulance (eff 04/95)
- E = Enteral/parenteral nutrients/supplies
(eff 04/95)
- F = Ambulatory surgical center (facility usage for surgical services)
- G = Immunosuppressive drugs
- H = Hospice services (discontinued 01/95)
- I = Purchase of DME (installment basis)
(discontinued 04/95)
- J = Diabetic shoes (eff 04/95)
- K = Hearing items and services (eff 04/95)
- L = ESRD supplies (eff 04/95)
(renal supplier in the home before 04/95)
- M = Monthly capitation payment for dialysis
- N = Kidney donor
- P = Lump sum purchase of DME, prosthetics, orthotics
- Q = Vision items or services
- R = Rental of DME
- S = Surgical dressings or other medical supplies
(eff 04/95)
- T = Psychological therapy (term. 12/31/97)
outpatient mental health limitation (eff. 1/1/98)
- U = Occupational therapy
- V = Pneumococcal/flu vaccine (eff 01/96),
Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),
Pneumococcal only before 04/95
- W = Physical therapy
- Y = Second opinion on elective surgery
(obsoleted 1/97)
- Z = Third opinion on elective surgery
(obsoleted 1/97)

DOCINDCD

(LINE_ADDTNL_CLM_DCMTN_IND_CD)

Line Additional Claim Documentation Indicator Table

- 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 = Recertification CMN/prescription/other documentation

PLCSRVC

(LINE_PLC_SRVC_CD)

Line Place Of Service Table

Prior To 1/92

1 = Office
 2 = Home
 3 = Inpatient hospital
 4 = SNF
 5 = Outpatient hospital
 6 = Independent lab
 7 = Other
 8 = Independent kidney disease treatment center
 9 = Ambulatory
 A = Ambulance service
 H = Hospice
 M = Mental health, rural mental health
 N = Nursing home
 R = Rural codes

 Effective 1/92

11 = Office
 12 = Home
 21 = Inpatient hospital
 22 = Outpatient hospital
 23 = Emergency room - hospital
 24 = Ambulatory surgical center
 25 = Birthing center
 26 = Military treatment facility
 31 = Skilled nursing facility
 32 = Nursing facility
 33 = Custodial care facility
 34 = Hospice
 35 = Adult living care facilities (ALCF)
 (eff. NYD - added 12/3/97)
 41 = Ambulance - land
 42 = Ambulance - air or water
 50 = Federally qualified health centers
 (eff. 10/1/93)
 51 = Inpatient psychiatric facility
 52 = Psychiatric facility partial hospitalization
 53 = Community mental health center
 54 = Intermediate care facility/mentally retarded
 55 = Residential substance abuse treatment facility
 56 = Psychiatric residential treatment center
 60 = Mass immunizations center (eff. 9/1/97)
 61 = Comprehensive inpatient rehabilitation facility
 62 = Comprehensive outpatient rehabilitation facility
 65 = End stage renal disease treatment facility
 71 = State or local public health clinic
 72 = Rural health clinic
 81 = Independent laboratory
 99 = Other unlisted facility

PAYINDCD

 (LINE_PMT_IND_CD)

Line Payment Indicator Table

 1 = Actual charge
 2 = Customary charge
 3 = Prevailing charge (adjusted, unadjusted gap fill, etc)
 4 = Other (ASC fees, radiology and outpatient limits, and non-payment because of denial.
 5 = Lab fee schedule
 6 = Physician fee schedule - full fee schedule amount
 7 = Physician fee schedule - transition
 8 = Clinical psychologist fee schedule
 9 = DME and prosthetics/orthotics fee schedules (eff. 4/97)

PROINDCD

 (LINE_PRCSG_IND_CD)

Line Processing Indicator Table

 A = Allowed

B = Benefits exhausted
 C = Noncovered care
 D = Denied (existed prior to 1991; 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 (eff. 7/76)
 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 = Bundled test, no payment (eff. 1/1/98)

PRTCPTG

(LINE_PRVDR_PRTGPTG_IND_CD)

Line Provider Participating Indicator Table

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-participating.
 6 = Assignment not accepted and all covered and allowed expenses applied to deductible non-participating.
 7 = Participating provider not accepting assignment.

RIC_CD

(NCH_NEAR_LINE_RIC_CD)

NCH Near-Line Record Identification Code Table

O = Part B physician/supplier claim record (processed by local carriers; can include DMEPOS services)
 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)
 U = Both Part A and B institutional home health agency (HHA) claim records -- due to HHPPS and HHA A/B split. (effective 10/00)
 M = Part B DMEPOS claim record (processed by DME Regional Carrier) (effective 10/93)

STUS_CD

(PTNT_DSCHRG_STUS_CD)

Patient Discharge Status Table

01 = Discharged to home/self care (routine

- charge).
- 02 = Discharged/transferred to other short term general hospital for inpatient care.
- 03 = Discharged/transferred to skilled nursing facility (SNF) - (For hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF).
- 04 = Discharged/transferred to intermediate care facility (ICF).
- 05 = Discharged/transferred to another type of institution for inpatient care (including distinct parts).
- 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 a home IV drug therapy provider.
- 09 = Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
- 20 = Expired (did not recover - Christian Science patient).
- 30 = Still patient.
- 40 = Expired at home (hospice claims only)
- 41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
- 42 = Expired - place unknown (Hospice claims only)
- 50 = Hospice - home (eff. 10/96)
- 51 = Hospice - medical facility (eff. 10/96)
- 61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (to be implemented in 1999)
- 71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (to be implemented in 1999).
- 72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (to be implemented in 1999).

DED

 (REV_CNTR_DDCTBL_COINSRNC_CD)

Revenue Center Deductible Coinsurance Code

- 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. (For multiple HCPCS per single revenue center code)

For revenue center code 0001, the following MSP override values may be present:

- 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)

CEN

 (REV_CNTR_CD)

Revenue Center Table

- 0001 = Total charge

0022 = SNF claim paid under PPS submitted as TOB 21X, effective for cost reporting periods beginning on or after 7/1/98 (dates of service after 6/30/98). NOTE: This code may appear multiple times on a claim to identify different HIPPS Rate Code/assessment periods.

0023 = Home Health services paid under PPS submitted as TOB 32X and 33X, effective 10/00. This code may appear multiple times on a claim to identify different HIPPS/Home Health Resource Groups (HRG).

0100 = All inclusive rate-room and board plus ancillary

0101 = All inclusive rate-room and board

0110 = Private medical or general-general classification

0111 = Private medical or general-medical/surgical/GYN

0112 = Private medical or general-OB

0113 = Private medical or general-pediatric

0114 = Private medical or general-psychiatric

0115 = Private medical or general-hospice

0116 = Private medical or general-detoxification

0117 = Private medical or general-oncology

0118 = Private medical or general-rehabilitation

0119 = Private medical or general-other

0120 = Semi-private 2 bed (medical or general) general classification

0121 = Semi-private 2 bed (medical or general) medical/surgical/GYN

0122 = Semi-private 2 bed (medical or general)-OB

0123 = Semi-private 2 bed (medical or general)-pediatric

0124 = Semi-private 2 bed (medical or general)-psychiatric

0125 = Semi-private 2 bed (medical or general)-hospice

0126 = Semi-private 2 bed (medical or general) detoxification

0127 = Semi-private 2 bed (medical or general)-oncology

0128 = Semi-private 2 bed (medical or general) rehabilitation

0129 = Semi-private 2 bed (medical or general)-other

0130 = Semi-private 3 and 4 beds-general classification

0131 = Semi-private 3 and 4 beds-medical/surgical/GYN

0132 = Semi-private 3 and 4 beds-OB

0133 = Semi-private 3 and 4 beds-pediatric

0134 = Semi-private 3 and 4 beds-psychiatric

0135 = Semi-private 3 and 4 beds-hospice

0136 = Semi-private 3 and 4 beds-detoxification

0137 = Semi-private 3 and 4 beds-oncology

0138 = Semi-private 3 and 4 beds-rehabilitation

0139 = Semi-private 3 and 4 beds-other

0140 = Private (deluxe)-general classification

0141 = Private (deluxe)-medical/surgical/GYN

0142 = Private (deluxe)-OB

0143 = Private (deluxe)-pediatric

0144 = Private (deluxe)-psychiatric

0145 = Private (deluxe)-hospice

0146 = Private (deluxe)-detoxification

0147 = Private (deluxe)-oncology

0148 = Private (deluxe)-rehabilitation

0149 = Private (deluxe)-other

0150 = Room&Board ward (medical or general) general classification

0151 = Room&Board ward (medical or general) medical/surgical/GYN

0152 = Room&Board ward (medical or general)-OB

0153 = Room&Board ward (medical or general)-pediatric

0154 = Room&Board ward (medical or general)-psychiatric

0155 = Room&Board ward (medical or general)-hospice

0156 = Room&Board ward (medical or general)-detoxification

0157 = Room&Board ward (medical or general)-oncology

0158 = Room&Board ward (medical or general)-rehabilitation

0159 = Room&Board ward (medical or general)-other

0160 = Other Room&Board-general classification

0164 = Other Room&Board-sterile environment

0167 = Other Room&Board-self care

0169 = Other Room&Board-other

0170 = Nursery-general classification

0171 = Nursery-newborn level I (routine)

0172 = Nursery-premature newborn-level II (continuing care)

Revenue Center Table

CEN

 (REV_CNTR_CD)

0173 = Nursery-newborn-level III (intermediate care) (eff 10/96)

0174 = Nursery-newborn-level IV (intensive care) (eff 10/96)
 0175 = Nursery-neonatal ICU (obsolete eff 10/96)
 0179 = Nursery-other
 0180 = Leave of absence-general classification
 0182 = Leave of absence-patient convenience charges billable
 0183 = Leave of absence-therapeutic leave
 0184 = Leave of absence-ICF mentally retarded-any reason
 0185 = Leave of absence-nursing home (hospitalization)
 0189 = Leave of absence-other leave of absence
 0190 = Subacute care - general classification (eff. 10/97)
 0191 = Subacute care - level I (eff. 10/97)
 0192 = Subacute care - level II (eff. 10/97)
 0193 = Subacute care - level III (eff. 10/97)
 0194 = Subacute care - level IV (eff. 10/97)
 0199 = Subacute care - other (eff 10/97)
 0200 = Intensive care-general classification
 0201 = Intensive care-surgical
 0202 = Intensive care-medical
 0203 = Intensive care-pediatric
 0204 = Intensive care-psychiatric
 0206 = Intensive care-post ICU; redefined as
 intermediate ICU (eff 10/96)
 0207 = Intensive care-burn care
 0208 = Intensive care-trauma
 0209 = Intensive care-other intensive care
 0210 = Coronary care-general classification
 0211 = Coronary care-myocardial infraction
 0212 = Coronary care-pulmonary care
 0213 = Coronary care-heart transplant
 0214 = Coronary care-post CCU; redefined as
 intermediate CCU (eff 10/96)
 0219 = Coronary care-other coronary care
 0220 = Special charges-general classification
 0221 = Special charges-admission charge
 0222 = Special charges-technical support charge
 0223 = Special charges-UR service charge
 0224 = Special charges-late discharge, medically
 necessary
 0229 = Special charges-other special charges
 0230 = Incremental nursing charge rate-general
 classification
 0231 = Incremental nursing charge rate-nursery
 0232 = Incremental nursing charge rate-OB
 0233 = Incremental nursing charge rate-ICU (include
 transitional care)
 0234 = Incremental nursing charge rate-CCU (include
 transitional care)
 0235 = Incremental nursing charge rate-hospice
 0239 = Incremental nursing charge rate-other
 0240 = All inclusive ancillary-general classification
 0241 = All inclusive ancillary-basic
 0242 = All inclusive ancillary-comprehensive
 0243 = All inclusive ancillary-specialty
 0249 = All inclusive ancillary-other inclusive ancillary
 0250 = Pharmacy-general classification
 0251 = Pharmacy-generic drugs
 0252 = Pharmacy-nongeneric drugs
 0253 = Pharmacy-take home drugs
 0254 = Pharmacy-drugs incident to other diagnostic service-
 subject to payment limit
 0255 = Pharmacy-drugs incident to radiology-
 subject to payment limit
 0256 = Pharmacy-experimental drugs
 0257 = Pharmacy-non-prescription
 0258 = Pharmacy-IV solutions
 0259 = Pharmacy-other pharmacy
 0260 = IV therapy-general classification
 0261 = IV therapy-infusion pump
 0262 = IV therapy-pharmacy services (eff 10/94)
 0263 = IV therapy-drug supply/delivery (eff 10/94)
 0264 = IV therapy-supplies (eff 10/94)
 0269 = IV therapy-other IV therapy
 0270 = Medical/surgical supplies-general classification
 (also see 062X)
 0271 = Medical/surgical supplies-nonsterile supply
 Revenue Center Table

 0272 = Medical/surgical supplies-sterile supply

CEN

 (REV_CNTR_CD)

0273 = Medical/surgical supplies-take home supplies
 0274 = Medical/surgical supplies-prosthetic/orthotic devices
 0275 = Medical/surgical supplies-pace maker
 0276 = Medical/surgical supplies-intraocular lens
 0277 = Medical/surgical supplies-oxygen-take home
 0278 = Medical/surgical supplies-other implants
 0279 = Medical/surgical supplies-other devices
 0280 = Oncology-general classification
 0289 = Oncology-other oncology
 0290 = DME (other than renal)-general classification
 0291 = DME (other than renal)-rental
 0292 = DME (other than renal)-purchase of new DME
 0293 = DME (other than renal)-purchase of used DME
 0294 = DME (other than renal)-related to and listed as DME
 0299 = DME (other than renal)-other
 0300 = Laboratory-general classification
 0301 = Laboratory-chemistry
 0302 = Laboratory-immunology
 0303 = Laboratory-renal patient (home)
 0304 = Laboratory-non-routine dialysis
 0305 = Laboratory-hematology
 0306 = Laboratory-bacteriology & microbiology
 0307 = Laboratory-urology
 0309 = Laboratory-other laboratory
 0310 = Laboratory pathological-general classification
 0311 = Laboratory pathological-cytology
 0312 = Laboratory pathological-histology
 0314 = Laboratory pathological-biopsy
 0319 = Laboratory pathological-other
 0320 = Radiology diagnostic-general classification
 0321 = Radiology diagnostic-angiocardigraphy
 0322 = Radiology diagnostic-arthrography
 0323 = Radiology diagnostic-arteriography
 0324 = Radiology diagnostic-chest X-ray
 0329 = Radiology diagnostic-other
 0330 = Radiology therapeutic-general classification
 0331 = Radiology therapeutic-chemotherapy injected
 0332 = Radiology therapeutic-chemotherapy oral
 0333 = Radiology therapeutic-radiation therapy
 0335 = Radiology therapeutic-chemotherapy IV
 0339 = Radiology therapeutic-other
 0340 = Nuclear medicine-general classification
 0341 = Nuclear medicine-diagnostic
 0342 = Nuclear medicine-therapeutic
 0349 = Nuclear medicine-other
 0350 = Computed tomographic (CT) scan-general classification
 0351 = CT scan-head scan
 0352 = CT scan-body scan
 0359 = CT scan-other CT scans
 0360 = Operating room services-general classification
 0361 = Operating room services-minor surgery
 0362 = Operating room services-organ transplant, other than kidney
 0367 = Operating room services-kidney transplant
 0369 = Operating room services-other operating room services
 0370 = Anesthesia-general classification
 0371 = Anesthesia-incident to RAD and subject to the payment limit
 0372 = Anesthesia-incident to other diagnostic service and subject to the payment limit
 0374 = Anesthesia-acupuncture
 0379 = Anesthesia-other anesthesia
 0380 = Blood-general classification
 0381 = Blood-packed red cells
 0382 = Blood-whole blood
 0383 = Blood-plasma
 0384 = Blood-platelets
 0385 = Blood-leukocytes
 0386 = Blood-other components
 0387 = Blood-other derivatives (cryoprecipitates)
 0389 = Blood-other blood

CEN

 (REV_CNTR_CD)

Revenue Center Table

0390 = Blood storage and processing-general

classification
 0391 = Blood storage and processing-blood
 administration
 0399 = Blood storage and processing-other
 0400 = Other imaging services-general classification
 0401 = Other imaging services-diagnostic mammography
 0402 = Other imaging services-ultrasound
 0403 = Other imaging services-screening mammography
 (eff 1/1/91)
 0404 = Other imaging services-positron emission
 tomography (eff 10/94)
 0409 = Other imaging services-other
 0410 = Respiratory services-general classification
 0412 = Respiratory services-inhalation services
 0413 = Respiratory services-hyperbaric oxygen therapy
 0419 = Respiratory services-other
 0420 = Physical therapy-general classification
 0421 = Physical therapy-visit charge
 0422 = Physical therapy-hourly charge
 0423 = Physical therapy-group rate
 0424 = Physical therapy-evaluation or re-evaluation
 0429 = Physical therapy-other
 0430 = Occupational therapy-general classification
 0431 = Occupational therapy-visit charge
 0432 = Occupational therapy-hourly charge
 0433 = Occupational therapy-group rate
 0434 = Occupational therapy-evaluation or re-evaluation
 0439 = Occupational therapy-other (may include
 restorative therapy)
 0440 = Speech language pathology-general classification
 0441 = Speech language pathology-visit charge
 0442 = Speech language pathology-hourly charge
 0443 = Speech language pathology-group rate
 0444 = Speech language pathology-evaluation or
 re-evaluation
 0449 = Speech language pathology-other
 0450 = Emergency room-general classification
 0451 = Emergency room-entala emergency medical screening
 services (eff 10/96)
 0452 = Emergency room-ER beyond entala screening
 (eff 10/96)
 0456 = Emergency room-urgent care (eff 10/96)
 0459 = Emergency room-other
 0460 = Pulmonary function-general classification
 0469 = Pulmonary function-other
 0470 = Audiology-general classification
 0471 = Audiology-diagnostic
 0472 = Audiology-treatment
 0479 = Audiology-other
 0480 = Cardiology-general classification
 0481 = Cardiology-cardiac cath lab
 0482 = Cardiology-stress test
 0483 = Cardiology-Echocardiology
 0489 = Cardiology-other
 0490 = Ambulatory surgical care-general classification
 0499 = Ambulatory surgical care-other
 0500 = Outpatient services-general classification
 (deleted 9/93)
 0509 = Outpatient services-other (deleted 9/93)
 0510 = Clinic-general classification
 0511 = Clinic-chronic pain center
 0512 = Clinic-dental center
 0513 = Clinic-psychiatric
 0514 = Clinic-OB-GYN
 0515 = Clinic-pediatric
 0516 = Clinic-urgent care clinic (eff 10/96)
 0517 = Clinic-family practice clinic (eff 10/96)
 0519 = Clinic-other
 0520 = Free-standing clinic-general classification
 0521 = Free-standing clinic-rural health clinic
 0522 = Free-standing clinic-rural health home
 0523 = Free-standing clinic-family practice
 0526 = Free-standing clinic-urgent care (eff 10/96)
 0529 = Free-standing clinic-other
 0530 = Osteopathic services-general classification

Revenue Center Table

0531 = Osteopathic services-osteopathic therapy

0539 = Osteopathic services-other
 0540 = Ambulance-general classification
 0541 = Ambulance-supplies
 0542 = Ambulance-medical transport
 0543 = Ambulance-heart mobile
 0544 = Ambulance-oxygen
 0545 = Ambulance-air ambulance
 0546 = Ambulance-neo-natal ambulance
 0547 = Ambulance-pharmacy
 0548 = Ambulance-telephone transmission EKG
 0549 = Ambulance-other
 0550 = Skilled nursing-general classification
 0551 = Skilled nursing-visit charge
 0552 = Skilled nursing-hourly charge
 0559 = Skilled nursing-other
 0560 = Medical social services-general classification
 0561 = Medical social services-visit charge
 0562 = Medical social services-hourly charges
 0569 = Medical social services-other
 0570 = Home health aid (home health)-general classification
 0571 = Home health aid (home health)-visit charge
 0572 = Home health aid (home health)-hourly charge
 0579 = Home health aid (home health)-other
 0580 = Other visits (home health)-general
 classification (under HHPPS, not allowed
 as covered charges)
 0581 = Other visits (home health)-visit charge
 (under HHPPS, not allowed as covered charges)
 0582 = Other visits (home health)-hourly charge
 (under HHPPS, not allowed as covered charges)
 0589 = Other visits (home health)-other
 (under HHPPS, not allowed as covered charges)
 0590 = Units of service (home health)-general
 classification (under HHPPS, not allowed
 as covered charges)
 0599 = Units of service (home health)-other
 (under HHPPS, not allowed as covered charges)
 0600 = Oxygen-general classification
 0601 = Oxygen-stat or port equip/supply or count
 0602 = Oxygen-stat/equip/under 1 LPM
 0603 = Oxygen-stat/equip/over 4 LPM
 0604 = Oxygen-stat/equip/portable add-on
 0610 = Magnetic resonance technology (MRT)-general
 classification
 0611 = MRT/MRI-brain (including brainstem)
 0612 = MRT/MRI-spinal cord (including spine)
 0614 = MRT/MRI-other
 0615 = MRT/MRA-Head and Neck
 0616 = MRT/MRA-Lower Extremities
 0618 = MRT/MRA-other
 0619 = MRT/Other MRI
 0621 = Medical/surgical supplies-incident to radiology-
 subject to the payment limit - extension of 027X
 0622 = Medical/surgical supplies-incident to other
 diagnostic service-subject to the payment limit -
 extension of 027X
 0623 = Medical/surgical supplies-surgical dressings
 (eff 1/95) - extension of 027X
 0624 = Medical/surgical supplies-medical investigational
 devices and procedures with FDA approved IDE's
 (eff 10/96) - extension of 027X
 0630 = Drugs requiring specific identification-general
 classification
 0631 = Drugs requiring specific identification-single drug
 source (eff 9/93)
 0632 = Drugs requiring specific identification-multiple drug
 source (eff 9/93)
 0633 = Drugs requiring specific identification-restrictive
 prescription (eff 9/93)
 0634 = Drugs requiring specific identification-EPO under 10,000 units
 0635 = Drugs requiring specific identification-EPO 10,000 units or more
 0636 = Drugs requiring specific identification-detailed coding (eff 3/92)
 0637 = Self-administered drugs administered in an
 emergency situation - not requiring detailed
 coding

CEN

 (REV_CNTR_CD)

Revenue Center Table

0640 = Home IV therapy-general classification

(eff 10/94)
0641 = Home IV therapy-nonroutine nursing
(eff 10/94)
0642 = Home IV therapy-IV site care, central line
(eff 10/94)
0643 = Home IV therapy-IV start/change peripheral line
(eff 10/94)
0644 = Home IV therapy-nonroutine nursing, peripheral line
(eff 10/94)
0645 = Home IV therapy-train patient/caregiver, central
line (eff 10/94)
0646 = Home IV therapy-train disabled patient, central
line (eff 10/94)
0647 = Home IV therapy-train patient/caregiver, peripheral
line (eff 10/94)
0648 = Home IV therapy-train disabled patient, peripheral
line (eff 10/94)
0649 = Home IV therapy-other IV therapy services
(eff 10/94)
0650 = Hospice services-general classification
0651 = Hospice services-routine home care
0652 = Hospice services-continuous home care-1/2
0655 = Hospice services-inpatient care
0656 = Hospice services-general inpatient care
(non-respite)
0657 = Hospice services-physician services
0659 = Hospice services-other
0660 = Respite care (HHA)-general classification
(eff 9/93)
0661 = Respite care (HHA)-hourly charge/skilled nursing
(eff 9/93)
0662 = Respite care (HHA)-hourly charge/home health aide/
homemaker (eff 9/93)
0670 = OP special residence charges - general
classification
0671 = OP special residence charges - hospital based
0672 = OP special residence charges - contracted
0679 = OP special residence charges - other special
residence charges
0700 = Cast room-general classification
0709 = Cast room-other
0710 = Recovery room-general classification
0719 = Recovery room-other
0720 = Labor room/delivery-general classification
0721 = Labor room/delivery-labor
0722 = Labor room/delivery-delivery
0723 = Labor room/delivery-circumcision
0724 = Labor room/delivery-birthing center
0729 = Labor room/delivery-other
0730 = EKG/ECG-general classification
0731 = EKG/ECG-Holter monitor
0732 = EKG/ECG-telemetry (include fetal monitoring until
9/93)
0739 = EKG/ECG-other
0740 = EEG-general classification
0749 = EEG (electroencephalogram)-other
0750 = Gastro-intestinal services-general classification
0759 = Gastro-intestinal services-other
0760 = Treatment or observation room-general classification
0761 = Treatment or observation room-treatment room
(eff 9/93)
0762 = Treatment or observation room-observation room
(eff 9/93)
0769 = Treatment or observation room-other
0770 = Preventative care services-general classification
(eff 10/94)
0771 = Preventative care services-vaccine administration
(eff 10/94)
0779 = Preventative care services-other (eff 10/94)
0780 = Telemedicine - general classification (eff 10/97)
0789 = Telemedicine - telemedicine (eff 10/97)
0790 = Lithotripsy-general classification
0799 = Lithotripsy-other
0800 = Inpatient renal dialysis-general classification
0801 = Inpatient renal dialysis-inpatient hemodialysis

Revenue Center Table

0802 = Inpatient renal dialysis-inpatient peritoneal

(non-CAPD)

0803 = Inpatient renal dialysis-inpatient CAPD
0804 = Inpatient renal dialysis-inpatient CCPD
0809 = Inpatient renal dialysis-other inpatient dialysis
0810 = Organ acquisition-general classification
0811 = Organ acquisition-living donor (eff 10/94);
prior to 10/94, defined as living donor kidney
0812 = Organ acquisition-cadaver donor (eff 10/94);
prior to 10/94, defined as cadaver donor kidney
0813 = Organ acquisition-unknown donor (eff 10/94)
prior to 10/94, defined as unknown donor kidney
0814 = Organ acquisition - unsuccessful organ search-
donor bank charges (eff 10/94); prior to 10/94,
defined as other kidney acquisition
0815 = Organ acquisition-cadaver donor-heart
(obsolete, eff 10/94)
0816 = Organ acquisition-other heart acquisition
(obsolete, eff 10/94)
0817 = Organ acquisition-donor-liver
(obsolete, eff 10/94)
0819 = Organ acquisition-other donor (eff 10/94);
prior to 10/94, defined as other
0820 = Hemodialysis OP or home dialysis-general
classification
0821 = Hemodialysis OP or home dialysis-hemodialysis-
composite or other rate
0822 = Hemodialysis OP or home dialysis-home supplies
0823 = Hemodialysis OP or home dialysis-home equipment
0824 = Hemodialysis OP or home dialysis-maintenance/100%
0825 = Hemodialysis OP or home dialysis-support services
0829 = Hemodialysis OP or home dialysis-other
0830 = Peritoneal dialysis OP or home-general
classification
0831 = Peritoneal dialysis OP or home-peritoneal-
composite or other rate
0832 = Peritoneal dialysis OP or home-home supplies
0833 = Peritoneal dialysis OP or home-home equipment
0834 = Peritoneal dialysis OP or home-maintenance/100%
0835 = Peritoneal dialysis OP or home-support services
0839 = Peritoneal dialysis OP or home-other
0840 = CAPD outpatient-general classification
0841 = CAPD outpatient-CAPD/composite or other rate
0842 = CAPD outpatient-home supplies
0843 = CAPD outpatient-home equipment
0844 = CAPD outpatient-maintenance/100%
0845 = CAPD outpatient-support services
0849 = CAPD outpatient-other
0850 = CCPD outpatient-general classification
0851 = CCPD outpatient-CCPD/composite or other rate
0852 = CCPD outpatient-home supplies
0853 = CCPD outpatient-home equipment
0854 = CCPD outpatient-maintenance/100%
0855 = CCPD outpatient-support services
0859 = CCPD outpatient-other
0880 = Miscellaneous dialysis-general classification
0881 = Miscellaneous dialysis-ultrafiltration
0882 = Miscellaneous dialysis-home dialysis aide visit
(eff 9/93)
0889 = Miscellaneous dialysis-other
0890 = Other donor bank-general classification; changed to
reserved for national assignment (eff 4/94)
0891 = Other donor bank-bone; changed to
reserved for national assignment (eff 4/94)
0892 = Other donor bank-organ (other than kidney); changed
to reserved for national assignment (eff 4/94)
0893 = Other donor bank-skin; changed to
reserved for national assignment (eff 4/94)
0899 = Other donor bank-other; changed to
reserved for national assignment (eff 4/94)
0900 = Psychiatric/psychological treatments-general
classification
0901 = Psychiatric/psychological treatments-electroshock
treatment
0902 = Psychiatric/psychological treatments-milieu therapy
0903 = Psychiatric/psychological treatments-play therapy

Revenue Center Table

0904 = Psychiatric/psychological treatments-activity

therapy (eff 4/94)

0909 = Psychiatric/psychological treatments-other

0910 = Psychiatric/psychological services-general classification

0911 = Psychiatric/psychological services-rehabilitation

0912 = Psychiatric/psychological services-day care-redefined 10/97 to less Intensive

0913 = Psychiatric/psychological services-night care redefined 10/97 to Intensive

0914 = Psychiatric/psychological services-individual therapy

0915 = Psychiatric/psychological services-group therapy

0916 = Psychiatric/psychological services-family therapy

0917 = Psychiatric/psychological services-biofeedback

0918 = Psychiatric/psychological services-testing

0919 = Psychiatric/psychological services-other

0920 = Other diagnostic services-general classification

0921 = Other diagnostic services-peripheral vascular lab

0922 = Other diagnostic services-electromyogram

0923 = Other diagnostic services-pap smear

0924 = Other diagnostic services-allergy test

0925 = Other diagnostic services-pregnancy test

0929 = Other diagnostic services-other

0940 = Other therapeutic services-general classification

0941 = Other therapeutic services-recreational therapy

0942 = Other therapeutic services-education/training (include diabetes diet training)

0943 = Other therapeutic services-cardiac rehabilitation

0944 = Other therapeutic services-drug rehabilitation

0945 = Other therapeutic services-alcohol rehabilitation

0946 = Other therapeutic services-routine complex medical equipment

0947 = Other therapeutic services-ancillary complex medical equipment (eff 3/92)

0949 = Other therapeutic services-other

0951 = Professional Fees-athletic training

0952 = Professional Fees-kinesiotherapy

0960 = Professional fees-general classification

0961 = Professional fees-psychiatric

0962 = Professional fees-ophthalmology

0963 = Professional fees-anesthesiologist (MD)

0964 = Professional fees-anesthetist (CRNA)

0969 = Professional fees-other

0971 = Professional fees-laboratory

0972 = Professional fees-radiology diagnostic

0973 = Professional fees-radiology therapeutic

0974 = Professional fees-nuclear medicine

0975 = Professional fees-operating room

0976 = Professional fees-respiratory therapy

0977 = Professional fees-physical therapy

0978 = Professional fees-occupational therapy

0979 = Professional fees-speech pathology

0981 = Professional fees-emergency room

0982 = Professional fees-outpatient services

0983 = Professional fees-clinic

0984 = Professional fees-medical social services

0985 = Professional fees-EKG

0986 = Professional fees-EEG

0987 = Professional fees-hospital visit

0988 = Professional fees-consultation

0989 = Professional fees-private duty nurse

0990 = Patient convenience items-general classification

0991 = Patient convenience items-cafeteria/guest tray

0992 = Patient convenience items-private linen service

0993 = Patient convenience items-telephone/telegraph

0994 = Patient convenience items-tv/radio

0995 = Patient convenience items-nonpatient room rentals

0996 = Patient convenience items-late discharge charge

0997 = Patient convenience items-admission kits

0998 = Patient convenience items-beauty shop/barber

0999 = Patient convenience items-other

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(REV_CNTR_CD)

Revenue Center Table

NOTE: Following Revenue Codes reported for NHCMQ (RUGS) demo claims effective 2/96.

9000 = RUGS-no MDS assessment available
 9001 = Reduced physical functions- RUGS PA1/ADL index of 4-5
 9002 = Reduced physical functions- RUGS PA2/ADL index of 4-5
 9003 = Reduced physical functions- RUGS PB1/ADL index of 6-8
 9004 = Reduced physical functions- RUGS PB2/ADL index of 6-8
 9005 = Reduced physical functions- RUGS PC1/ADL index of 9-10
 9006 = Reduced physical functions- RUGS PC2/ADL index of 9-10
 9007 = Reduced physical functions- RUGS PD1/ADL index of 11-15
 9008 = Reduced physical functions- RUGS PD2/ADL index of 11-15
 9009 = Reduced physical functions- RUGS PE1/ADL index of 16-18
 9010 = Reduced physical functions- RUGS PE2/ADL index of 16-18
 9011 = Behavior only problems- RUGS BA1/ADL index of 4-5
 9012 = Behavior only problems- RUGS BA2/ADL index of 4-5
 9013 = Behavior only problems- RUGS BB1/ADL index of 6-10
 9014 = Behavior only problems- RUGS BB2/ADL index of 6-10
 9015 = Impaired cognition- RUGS IA1/ADL index of 4-5
 9016 = Impaired cognition- RUGS IA2/ADL index of 4-5
 9017 = Impaired cognition- RUGS IB1/ADL index of 6-10
 9018 = Impaired cognition- RUGS IB2/ADL index of 6-10
 9019 = Clinically complex- RUGS CA1/ADL index of 4-5
 9020 = Clinically complex- RUGS CA2/ADL index of 4-5d
 9021 = Clinically complex- RUGS CB1/ADL index of 6-10
 9022 = Clinically complex- RUGS CB2/ADL index of 6-10d
 9023 = Clinically complex- RUGS CC1/ADL index of 11-16
 9024 = Clinically complex- RUGS CC2/ADL index of 11-16d
 9025 = Clinically complex- RUGS CD1/ADL index of 17-18
 9026 = Clinically complex- RUGS CD2/ADL index of 17-18d
 9027 = Special care- RUGS SSA/ADL index of 7-13
 9028 = Special care- RUGS SSB/ADL index of 14-16
 9029 = Special care- RUGS SSC/ADL index of 17-18
 9030 = Extensive services- RUGS SE1/1 procedure
 9031 = Extensive services- RUGS SE2/2 procedures
 9032 = Extensive services- RUGS SE3/3 procedures
 9033 = Low rehabilitation- RUGS RLA/ADL index of 4-11
 9034 = Low rehabilitation- RUGS RLB/ADL index of 12-18
 9035 = Medium rehabilitation- RUGS RMA/ADL index of 4-7
 9036 = Medium rehabilitation- RUGS RMB/ADL index of 8-15
 9037 = Medium rehabilitation- RUGS RMC/ADL index of 16-18
 9038 = High rehabilitation- RUGS RHA/ADL index of 4-7
 9039 = High rehabilitation- RUGS RHB/ADL index of 8-11
 9040 = High rehabilitation- RUGS RHC/ADL index of 12-14
 9041 = High rehabilitation- RUGS RHD/ADL index of 15-18
 9042 = Very high rehabilitation- RUGS RVA/ADL index of 4-7
 9043 = Very high rehabilitation- RUGS RVB/ADL index of 8-13
 9044 = Very high rehabilitation- RUGS RVC/ADL index of 14-18

Changes effective for providers entering

RUGS Demo Phase III as of 1/1/97 or later

9019 = Clinically complex- RUGS CA1/ADL index of 11
 9020 = Clinically complex- RUGS CA2/ADL index of 11d
 9021 = Clinically complex- RUGS CB1/ADL index of 12-16
 9022 = Clinically complex- RUGS CB2/ADL index of 12-16d
 9023 = Clinically complex- RUGS CC1/ADL index of 17-18
 9024 = Clinically complex- RUGS CC2/ADL index of 17-18d
 9025 = Special care- RUGS SSA/ADL index of 14
 9026 = Special care- RUGS SSB/ADL index of 15-16
 9027 = Special care- RUGS SSC/ADL index of 17-18
 9028 = Extensive services- RUGS SE1/ADL index 7-18/1 procedure
 9029 = Extensive services- RUGS SE2/ADL index 7-18/2 procedures
 9030 = Extensive services- RUGS SE3/ADL index 7-18/3 procedures
 9031 = Low rehabilitation- RUGS RLA/ADL index of 4-13
 9032 = Low rehabilitation- RUGS RLB/ADL index of 14-18
 9033 = Medium rehabilitation- RUGS RMA/ADL index of 4-7
 9034 = Medium rehabilitation- RUGS RMB/ADL index of 8-14
 9035 = Medium rehabilitation- RUGS RMC/ADL index of 15-18
 9036 = High rehabilitation- RUGS RHA/ADL index of 4-7
 9037 = High rehabilitation- RUGS RHB/ADL index of 8-12
 9038 = High rehabilitation- RUGS RHC/ADL index of 13-18
 9039 = Very High rehabilitation- RUGS RVA/ADL index of 4-8
 9040 = Very high rehabilitation- RUGS RVB/ADL index of 9-15
 9041 = Very high rehabilitation- RUGS RVC/ADL index of 16
 9042 = Very high rehabilitation- RUGS RUA/ADL index of 4-8
 9043 = Very high rehabilitation- RUGS RUB/ADL index of 9-15
 9044 = Ultra high rehabilitation- RUGS RUC/ADL index of 16-18

BETOS

(BETOS_TB)

BETOS Table

M1A = Office visits - new
M1B = Office visits - established

M2A = Hospital visit - initial
M2B = Hospital visit - subsequent
M2C = Hospital visit - critical care
M3 = Emergency room visit
M4A = Home visit
M4B = Nursing home visit
M5A = Specialist - pathology
M5B = Specialist - psychiatry
M5C = Specialist - ophthalmology
M5D = Specialist - other
M6 = Consultations
P0 = Anesthesia
P1A = Major procedure - breast
P1B = Major procedure - colectomy
P1C = Major procedure - cholecystectomy
P1D = Major procedure - turp
P1E = Major procedure - hysterectomy
P1F = Major procedure - explor/decompr/excisdisc
P1G = Major procedure - Other
P2A = Major procedure, cardiovascular-CABG
P2B = Major procedure, cardiovascular-Aneurysm repair
P2C = Major Procedure, cardiovascular-Thromboendarterectomy
P2D = Major procedure, cardiovascular-Coronary angioplasty (PTCA)
P2E = Major procedure, cardiovascular-Pacemaker insertion
P2F = Major procedure, cardiovascular-Other
P3A = Major procedure, orthopedic - Hip fracture repair
P3B = Major procedure, orthopedic - Hip replacement
P3C = Major procedure, orthopedic - Knee replacement
P3D = Major procedure, orthopedic - other
P4A = Eye procedure - corneal transplant
P4B = Eye procedure - cataract removal/lens insertion
P4C = Eye procedure - retinal detachment
P4D = Eye procedure - treatment
P4E = Eye procedure - other
P5A = Ambulatory procedures - skin
P5B = Ambulatory procedures - musculoskeletal
P5C = Ambulatory procedures - inguinal hernia repair
P5D = Ambulatory procedures - lithotripsy
P5E = Ambulatory procedures - other
P6A = Minor procedures - skin
P6B = Minor procedures - musculoskeletal
P6C = Minor procedures - other (Medicare fee schedule)
P6D = Minor procedures - other (non-Medicare fee schedule)
P7A = Oncology - radiation therapy
P7B = Oncology - other
P8A = Endoscopy - arthroscopy
P8B = Endoscopy - upper gastrointestinal
P8C = Endoscopy - sigmoidoscopy
P8D = Endoscopy - colonoscopy
P8E = Endoscopy - cystoscopy
P8F = Endoscopy - bronchoscopy
P8G = Endoscopy - laparoscopic cholecystectomy
P8H = Endoscopy - laryngoscopy
P8I = Endoscopy - other
P9A = Dialysis services
I1A = Standard imaging - chest
I1B = Standard imaging - musculoskeletal
I1C = Standard imaging - breast
I1D = Standard imaging - contrast gastrointestinal
I1E = Standard imaging - nuclear medicine
I1F = Standard imaging - other
I2A = Advanced imaging - CAT: head
I2B = Advanced imaging - CAT: other
I2C = Advanced imaging - MRI: brain
I2D = Advanced imaging - MRI: other
I3A = Echography - eye
I3B = Echography - abdomen/pelvis
I3C = Echography - heart
I3D = Echography - carotid arteries
I3E = Echography - prostate, transrectal
I3F = Echography - other
I4A = Imaging/procedure - heart including cardiac catheter
I4B = Imaging/procedure - other
T1A = Lab tests - routine venipuncture (non Medicare fee schedule)

BETOS

(BETOS_TB)

BETOS Table

T1B = Lab tests - automated general profiles
T1C = Lab tests - urinalysis
T1D = Lab tests - blood counts

T1E = Lab tests - glucose
 T1F = Lab tests - bacterial cultures
 T1G = Lab tests - other (Medicare fee schedule)
 T1H = Lab tests - other (non-Medicare fee schedule)
 T2A = Other tests - electrocardiograms
 T2B = Other tests - cardiovascular stress tests
 T2C = Other tests - EKG monitoring
 T2D = Other tests - other
 D1A = Medical/surgical supplies
 D1B = Hospital beds
 D1C = Oxygen and supplies
 D1D = Wheelchairs
 D1E = Other DME
 D1F = Orthotic devices
 O1A = Ambulance
 O1B = Chiropractic
 O1C = Enteral and parenteral
 O1D = Chemotherapy
 O1E = Other drugs
 O1F = Vision, hearing and speech services
 O1G = Influenza immunization
 Y1 = Other - Medicare fee schedule
 Y2 = Other - non-Medicare fee schedule
 Z1 = Local codes
 Z2 = Undefined codes

SUP_TYPE

DMERC Line Supplier Type Table

 DMERC_LINE_SUPLR_TYPE_TB

- 0 = Clinics, groups, associations, partnerships, or other entities for whom the carrier's own ID number has been assigned.
- 1 = Physicians or suppliers billing as solo practitioners for whom SSN's are shown in the physician ID code field.
- 2 = Physicians or suppliers billing as solo practitioners for whom the carrier's own physician ID code is shown.
- 3 = Suppliers (other than sole proprietorship) for whom EI numbers are used in coding the ID field.
- 4 = Suppliers (other than sole proprietorship) for whom the carrier's own code has been shown.
- 5 = Institutional providers and independent laboratories for whom EI numbers are used in coding the ID field.
- 6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.
- 7 = Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field.
- 8 = Other entities for whom EI numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.

HCPCS

Claim SNF & HHA Health Insurance

PPS Table

 (CLM_HIPPS_TB)

***** SNF PPS HIPPS *****
 *****1st 3 positions (RUGS-III group)*****

AAA = Default: No assessment

BA1,BA2,BB1,BB2 = Behavior only problems (e.g., physical/verbal abuse)

CA1,CA2,CB1,CB2 = Clinically-complex conditions (e.g., chemo, dialysis)

CC1,CC2

IA1,IA2,IB1,IB2 = Impaired cognition (e.g., impaired cognition (e.g., short-term memory)

PA1,PA2,PB1,PB2 = Reduced physical functions

PC1,PC2,PD1,PD2

PE1,PE2

RHA,RHB,RHC,RLA = Low/medium/high rehabilitation

RLB,RMA,RMB,RMC

RUA,RUB,RUC,RVA = Very high/ultra high rehabilitation: highest level

RVB,RVC

SE1,SE2,SE3 = Extensive services; e.g.; IV feed trach care

SSA,SSB,SSC = Special care; e.g.; coma, burns

*****Positions 4 & 5 represent HIPPS modifier/*****
 ***** assessment type indicator *****

00 = No assessment completed

01 = Medicare 5-day assessment/not an initial admission assessment

02 = Medicare 30-day full assessment

03 = Medicare 60-day full assessment

04 = Medicare 90-day full assessment

05 = Medicare Readmission/Return required assessment (eff. 10/2000)

07 = Medicare 14-day full or comprehensive assessment/not an initial admission assessment

08 = Off-cycle Other Medicare Required Assessment (OMRA)

11 = Admission assessment AND Medicare 5-day (or readmission/return) assessment

17 = Medicare 14-day required assessment AND initial admission assessment (eff. 10/2000)

18 = OMRA replacing Medicare 5-day required assessment (eff. 10/2000)

28 = OMRA replacing Medicare 30-day required assessment (eff. 10/2000)

30 = Off-cycle significant change assessment (outside assessment window) (eff. 10/2000)

31 = Significant change assessment replaces Medicare 5-day assessment (eff. 10/2000)

32 = Significant change assessment replaces Medicare 30-day assessment

33 = Significant change assessment replaces Medicare 6--day assessment

34 = Significant change assessment replaces Medicare 90-day assessment

35 = Significant change assessment replaces a Medicare readmission/return assessment

37 = Significant change assessment replaces Medicare 14-day assessment

38 = OMRA replacing Medicare 60-day required assessment

40 = Off-cycle significant correction assessment of a prior assessment (outside assessment window) (eff. 10/2000)

41 = Significant correction of prior full assessment replaces a Medicare 5-day assessment

42 = Significant correction of prior full assessment replaces a Medicare 30-day assessment

43 = Significant correction of prior full assessment replaces a Medicare 60-day assessment

44 = Significant correction of prior full assessment replaces a Medicare 90-day assessment

45 = Significant correction of a prior assessment
 replaces a readmission/return assessment
 (eff. 10/2000)
 47 = Significant correction of prior full assessment
 replaces a Medicare 14-day required assessment
 48 = OMRA replacing Medicare 90-day required assessment
 54 = Quarterly review assessment - Medicare 90-day
 full assessment
 78 = OMRA replacing a Medicare 14-day assessment
 (eff. 10/2000)

*****Claim Home Health PPS HIPPS Table*****
 ***** KEY *****

Position 1 = 'H'
 Position 2 = Clinical (A = MIN, B = LOW, C = MOD, D =HIGH)
 Position 3 = Functional (E = MIN, F = LOW, G = MOD, H = HIGH, I = MAX)
 Position 4 = Service (J = MIN, K = LOW, L = MOD, M = HIGH)
 Position 5 = identifies which elements of the code were
 computed or derived:
 1 = 2nd, 3rd, 4th positions computed
 2 = 2nd position derived
 3 = 3rd position derived
 4 = 4th position derived
 5 = 2nd & 3rd positions derived
 6 = 3rd & 4th positions derived
 7 = 2nd & 4th positions derived
 8 = 2nd, 3rd, 4th positions derived

1 NOFAY_CD

 CLM_MDCR_NPMT_RSN_TB

Claim Medicare Non-Payment Reason Table

A = Covered worker's compensation (Obsolete)
 B = Benefit exhausted
 C = Custodial care - noncovered care
 (includes all 'beneficiary at fault'
 waiver cases) (Obsolete)
 E = HMO out-of-plan services not emergency
 or urgently needed (Obsolete)
 E = MSP cost avoided - IRS/SSA/HCFR Data
 Match (eff. 7/00)
 F = MSP cost avoid HMO Rate Cell (eff. 7/00)
 G = MSP cost avoided Litigation Settlement
 (eff. 7/00)
 H = MSP cost avoided Employer Voluntary
 Reporting (eff. 7/00)
 J = MSP cost avoid Insurer Voluntary
 Reporting (eff. 7/00)
 K = MSP cost avoid Initial Enrollment
 Questionnaire (eff. 7/00)
 N = All other reasons for nonpayment
 P = Payment requested
 Q = MSP cost avoided Voluntary Agreement
 (eff. 7/00)
 R = Benefits refused, or evidence not
 submitted
 T = MSP cost avoided - IEQ contractor
 (eff. 9/76) (obsolete 6/30/00)
 U = MSP cost avoided - HMO rate cell
 adjustment (eff. 9/76) (Obsolete 6/30/00)
 V = MSP cost avoided - litigation
 settlement (eff. 9/76) (Obsolete 6/30/00)
 W = Worker's compensation (Obsolete)
 X = MSP cost avoided - generic
 Y = MSP cost avoided - IRS/SSA data
 match project (obsolete 6/30/00)
 Z = Zero reimbursement RAPS -- zero reimbursement
 made due to medical review intervention or
 where provider specific zero payment has been
 determined. (effective with HHPPS - 10/00)