Appendix for SEER-Medicare 11/2016 Claims Files
May 31, 2017

BIC (BENE_IDENT_TB) Social Security Administration:

Beneficiary Identification Code (BIC) Table

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)

BIC (BENE_IDENT_TB) Social Security Administration:

Beneficiary Identification Code (BIC) Table

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)
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 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)

BIC
(BENE_IDENT_TB)
Social Security Administration:

Beneficiary Identification Code (BIC) Table

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)

BIC (BENE_IDENT_TB) Social Security Administration:	Beneficiary Identification Code (BIC) Table
	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
	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 (BENE_PRMRY_PYR_TB)	Beneficiary Primary Payer Table
	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

PRPAY_CD (BENE_PRMRY_PYR_TB)	Beneficiary Primary Payer Table
	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) 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) ***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 supposed to be effective after 12/90, but may have been used prior to that date.)
ENTRY_CD (CARR_CLM_ENTRY_TB)	Carrier Claim Entry Table
	1 = Original debit; void of original debit (If CLM_DISP_CD = 3, code 1 means voided original debit) 3 = Full credit 5 = Replacement debit 9 = Accrete bill history only (internal; effective 2/22/91)

PMTDNLCD (CARR_CLM_PMT_DNL_TB)	Carrier Claim Payment Denial Table
Valid values effective 1/2011 (2-byte values are replacing the character values)	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) 00= MSP cost avoided - COB Contractor 12= MSP cost avoided - BC/BS Voluntary Agreements 13= MSP cost avoided - Office of Personnel Management 14= MSP cost avoided - Workman's Compensation (WC) Datamatch 15= MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006) 16= MSP cost avoided - Liability Insurer VDSA (eff.4/2006) 17= MSP cost avoided - No-Fault Insurer VDSA (eff.4/2006) 18= MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement (eff.4/2006)

PMTDNLCD (CARR_CLM_PMT_DNL_TB)	Carrier Claim Payment Denial Table
	21= MSP cost avoided - MIR Group Health Plan (eff.1/2009) 22= MSP cost avoided - MIR non-Group Health Plan (eff.1/2009) 25= MSP cost avoided - Recovery Audit Contractor - California (eff.10/2005) 26= MSP cost avoided - Recovery Audit Contractor - Florida (eff.10/2005) NOTE: Effective 4/1/02, the Carrier claim payment denial code was expanded to a 2-byte field. The NCH instituted a crosswalk from the 2-byte code to a 1-byte character code. Below are the character codes (found in NCH & NMUD). At some point, NMUD will carry the 2-byte code but NCH will continue to have the 1-byte character code. ! = MSP cost avoided - COB Contractor ('00' 2-byte code) @ = MSP cost avoided - BC/BS Voluntary Agreements ('12' 2-byte code) # = MSP cost avoided - Office of Personnel Management ('13' 2-byte code) $ = MSP cost avoided - Workman's Compensation (WC) Datamatch ('14' 2-byte code) * = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) ('15' 2-byte code) (eff. 4/2006) (= MSP cost avoided - Liability Insurer VDSA ('16' 2-byte code) (eff. 4/2006)) = MSP cost avoided - No-Fault Insurer VDSA ('17' 2-byte code) (eff. 4/2006) + = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement ('18' 2 -byte code) (eff. 4/2006) < = MSP cost avoided - MIR Group Health Plan ('21' 2-byte code) (eff. 1/2009) > = MSP cost avoided - MIR non-Group Health Plan ('22' 2-byte code) (eff. 1/2009) % = MSP cost avoided - Recovery Audit Contractor - California ('25' 2-byte code) (eff. 10/2005) & = MSP cost avoided - Recovery Audit Contractor - Florida ('26' 2-byte code) (eff. 10/2005)
MTUSIND (for NCH) (CARR_LINE_MTUS_IND_TB)	Carrier Line Miles/Time/Units Indicator Table
	0 = Values reported as zero (no allowed activities) 1 = Transportation (ambulance) miles 2 = Anesthesia time units

MTUSIND (for NCH) (CARR_LINE_MTUS_IND_TB)	Carrier Line Miles/Time/Units Indicator Table 3 = Services 4 = Oxygen units 5 = Units of blood 6 = Anesthesia base and time units (prior to 1991; from BMAD)
MTUSIND (for DME) (DMERC_LINE_MTUS_IND_TB)	DMERC Line Miles/Time/Units Indicator Table 0 = Values reported as zero 3 = Number of services 4 = Oxygen volume units 6 = Drug dosage -- since early 1994 this value has incorrectly been placed on DMERC claims. The DMERCs were overriding the MTUS indicator with a '6' if the claim was submitted with an NDC code. NOTE: It was recently discovered that this problem has been corrected -- no date on when the correction became effective.
PRV_TYPE (CARR_LINE_PRVDR_TYPE_TB)	Carrier Line Provider Type Table 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 SS numbers are shown in the physician ID code field. 2 = Physicians or suppliers billing as solo-practitioners for the carrier's own physician ID code is shown. 3 = Suppliers (other sole) 4 = Suppliers (other than sole proprietorship) for whom the carrier's own code has been shown. 5 = Institutional providers and independent laboratories for whom E1 numbers are used in code 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 E1 numbers are used in coding the ID field

ASTNT_CD (CARR_LINE_RDCD_PHYSN_ ASTNT_TB)	Carrier Line Part B Reduced Physician Assistant Table
	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) (CARR_NUM_TB)	Carrier Number Table
	00510 = Alabama - CAHABA (eff. 1983; term. 05/2009) (replaced by MAC #10102 -- see below) 00511 = Georgia - CAHABA (eff. 1998; term. 06/2009) (replaced by MAC #10202 -- see below) 00512 = Mississippi - CAHABA (eff. 2000) 00520 = Arkansas BC/BS (eff. 1983) 00521 = New Mexico - Arkansas BC/BS (eff. 1998; term. 02/2008) (replaced by MAC #04202 -- see below) 00522 = Oklahoma - Arkansas BC/BS (eff. 1998; term. 02/2008) (replaced by MAC #04302 -- see below) 00523 = Missouri East - Arkansas BC/BS (eff. 1999; term. 02/2008) (replaced by MAC #05392 -- see below) 00524 = Rhode Island - Arkansas BC/BS (eff. 2004; term. 01/2009) (replaced by MAC #14402 -- see below) 00528 = Louisiana - Arkansas BS (eff. 1984) 00542 = California BS (eff. 1983; term. 05/2009) 00550 = Colorado BS (eff. 1983; term. 11/1994) 00570 = Delaware - Pennsylvania BS (eff. 1983; term. 07/1997) 00580 = District of Columbia - Pennsylvania BS (eff. 1983; term. 08/1997) 00590 = Florida - First Coast (eff. 1983; term. 01/2009) (replaced by MAC #09102 -- see below) 00591 = Connecticut - First Coast (eff. 2000; term. 07/2008) (replaced by MAC #13102 -- see below)

FI_NUM (IN NCH, DME) (CARR_NUM_TB)

Carrier Number Table

00621 = Illinois BS - HCSC (eff. 1983; term. 08/1997)

00623 = Michigan - Illinois Blue Shield (eff. 1995; term. 08/1997)

00630 = Indiana - Administar (eff. 1983) (term. 08/19/2012) (replaced by MAC #08102 -- see below)

00635 = DMERC-B - Administar (eff. 1993; term. 06/2006) (replaced by MAC #17003 -- see below)

00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 11/1996)

00645 = Nebraska - Iowa BS (eff. 1985; term. 11/1994)

00650 = Kansas BCBS (eff. 1983) (term. 02/2008) (replaced by MAC #05202 -- see below)

00651 = Missouri - Kansas BCBS (eff. 1983; term. 02/2008) (replaced by MAC #05202 -- see below)

00655 = Nebraska - Kansas BC/BS (eff. 1988; term. 02/2008) (replaced by MAC #05402 -- see below)

00660 = Kentucky - Administar (eff. 1983; term. 04/2011)

00662 = PFDC (Floyd Epps) (terminated)

00663 = FQHC Pilot Demo (CAFM - Ayers-Ramsey) (term. 11/2011)

00690 = Maryland BS (terminated)

00691 = CAREFIRST - CWF (terminated)

00700 = Massachusetts BS (eff. 1983; term. 11/1996)

00710 = Michigan BS (eff. 1983; term. 09/2000)

00720 = Minnesota BS (eff. 1983; term. 09/2000)

00740 = Western Missouri - Kansas BS (eff. 1983; term. 06/1997) (replaced by MAC #05302 -- see below)

00751 = Montana BC/BS (eff. 1983; term. 11/2006) (replaced by MAC # 03202 -- see below)

00770 = New Hampshire/Vermont Physician Services (eff. 1983; term. 12/1988)

00780 = New Hampshire - Massachusetts BS (eff. 1985; term. 04/1997)

00781 = Vermont - Massachusetts BS (eff. 1985; term. 06/1997)

00801 = New York - Healthnow (eff. 1983; term. 08/2008) (replaced by MAC #13282 -- see below)

00803 = New York - Empire BS (eff. 1983; term. 07/2008) (replaced by MAC #13202 -- see below)

00804 = New York - Rochester BS (term. 02/1999) (replaced by MAC # 12402 -- see below)

00805 = New Jersey - Empire BS (eff. 3/99; term. 11/2008) (replaced by MAC # 12402 -- see below)

00811 = DMERC (A) - Healthnow (eff. 2000; term. 06/2006) (replaced by MAC #16003 -- see below)

FI_NUM (IN NCH, DME) (CARR_NUM_TB)

Carrier Number Table

00820 = North Dakota - Noridian (eff. 1983; term. 11/2006) (replaced by MAC #03302 -- see below)

00823 = Utah - Noridian (eff. 12/1/2005; term. 11/2006) (replaced by MAC #03502 -- see below)

00824 = Colorado - Noridian (eff. 1995; term. 02/2008) (term. 2008) (replaced by MAC #04102 -- see below)

00825 = Wyoming - Noridian (eff. 1990; term. 11/2006) (replaced by MAC #03602 -- see below)

00826 = Iowa - Noridian (eff. 1999; term. 01/2008) (replaced by MAC #05102 -- see below)

00831 = Alaska - Noridian (eff. 1998)

00832 = Arizona - Noridian (eff. 1998; term. 11/2006) (replaced by MAC # 03102 -- see below)

00833 = Hawaii - Noridian (eff. 1998; term. 07/2008) (replaced by MAC # 01202 -- see below)

00834 = Nevada - Noridian (eff. 1998; term. 07/2008) (replaced by MAC # 01302 -- see below)

00835 = Oregon - Noridian (eff. 1998)

00836 = Washington - Noridian (eff. 1998)

00860 = New Jersey - Pennsylvania BS (eff. 1988; term. 02/1998)

00865 = Pennsylvania - Highmark (eff. 1983; term. 12/2008) (replaced by MAC # 12502 -- see below)

00870 = Rhode Island BS (eff. 1983; term. 02/1999)

00880 = South Carolina - Palmetto (eff. 1983; term. 06/2011)

00881 = South Carolina BS-P&E (terminated)

00882 = RRB - South Carolina PGBA (eff. 2000)

00883 = Ohio - Palmetto (eff. 2002; term. 06/2011)

00884 = West Virginia - Palmetto (eff. 2002; term. 06/2011)

00885 = DMERC C - Palmetto (eff. 1993; term. 05/2006) (replaced by MAC #18003 -- see below)

00888 = PLAMETTO DRUGS (terminated)

00889 = South Dakota - Noridian (eff. 4/1/2006; term. 11/2006) (replaced by MAC # 03402 -- see below)

00900 = Texas - Trailblazer (eff. 1983; term. 06/2008) (replaced by MAC # 04402 -- see below)

00901 = Maryland - Trailblazer (eff. 1995; term. 07/2008) (replaced by MAC # 12302 -- see below)

00902 = Delaware - Trailblazer (eff. 1998; term. 07/2008) (replaced by MAC # 12102 -- see below)

00903 = District of Columbia - Trailblazer (eff. 1998; term. 07/2008) (replaced by MAC # 12202 -- see below)

00904 = Virginia - Trailblazer (eff. 2000; term. 03/2011) (replaced by MAC # 11302 -- see below)

FI_NUM (IN NCH, DME) (CARR_NUM_TB)

Carrier Number Table

00910 = Utah BS (eff. 1983; term. 09/2006)
00930 = Washington BS (Washington Phy. Ser.) (term. 07/1998)
0093Q = Washington-Whatcom County BS (term. 10/1998)
0093R = Washington-Yakima County BS (term. 09/2000)
00931 = Washington-Lewis County BS
00932 = Washington BS
00934 = Washington-Chelan County BS
00935 = Washington-Kisap County BS (term. 12/1994)
00936 = Washington-Spokane County BS
0093B = Washington-Clallam County BS (terminated)
0093C = Washington-Clark County BS (terminated)
0093D = Washington-Columbia County BS (terminated)
0093E = Washington-CO WLITZ County BS (terminated)
0093F = Washington-Grays Harbor County BS (terminated)
0093G = Washington-Jefferson County BS (terminated)
0093H = Washington-Kittitas County BS (terminated)
0093I = Washington-Lewis County BS (terminated)
0093J = Washington-Pacific County BS (terminated)
0093K = Washington-Tacoma BS (terminated)
0093L = Washington-Skagit County BS (terminated)
0093M = Washington-Snohomish County BS (terminated)
0093N = Washington-Thurston County BS (terminated)
0093P = Washington-Walla Walla County BS (term. 11/2000)
00950 = Wisconsin - Milwaukee Surgical (term. 07/1997)
00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)
00952 = Illinois - Wisconsin Phy Svc (eff. 1999)
00953 = Michigan - Wisconsin Phy Svc (eff. 1999) (term. 07/15/2012) (replaced by MAC #08202 -- see below)
00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
00960 = WPS Part D GAP (CAFM) (Truffer) (eff. 01/2010)
00973 = Puerto Rico - Triple S, Inc. (eff. 1983; term. 02/2009) (replaced by MAC # 09302 -- see below)
00974 = Virgin Islands - Triple S, Inc. (term. 02/2009)
01020 = Alaska - AETNA (eff. 1983; term. 07/1997)
01030 = Arizona - AETNA (eff. 1983; term. 07/1997)
01040 = Georgia - AETNA (eff. 1988; term. 07/1997)
01070 = Connecticut - AETNA (term. 07/1997)
01120 = Hawaii - AETNA (eff. 1983; term. 1997)
01290 = Nevada - AETNA (eff. 1983; term. 10/1994)
01360 = New Mexico - AETNA (eff. 1986; term. 07/1998)
01370 = Oklahoma - AETNA (eff. 1983; term. 02/1996)
01380 = Oregon - AETNA (eff. 1983; term. 09/2000)
01390 = Washington - AETNA (eff. 1994; term. 09/2000)

FI_NUM (IN NCH, DME) (CARR_NUM_TB)

Carrier Number Table

02050 = California - TOLIC (eff. 1983; term. 09/1991)
02051 = OCCIDENTAL - P&E (eff. 1983; term. 12/1998)
02831 = WEST.CONSORT.OCCIDENTAL-ALASKA (term. 07/2002)
02832 = WEST.CONSORT.OCCIDENTAL-ALASKA (term. 07/2002)
02833 = WEST.CONSORT.OCCIDENTAL-ALASKA
02834 = WEST.CONSORT.OCCIDENTAL-ALASKA (term. 11-1988)
02835 = WEST.CONSORT.OCCIDENTAL-ALASKA
02836 = WEST.CONSORT.OCCIDENTAL-ALASKA (term. 12-1988)
03070 = Connecticut General Life Insurance Co. (eff. 1983; term. 04/1997)
04110 = GEORGIA - JOHN HANCOCK (term. 04/1997)
04220 = MASSACHUSETTS - JOHN HANCOCK (term. 04/1997)
05130 = Idaho - CIGNA (eff. 1983)
05320 = New Mexico - Equitable Insurance (eff. 1983; term. 1985)
05330 = NEW YORK - Equitable
05440 = Tennessee - CIGNA (eff. 1983; term. 08/2009) (replaced by MAC #10302 - see below)
05530 = Wyoming - Equitable Insurance (eff. 1983) (term. 1989)
05535 = North Carolina - CIGNA (eff. 1988)
05655 = DMERC-D Alaska - CIGNA (eff. 1993; term. 09/2006) (replaced by MAC #19003 -- see below)
06140 = ILLINOIS - CONTINENTAL CASUALTY (term. 11/2008)
07180 = Kentucky - Metropolitan (term. 11/2000)
07330 = New York - Metropolitan (term. 08/1994)
08190 = Louisiana - Pan American
09200 = Maine-Union Mutual (terminated)
10070 = RRB-United Healthcare (term. 02/2004)
10071 = RRB-United Healthcare (terminated)
10072 = RRB-United Healthcare (terminated)
10073 = RRB-United Healthcare (terminated)
10074 = RRB-United Healthcare (term. 09/2000)
10075 = RRB-United Healthcare (terminated)
10076 = RRB-United Healthcare (terminated)
10230 = Connecticut - Metra Health (eff. 1986) (terminated)
10240 = Minnesota - Metra Health (eff. 1983) (term. 08/1994)
10250 = Mississippi - Metra Health (eff. 1983) (term. 09/2000)
10490 = Virginia - Metra Health (eff. 1983) (term. 05/1997)
10555 = DMERC A - United Healthcare (eff. 1993) (term. 12/1993)

FI_NUM (IN NCH, DME) (CARR_NUM_TB)

Carrier Number Table

11260 = General American Life of Missouri (eff. 1983; term. 1998)

14330 = New York - GHI (eff. 1983; term. 07/2008) (replaced by MAC #13292 -- see below)

16360 = Ohio - Nationwide Insurance Co. (eff. 1983) (term. 2002)

16510 = West Virginia - Nationwide Insurance Co. (eff. 1983) (term. 2002)

21200 = Maine - Massachusetts BS (eff. 1983) (term. 1998)

25370 = Okalhoma Dept of Public Welfare (terminated)

31140 = N. California - National Heritage Ins. (eff. 1997; term. 08/2008) (replaced by MAC #01102 -- see below)

31142 = Maine - National Heritage Ins. (eff. 1998; term. 05-2009) (replaced with MAC # 14102 - see below)

31143 = Massachusetts - National Heritage Ins. (eff. 1998; term. 05-2009) (replaced with MAC # 14202 - see below)

31144 = New Hampshire - National Heritage Ins. (eff. 1998; term. 05-2009) (replaced with MAC # 14302 - see below)

31145 = Vermont - National Heritage Ins. (eff. 1998; term. 05-2009)

31146 = So. California - NHIC (eff. 2000; term. 08/2008)

41260 = Missouri-General American (terminated)

80884 = Contractor ID for Physician Risk Adjustment Data (data not sent through CWF; but through Palmetto)

88001 = Retiree Drugs Subsidy Program (terminated)

88002 = Retiree Drugs Subsidy Program (ViPS) (CAFM) (terminated)

Medicare Administrative Contractors (MACs)

JURISDICTION 1 -- Part B MACs

01002 = J1 Roll-up

01102 = California (eff. 9/1/08) (replaces carrier #00832)

01192 = Palmetto GBA J1 (S CA) (eff. 09/01/2008)

01202 = Hawaiia (eff. 8/1/08) (replaces carrier #00833)

01302 = Nevada (eff. 8/1/08) (replaces carrier #00834)

02002 = JF Roll-up (2/3)

02102 = Alaska - Noridian Admin Svcs (eff. 02/01/2012)

02202 = Idaho - Noridian Admin Svcs (eff. 02/01/2012)

02302 = Oregon - Noridian Admin Svcs (eff. 02/01/2012)

02402 = Washington - Noridian Admin Svcs (eff. 02/01/2012)

JURISDICTION 3 -- Part B MACs

FI_NUM (IN NCH, DME) (CARR_NUM_TB)

Carrier Number Table

03002 = JF Roll-up (2/3) (orig. J3)
03102 = Arizona (eff. 12/1/06) (replaces carrier #00832)
03202 = Montana (eff. 12/1/06) (replaces carrier #00751)
03302 = N. Dakota (eff. 12/1/06) (replaces carrier #00820)
03402 = S. Dakota (eff. 12/1/06) (replaces carrier #00889)
03502 = Utah (eff. 12/1/06) (replaces carrier #00823)
03602 = Wyoming (eff. 12/1/06) (replaces carrier #00825)

JURISDICTION 4 -- Part B MACs

04002 = J4 Roll-up
04102 = Colorado (eff. 03/01/2008) (replaces carrier #00550) (terminated)
04202 = New Mexico (eff. 03/01/2008) (replaces carrier #00521)
04302 = Oklahoma (eff. 03/01/2008) (replaces carrier #00522)
04402 = Texas (eff. 06/01/2008) (replaces carrier #00900)

JH Roll-up (4/7)
04112 = Colorado - Novitas Solutions JH (eff. 11/17/2012)
04212 = New Mexico - Novitas Solutions JH (eff. 11/17/2012)
04312 = Oklahoma - Novitas Solutions JH (eff. 11/17/2012)
04412 = Texas - Novitas Solutions JH (eff. 11/17/2012)

JURISDICTION 5 -- Part B MACs

05002 = J5 Roll-up
05102 = Iowa (eff.2/1/08) (replaces carrier #00826)
05202 = Kansas (eff. 3/1/08) (replaces carrier #00650)
05302 = W. Missouri(eff. 3/1/08) (replaces carrier #00651 or 00740)
05392 = E. Missouri (eff. 6/1/08) (replaces carrier #00523)
05402 = Nebraska (eff. 3/1/08) (replaces carrier #00655)
06002 = J6 Roll-up
06102 = Illinois
06202 = Minnesota
06302 = Wisconsin
07002 = JH Roll-up (4/7)
07102 = Arkansas-Novitas Solutions JH (eff. 08/11/2012) (CR7812)
07202 = Louisiana - Novitas Solutions JH (eff. 08/11/2012)
07302 = Mississipppi - Novitas Solutions JH (eff. 10/20/2012)

JURISDICTION 8 -- Part B MACs

FI_NUM (IN NCH, DME) (CARR_NUM_TB)

Carrier Number Table

08002 = J8 Roll-up
08102 = Indiana (eff.8/20/2012) (replaces carrier #00630)
08202 = Michigan (eff.7/16/2012) (replaces carrier #00953)

JURISDICTION 9 -- Part B MACs

09002 = J9 Roll-up
09102 = Florida - First Coast (eff. 02/2009) (replaces carrier #00590)
09202 = Puerto Rico - First Coast (eff.03/2009) (replaces carrier #00973)
09302 = Virgin Island - First Coast (eff.03/2009) (replaces carrier #00974)

JURISDICTION 10 -- Part B MACs

10002 = J10 Roll-up
10102 = Alabama (eff.5/4/09) (replaces carrier #00510)
10202 = Georgia (eff.8/3/09) (replaces carrier #00511)
10302 = Tennessee (eff.9/1/09) (replaces carrier #05440)

COB Contractor Numbers in CWF

11100 = MSP/COB Contr. 6000 COB Contractor
11101 = MSP/COB Contr. 6010 Initial Enrollment Questionaire (IEQ)
11102 = MSP/COB Contr. 6020 IRS/SSA/CMS/Data Match.
11103 = MSP/COB Contr. 6030 HMO Rate Call
11104 = MSP/COB Contr. 6040 Litigation Settlement
11105 = MSP/COB Contr. 6050 Employer Voluntary Reporting
11106 = MSP/COB Contr. 6060 Insurer Voluntary Reporting
11107 = MSP/COB Contr. 6070 First Claim Development
11108 = MSP/COB Contr. 6080 Trauma Code Development
11109 = MSP/COB Contr. 6090 Secondary Claims Investigation
11110 = MSP/COB Contr. 7000 Self Reports
11111 = MSP/COB Contr. 7010 411.25
11112 = MSP/COB Contr. 7012 BCBS Voluntary Agreements
11113 = MSP/COB Contr. 7013 OPM Data Match (OPM)
11114 = MSP/COB Contr. 7014 State Workers' Compensation
11115 = MSP/COB Contr. 7015 WC Insurer Vol Data Sharing Agreement

FI_NUM (IN NCH, DME) (CARR_NUM_TB)

Carrier Number Table

11116 = MSP/COB Contr. 7016 Liabilty Ins Vol Data Sharing Agreement
11117 = MSP/COB Contr. 7017 Vol Data Sharing Agreement (No...
11118 = MSP/COB Contr. 7018 Pharmacy Benefit Manager Data
11119 = MSP/COB Contr. 7019 Workers' Compensation Medicare ...
11120 = MSP/COB Contr. 7020 To be determined
11121 = MSP/COB Contr. 7021 MIR Group Health Plan
11122 = MSP/COB Contr. 7022 MIR non-Group Health Plan
11123 = MSP/COB Contr. 7023 To be determined
11124 = MSP/COB Contr. 7024 To be determined
11125 = MSP/COB Contr. 7025 Recovery Audit Contractor - California
11126 = MSP/COB Contr. 7026 Recovery Audit Contractor - Florida
11127 = MSP/COB Contr. 7027 To be determined
11139 = MSP/COB Contr. 7039 Group Health PlanRecovery (eff. 01/01/2013) (CR7906)
11140 = MSP/COB Contr.
11141 = MSP/COB Contr. 7041 Non-Group Health Plan Non-ORM (eff. 01/01/2013) (CR7906) = MSP/COB Contr. 7041 COB/MSPRC (redefined (description) via CR7906)
11142 = MSP/COB Contr. 7042 Non-Group Health Plan Recovery (eff. 01/01/2013) (CR7906)
11143 = MSP/COB Contr. 7043 COBC/Medicare Part C/Medicare Advantage
11144 = MSP/COB Contr. 7044 To be determined
11199 = MSP/COB Contr. 7099 To be determined

JURISDICTION 11 -- Part B MACs

11002 = J11 Roll-up
11202 = South Carolina - Palmetto Gov. Benefits Admin. (PGBA)
11302 = Virginia (eff.3/19/2011) Palmetto Gov. Benefits Admin. (PGBA) (replaces carrier #00904)
11402 = West Virginia (eff.6/18/2011) Palmetto Gov. Benefits Admin. (PGBA)
11502 = North Carolina (eff.5/28/2011) Palmetto Gov. Benefits Admin. (PGBA)

JURISDICTION 12 -- Part B MACs

12002 = J12 Roll-up

FI_NUM (IN NCH, DME) (CARR_NUM_TB)

Carrier Number Table

12102 = Delaware (eff. 7/11/2008) (replaces carrier # 00902)

12202 = District of Columbia (eff. 7/11/2008) (replaces carrier # 00903) NOTE: Includes Montgomery & Prince Georges Counties in Maryland and Fairfax Counties and the City of Alexandria, VA

12302 = Maryland (eff. 7/11/2008) (replaces carrier # 00901)

12402 = New Jersey (eff. 11/14/2008) (replaces carrier # 00805)

12502 = Pennsylvania (eff. 12/12/2008) (replaces carrier # 00865)

JURISDICTION 13 -- Part B MACs

13002 = J13 Roll-up

13102 = Connecticut (eff. 8/1/2008) (replaces carrier # 00591)

13202 = E. New York (eff. 7/18/2008) (replaces carrier # 00803)

13282 = W. New York (eff. 9/1/2008) (replaces carrier # 00801)

13292 = New York (Queens) (eff. 7/18/2008) (replaces carrier # 14330)

JURISDICTION 14 -- Part B MACs

14002 = J14 Roll-up

14102 = Maine (eff. 6/1/2009) (replaces carrier # 31142)

14202 = Massachusetts (eff. 6/1/2009) (replaces carrier # 31143)

14302 = N. Hampshire (eff. 6/1/2009) (replaces carrier # 31144)

14402 = Rhode Island (eff. 5/1/2009) (replaces carrier # 00524)

14502 = Vermont (eff. 6/1/2009) (replaces carrier # 31145)

15002 = J15 Roll-up

15102 = Kentucky (eff. 4/30/2011) CGS Government Services

15202 = Ohio (eff. 06/15/2011)

CGS Government Services

Durable Medical Equipment (DME) MACs

16003 = National Heritage Insurance Company (NHIC) (A) (eff. 7/1/06) (replaces carrier #00811)

17003 = Administar Federal, Inc. (B) (eff. 7/1/06) (replaces carrier # 00635)

18003 = Connecticut General (CIGNA) (C) (eff. 06/2006) (replaces carrier #00885)

19003 = Noridan Mutual Ins. Co (D) (eff. 10/1/06) (replaces carrier #05655)

33333 = MSP/COB Contr, 4000 Litigation Settlement

FI_NUM (IN NCH, DME) (CARR_NUM_TB)

Carrier Number Table

44410 = STC Testing
55555 = MSP/COB Contr, 3000 HMO Rate Cell Adjustment
66001 = Noridian Competitive Acquisition Program
66666 = MSP/COB Contr.
77001 = Program Safeguard Contractor (PSC) (Mike Lopatin)
77002 = Program Safeguard Contractor (PSC)
77003 = Program Safeguard Contractor (PSC)
77004 = Program Safeguard Contractor (PSC)
77005 = Program Safeguard Contractor (PSC)
77006 = Program Safeguard Contractor (PSC)
77007 = Program Safeguard Contractor (PSC)
77008 = Program Safeguard Contractor (PSC)
77009 = Program Safeguard Contractor (PSC)
77010 = Program Safeguard Contractor (PSC)
77011 = Program Safeguard Contractor (PSC)
77012 = Program Safeguard Contractor (PSC)
77013 = Zone Program Integrity Contractor (ZPICs) (Tara Ross)
77014 = Zone Program Integrity Contractor (ZPICs)
77015 = Zone Program Integrity Contractor (ZPICs)
77016 = Zone Program Integrity Contractor (ZPICs)
77017 = Zone Program Integrity Contractor (ZPICs)
77018 = Zone Program Integrity Contractor (ZPICs)
77019 = Zone Program Integrity Contractor (ZPICs)
77020 = Zone Program Integrity Contractor (ZPICs)
77021 = Zone Program Integrity Contractor (ZPICs)
77022 = Zone Program Integrity Contractor (ZPICs)
77023 = Zone Program Integrity Contractor (ZPICs)
77024 = Zone Program Integrity Contractor (ZPICs)
77025 = Zone Program Integrity Contractor (ZPICs)
77026 = Zone Program Integrity Contractor (ZPICs)
77027 = Zone Program Integrity Contractor (ZPICs)
77028 = Zone Program Integrity Contractor (ZPICs)
77777 = MSP/COB Contr. 1000 IRS/SSA/HCFA Data Match
78001 = Medicare Drug Integrity Contractor (MEDIC) (Tara Ross)
78002 = MEDIC Contractor
78003 = MEDIC Contractor
78004 = MEDIC Contractor
78005 = MEDIC Contractor
78006 = MEDIC Contractor
78007 = MEDIC Contractor
78008 = MEDIC Contractor
78009 = MEDIC Contractor
78010 = MEDIC Contractor

FI_NUM (IN NCH, DME) (CARR_NUM_TB)

Carrier Number Table

78011 = MEDIC Contractor
78012 = MEDIC Contractor
78013 = MEDIC Contractor
78014 = MEDIC Contractor
78015 = MEDIC Contractor
79001 = MSP Recovery Contractor
88888 = MSP/COB Contr. 5000 Voluntary Agreements
99999 = MSP/COB Contr. 2000 Initial Questionaire
Note: (CA) - 31140 & 31146
(MO) - 00523 & 00651
(NY) - 801 & 803 & 14330
Alaska-Oregon Aetna-Total (term. 09/2000)
Arizona-Nevada Aetna-Total (term. 09/2000)
Highmark-Total (term. 09/2000)
MASSACHUSETTS BS-Total (term. 09/2000)
MASSACHUSETTS BS TRI-STATE-Total (term. 09/2000)
New Mexico-Oklahoma-Total (terminated)
West.Consort.Occidental-Total (term. 09/2000)

FI_NUM (In Outpat.,HHA,Hosp) (FI_NUM_TB)

Fiscal Intermediary Number Table

00010 = Alabama BC - Alabama (replaced with MAC #10101 - see below)
00011 = Alabama BC - Iowa (replaced by MAC # 03401 -- see below)
00012 = Iowa (replaced by MAC # 05101 -- see below)
00020 = Arkansas BC - Arkansas
00021 = Arkansas BC - Rhode Island
00030 = Arizona BC (replaced by MAC # 03101 -- see below)
00040 = California BC (term. 12/00)
00050 = New Mexico BC/CO (term. 06/89)
00060 = Connecticut BC (term. 06/99)
00070 = Delaware BC - terminated 2/98
00080 = Florida BC (term. 03/88)
00090 = Florida BC (replaced with MAC #09101 -- see below)
00101 = Georgia BC (replaced with MAC #10201 -- see below)
00121 = Illinois - HCSC (term. 08/98)
00123 = Michigan - HCSC (term. 08/98)
00130 = Indiana BC/Administar Federal
00131 = Illinois - Administar
00140 = Iowa - Wellmark (term. 6/2000)

FI_NUM (In Outpat.,HHA,Hosp) (FI_NUM_TB)

Fiscal Intermediary Number Table

00150 = Kansas BC (term. 2008) (replaced with MAC # 05201 - see below)

00160 = Kentucky/Administar (replaced with MAC # 15101-see below)

00180 = Maine BC (replaced with MAC #14004 & 14101 -- see below)

00181 = Maine BC - Massachusetts

00190 = Maryland BC (term. 9/2005)

00200 = Massachusetts BC (term. 7/97)

00210 = Michigan BC (term. 9/94)

00220 = Minnesota BC (term. 07/99)

00230 = Mississippi BC

00231 = Mississippi BC/LA (term. 09/92)

00232 = Mississippi BC

00241 = Missouri BC (term. 9/92)

00242 = Missouri (replaced with MAC # 05301 --see below)

00250 = Montana BC (replaced by MAC # 03201 -- see below)

00260 = Nebraska BC (term. 2007) (replaced with MAC # 05401 - see below)

00270 = New Hampshire BC (replaced with MAC #14501 -- see below)

00280 = New Jersey BC (term. 8/2000)

00290 = New Mexico BC - terminated 11/95

00308 = New York - Empire BC (replaced with MAC # 12101, 13201 & 13101 -- see below)

00310 = North Carolina BC (term. 01/02)

00320 = North Dakota BC - North Dakota (replaced with MAC # 03301 - see below)

00322 = North Dakota BC - Washington & Alaska

00323 = North Dakota BC - Idaho, Oregon & Utah (replaced with MAC # 03501 --see below)

00332 = Ohio-Administar

00340 = Oklahoma BC (term. 2008) (replaced with MAC # 04301 - see below)

00350 = Oregon BC

00351 = Oregon BC/ID. (term. 09/88)

00355 = Oregon-CWF

00362 = Independence BC - terminated 8/97

00363 = Pennsylvania/Highmark - Veritus

00366 = Highmark (MD & DC) - Part A (eff. 10/2005)

00370 = Rhode Island BC (replaced with MAC #14401 - see below)

00380 = South Carolina BC - South Carolina (replaced with MAC #11004 & 11201 - see below)

FI_NUM (In Outpat.,HHA,Hosp) (FI_NUM_TB)

Fiscal Intermediary Number Table

00382 = South Carolina BC - North Carolina (replaced with MAC #11501 - see below)

00390 = Tennessee BC/Riverbend (replaced with MAC # 12001 & 10301 -- see below)

00400 = Texas BC (replaced with MAC #04101, 04201, 04401 - see below)

00410 = Utah BC (term. 09/00)

00423 = Virginia BC; Trigon (term. 08/99)

00430 = Washington/Alaska BC

00450 = Wisconsin BC - Wisconsin

00452 = Wisconsin BC - Michigan

00453 = Wisconsin BC - Virginia & West Virginia (replaced with MAC #11301 & 11401 - see below)

00454 = Wisconsin BC - California (replaced by MAC #01101, 01201 & 01301 -- see below)

00460 = Wyoming BC (replaced by MAC # 03601 -- see below)

00468 = N Carolina BC/CPRTIVA

00993 = BC/BS Assoc.

17120 = Hawaii Medical Service (term. 06/99)

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 = NE - Mutual of Omaha

57400 = Puerto Rico - Cooperativa (replaced with MAC # 09201)

61000 = Aetna (term. 06/97)

80883 = Contractor ID for Inpatient & Outpatient Risk Adjustment Data (data not sent through CWF; but through Palmetto)

Medicare Administrative Contractor Numbers

JURISDICTION 1 - PART A MACs

01101 = California (eff. 8/15/2008) (replaces FI #00454)

01201 = Hawaii (eff. 8/15/2008) (replaces FI #00454)

01301 = Nevada (eff. 8/15/2008) (replaces FI #00454)

JURISDICTION 3 - Part A MACs

03101 = Arizona (eff. 10/1/2006) (replaces FI #00030)

03201 = Montana (eff. 12/1/2006) (replaces FI #00250)

FI_NUM (In Outpat.,HHA,Hosp) (FI_NUM_TB)

Fiscal Intermediary Number Table

03301 = N. Dakota (eff. 12/1/2006) (replaces FI #00320)
03401 = S. Dakota (eff. 3/1/2007) (replaces FI #00011)
03501 = Utah (eff. 12/1/2006) (replaces FI #00323)
03601 = Wyoming (eff. 11/1/2006) (replaces FI #00460)

JURISDICTION 4 - Part A MACs

04101 = Colorado (eff. 6/16/2008) (replaces FI #00400)
04201 = New Mexico (eff. 6/16/2008) (replaces FI #00400)
04301 = Oklahoma (eff. 3/1/2008) (replaces FI #00340)
04401 = Texas (eff. 6/16/2008) (replaces FI #00400)

JURISDICTION 5 - Part A MACs

05101 = Iowa (eff. 5/1/2008) (replaces FI #00012)
05201 = Oklahoma (eff. 3/1/2008) (replaces FI #00150)
05301 = Missouri (eff. 5/1/2008) (replaces FI #00242)
05401 = Nebraska (eff. 12/1/2007) (replaces FI #00260)

JURISDICTION 9 - PART A MACs

09101 = Florida (eff. 2/13/2009) (replaces FI #00090)
09201 = PR/VI (eff. 03/1/2009) (replaces FI #57400)

JURISDICTION 10 - PART A MACs

10101 = Alabama (eff. 5/18/2009) (replaces FI #00010)
10201 = Georgia (eff. 8/3/2009) (replaces FI #00101)
10301 = Tennessee (eff. 8/3/2009) (replaces FI #00390)

JURISDICTION 11 - PART A MACs

11004 = Region C (eff. 1/24/2011) (replaces FI #00380)
11201 = South Carolina (eff. 1/24/2011) (replaces FI #00380)
11301 = Virginia (eff. 5/16/2011) (replaces FI #00453)
11401 = West Virginia (eff. 5/16/2011) (replaces FI #00453)
11501 = North Carolina (eff. 9/30/2010) (replaces FI #00390)

JURISDICTION 12 - PART A MACs

12001 = New Jersey (eff. 9/1/2008) (replaces FI # 00390)
12101 = Delaware (eff. 11/14/2008) (replaces FI # 00308)

FI_NUM (In Outpat.,HHA,Hosp) (FI_NUM_TB)

Fiscal Intermediary Number Table

JURISDICTION 13 - PART A MACs

13101 = Connecticut (eff. 11/4/2008) (replaces FI #00308)
13201 = New York (eff. 11/4/2008) (replaces FI #00308)

JURISDICTION 14 - PART A MACs

14004 = Region A (eff.5/15/2009) (replaces FI #00180)
14101 = Maine (eff. 5/15/2009) (replaces FI #00180)
14201 = Massachusetts (eff. 5/15/2009) (replaces FI #00181)
14401 = Rhode Island (eff. 6/1/2009) (replaces FI #00370)
14301 = New Hampshire (eff. 6/5/2009) (replaces FI #00270)
14501 = Vermont (eff. 6/5/2009) (replaces FI #00270)

JURISDICTION 15 - PART A MACs

15101 = Kentucky (eff.4/30/2011) (replaces FI #00160)

FAC_TYPE (CLM_FAC_TYPE_TB)

Claim Facility Type Table

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 (discontinued effective 10/1/05)
6 = Intermediate care
7 = Clinic or hospital-based renal dialysis facility
8 = Special facility or ASC surgery
9 = Reserved

FREQ_CD (CLM_FREQ_TB)

Claim Frequency Table

0 = Non-payment/zero claims
1 = Admit thru discharge claim
2 = Interim - first claim
3 = Interim - continuing claim (not valid for PPS claims)
4 = Interim - last claim (not valid for PPS claims)
5 = Late charge(s) only claim

FREQ_CD (CLM_FREQ_TB)	Claim Frequency Table
	6 = Reserved for national assignment; Adjustment of prior claim. Obsolete 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) A = Admission election notice - used when hospice or Religious Nonmedical Health Care Institution is submitting the HCFA- 1450 as an admission notice - hospice NOE only NOTE: This value is not present in the NCH claims data because when they are used the transaction does not represent a claim. This frequency code is used on hospice notices of election. Their purpose is to create a hospice benefit period in CWF. No paymentor utilization is reported on them. B = Hospice/Medicare Coordinated Care Demonstration/RNCHI - Termination/Revocation Notice - hospice NOE only (eff 9/93) NOTE: This value is not present in the NCH claims data because when they are used the transaction does not represent a claim. This frequency code is used on hospice notices of election. Their purpose is to create a hospice benefit period in CWF. No paymentor utilization is reported on them. C = Hospice change of provider notice - hospice NOE only (eff 9/93) NOTE: This value is not present in the NCH claims data because when they are used the transaction does not represent a claim. This frequency code is used on hospice notices of election. Their purpose is to create a hospice benefit period in CWF. No paymentor utilization D = Hospice/Medicare Coordinated Care Demonstration/RNHCI RNHCI - void/cancel - hospice NOE only (eff 9/93) NOTE: This value is not present in the NCH claims data because when they are used the transaction does not represent a claim. This frequency code is used on hospice notices of election. Their purpose is to create a hospice benefit period in CWF. No paymentor utilization E = Hospice change of ownership - hospice NOE only (eff 1/97) NOTE: This value is not present in the NCH claims claims data because when they are used the transaction does not represent a claim. This frequency code is used on hospice notices of election. Their purpose is to create a hospice benefit period in CWF. No paymentor utilization F = Beneficiary initiated adjustment claim (eff 10/93) G = CWF initiated adjustment claim (eff 10/93)

FREQ_CD (CLM_FREQ_TB)	Claim Frequency Table H = CMS initiated adjustment claim (eff 10/93) I = Intermediary adjustment claim (other than PRO or provider) - used to identify a debit adjustment initiated by CMS or an intermediary (other than QIO or Provider) - 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 initiated adjustment (eff 10/93) N = Reserved for national assignment O = Nonpayment/Zero claims P = Adjustment required by Quality Improvement Organization (QIO) -- formerly Peer Review Organization (PRO) Q = Claim Submitted for Reconsideration Outside of Timely Limits X = Replacement of Prior Abbreviated Encounter Submission (used by Medicare Advantage contractor or other plan required to submit encounter data); Special adjustment processing - used for QA editing (eff 8/92) Obsolete Z = New Abbreviated Encounter Submission (TOB '11Z') used for MCO enrollee hospital discharges 7/1/97 - 12/31/98; not stored in the NCH. Exception: Problem in startup months may have resulted in this abbreviated UB-92 being erroneously stored in the NCH.
HCPCS (CLM_HIPPS_TB)	Claim SNF & HHA Health Insurance PPS Table Please refer to the CMS website for the latest information on the HIPPS Codes. The URL is http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html (paste into browser address bar without any spaces)
LUPAIND (CLM_HHA_LUPA_IND_TB)	Claim HHA Low Utilization Payment Adjustment (LUPA) Indicator Code Table L = LUPA claim BLANK = Not a LUPA claim
HHA_RFRL (CLM_HHA_RFRL_TB)	Claim Home Health Referral Table 1 = Physician referral - The patient was admitted upon the recommendation of a personal physician.

HHA_RFRL (CLM_HHA_RFRL_TB)	Claim Home Health Referral Table
	2 = Clinic referral - The patient was admitted upon the recommendation of this facility's clinic physician. 3 = HMO referral - The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician. 4 = Transfer from hospital - The patient was admitted as an inpatient transfer from an acute care facility. 5 = Transfer from a skilled nursing facility (SNF) - The patient was admitted as an inpatient transfer from a SNF. 6 = Transfer from another health care facility - The patient was admitted as a transfer from a health care facility other than an acute care facility or SNF. 7 = Emergency room - The patient was admitted upon the recommendation of this facility's emergency room physcian. 8 = Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative. 9 = Information not available - The means by which the patient was admitted is not known. A = Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital. B = Transfer from another HHA - Beneficiaries are permitted to transfer from one HHA to another unrelated HHA under HH PPS. (eff. 10/00) C = Readmission to same HHA - If a beneficiary is discharged from an HHA and then re-admitted within the original 60-day episode, the original episode must be closed early and a new one created. NOTE: the use of this code will permit the agency to send a new RAP allowing all claims to be accepted by Medicare. (eff. 10/00)
ADMTYPE (CLM_IP_ADMSN_TYPE_TB)	Claim Inpatient Admission Type Table
	0 = Blank 1 = Emergency - The patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room. 2 = Urgent - The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.

ADMTYPE (CLM_IP_ADMSN_TYPE_TB)	Claim Inpatient Admission Type Table
	3 = Elective - The patient's condition permitted adequate time to schedule the availability of suitable accommodations. 4 = Newborn - Necessitates the use of special source of admission codes. 5 = Trauma Center - visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation. 6 THRU 8 = Reserved 9 = Unknown - Information not available.
NOPAY_CD (CLM_MDCR_NPMT_RSN_TB)	Claim Medicare Non-Payment Reason Table
	Valid Values effective 1/2011 (2-byte values are replacing the character values) 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/HCFA 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)

NOPAY_CD (CLM_MDCR_NPMT_RSN_TB)	Claim Medicare Non-Payment Reason Table

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)

00 = MSP cost avoided - COB Contractor

12 = MSP cost avoided - BCBS Voluntary Agreements

13 = MSP cost avoided - Office of Personnel Management

14 = MSP cost avoided - Workman's Compensation (WC) Datamatch

15 = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006)

16 = MSP cost avoided - Liability Insurer VDSA (eff. 4/2006)

17 = MSP cost avoided - No-Fault Insurer VDSA (eff. 4/2006)

18 = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement (eff. 4/2006)

21 = MSP cost avoided - MIR Group Heqalth Plan (eff. 1/2009)

22 = MSP cost avoided - MIR non-Group Health Plan (eff. 1/2009)

25 = MSP cost avoided - Recovery Audit Contractor - California (eff. 10/2005)

26 = MSP cost avoided - Recovery Audit Contractor - Florida (eff. 10/2005)

Prior to 1/2011, the character values below were used to represent the 2-byte values
NOTE: Effective 4/1/02, the Medicare nonpayment reason code was expanded to a 2-byte field. The NCH instituted a crosswalk from the 2-byte code to a 1-byte character code. Below are the character codes (found in NCH & NMUD). At some point, NMUD will carry the 2-byte code but NCH will continue to have the 1-byte character code.

! = MSP cost avoided - COB Contractor ('00' 2-byte code)

@ = MSP cost avoided - BC/BS Voluntary Agreements ('12' 2-byte code)

= MSP cost avoided - Office of Personnel Management ('13' 2-byte code)

$ = MSP cost avoided - Workman's Compensation (WC) Datamatch ('14' 2-byte code)

* = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) ('15' 2-byte code) (eff. 4/2006)

(= MSP cost avoided - Liability Insurer VDSA ('16' 2-byte code) (eff. 4/2006)

NOPAY_CD (CLM_MDCR_NPMT_RSN_TB)	Claim Medicare Non-Payment Reason Table
	) = MSP cost avoided - No-Fault Insurer VDSA ('17' 2-byte code) (eff. 4/2006) + = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement ('18' 2-byte code) (eff. 4/2006) < = MSP cost avoided - MIR Group Health Plan ('21' 2-byte code) (eff. 1/2009) > = MSP cost avoided - MIR non-Group Health Plan ('22' 2-byte code) (eff. 1/2009) % = MSP cost avoided - Recovery Audit Contractor - California ('25' 2-byte code) (eff. 10/2005) & = MSP cost avoided - Recovery Audit Contractor - Florida ('26' 2-byte code) (eff. 10/2005)
OPSRVTYP (CLM_OP_SRVC_TYPE_TB)	Claim Outpatient Service Type Table
	0 = Blank 1 = Emergency - The patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room. 2 = Urgent - The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation. 3 = Elective - The patient's condition permitted adequate time to schedule the availability of suitable accommodations. 5 THRU 8 = Reserved. 9 = Unknown - Information not available.
TRANS_CD (CLM_OP_TRANS_TYPE_TB)	Claim Outpatient Transaction Type Table
	A = Outpatient Psychiatric Hospital B = Outpatient TB Hospital C = Outpatient General Care Hospital D = Outpatient SNF E = Home Health Agency F = Comprehensive Health Care G = Clinical Rehab Agency H = Rural Health Clinic I = Satellite Dialysis Facility

TRANS_CD (CLM_OP_TRANS_TYPE_TB)	Claim Outpatient Transaction Type Table
	J = Limited Care Facility 0 = Christian Science SNF 1 = Psychiatric Hospital Facility 2 = TB Hospital Facility 3 = General Care Hospital 4 = Regulary SNF Spaces = Home Health/Hospice
POADIND (CLM_POA_IND_TB)	Claim Present on Admission (POA) Indicator
	Y = Diagnosis was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as 'Y' for the POA Indicator. N = Diagnosis was not present at the time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as 'N' for the POA Indicator. U = Documentation is insufficient to determine if the Condition was present at the time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as 'U' for the POA Indicator. NOTE: From 4/15/10 to 12/31/10, the MQR process assigned a 'U' to those POAs that came in blank. They did this because of the POA/DGNS issue. W = Clinically undetermined. Provider is unable to clinically determine whether condition was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as 'W' for the POA Indicator. NOTE: Inpatient claims received with a POA exempt ICD-9 code effective 10/1/11 are currently being returned to provider requesting a valid POA indicator. CMS has created a workaround to resolve this issue by adding a POA indicator 'W' to the affected ICD-9 code instead of leaving it blank. 1 = Unreported/not used - diagnosis codes exempt from POA reporting -- This code is equivalent to a blank on the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as '1' for the POA Indicator. The '1' POA Indicator should not be applied to any codes on the HAC list. Obsolete eff. 1/3/11 0 = This value was created by the NCH front-end system to replace a blank received in the POA field. Z = Denotes the end of the POA indicators (obsolete 1/2011).

POADIND (CLM_POA_IND_TB)	Claim Present on Admission (POA) Indicator X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future (obsolete 1/2011). Blank = identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the '1'). NOTE: NCH/NMUD will carry a '0' in place of a blank.
PPS_IND (CLM_PPS_IND_TB)	Claim PPS Indicator Table ***Effective NCH weekly process date 10/3/97 - 5/29/98*** 0 = not PPS bill (claim contains no PPS indicator) 2 = PPS bill (claim contains PPS indicator) ***Effective NCH weekly process date 6/5/98*** 0 = not applicable (claim contains neither PPS nor deemed insured MQGE status indicators) 1 = Deemed insured MQGE (claim contains deemed insured MQGE indicator but not PPS indicator) 2 = PPS bill (claim contains PPS indicator but no deemed insured MQGE status indicator) 3 = Both PPS and deemed insured MQGE (contains both PPS and deemed insured MQGE indicators)
PRCRRTRN (CLM_PRCR_RTRN_TB)	Claim Pricer Return Code Table *******Home Health Pricer Return Codes********** *****TOB 32X or 33X, DOS 10/1/2000 and after****** Home Health Payment Return Codes: 00 = Final payment where no outlier applies 01 = Final payment where outlier applies 03 = Initial percentage payment, 0% 04 = Initial percentage payment, 50% 05 = Initial percentage payment, 60% 06 = LUPA payment only 07 = Final payment, SCIC 08 = Final payment, SCIC with outlier 09 = Final payment, PEP 11 = Final payment, PEP with outlier

PRCRRTRN (CLM_PRCR_RTRN_TB)	Claim Pricer Return Code Table

12 = Final payment, SCIC within PEP
13 = FInal payment, SCIS within PEP with outlier

Home Health Error Return Codes:
10 = Invalid TOB
15 = Invalid PEP Days
16 = Invalid HRG Days, >60
20 = PEP indicator invalid
25 = Med review indicator invalid
30 = Invalid MSA code
35 = Invalid Initial Payment Indicator
40 = Dates < October 1, 2000 or invalid
70 = Invalid HRG Code
75 = No HRG present in 1st occurrence
80 = Invalid Revenue code
85 = No revenue code present on HH final claim/adjustment

*********Hospice Pricer Return Codes**********

**********TOB 81X or 82X**********

Hospice Payment Return Codes:
00 = Home rate returned

Hospice Error Return Codes:
10 = Bad units
20 = Bad units2 < 8
30 = Bad MSA code
40 = Bad hospice wage index from MSA file
50 = Bad bene wage index from MSA file
51 = Bad provider number

**********SNF Pricer Return Codes*********
**********TOB 21X**********

SNF Payment return codes:
00 = RUG III group rate returned

SNF Error return codes:
20 = Bad RUG code
30 = Bad MSA code
40 = Thru date < July 1, 1998 or invalid
50 = Invalid Federal blend for that year

PRCRRTRN (CLM_PRCR_RTRN_TB)	Claim Pricer Return Code Table

60 = Invalid Federal blend
61 = Federal blend = 0 and SNF thru date < January 1, 2000

****Inpatient Hospital Pricer Return Codes******
**********TOB 11X**********

Inpatient Hospital Payment return codes:
00 = Paid normal DRG payment
01 = Paid as a day outlier (Note: day outlier no longer being paid as of 10/1/97)
02 = Paid as a cost outlier
03 = Transfer paid on a per diem basis up to and including the ful DRG
05 = Transfer paid on a per diem basis up to and including the full DRG which also qualified for a cost outlier payment
06 = Provider refused cost outlier
10 = DRG is 209, 210, or 211 and post-acute transfer
12 = Post-acute transfer with specific DRGs. The following DRG's: 14, 113, 236, 263, 264, 429, 483
14 = Paid normal DRG payment with per diem days = or > GM ALOS
16 = Paid as a cost outlier with per diem days = or > GM ALOS
Inpatient Hospital Error return codes:
51 = No provider specific information found
52 = Invalid MSA# in provider file
53 = Waiver state - not calculated by PPS
54 = DRG < 001 or > 511, or = 214, 215, 221, 222, 438, 456, 457, 458
55 = Discharge date < provider effective start date or discharge date < MSA effective start date for PPS
56 = Invalid length of stay
57 = Review code invalid (Not 00, 03, 06, 07, 09)
58 = Total charges not numeric
61 = Lifetime reserve days not numeric or BILL-LTR-DAYS > 60
62 = Invalid number of covere days
65 = PAY-CODE not = A, B or C on provider specific file for capital
67 = Cost outlier with LOS > covered days

**********Outpatient PPS Pricer Return Codes******

Outpatient PPS Payment return codes:
01 = Line processed to payment

PRCRRTRN
(CLM_PRCR_RTRN_TB)

Claim Pricer Return Code Table

20 = Line processed but payment = 0 bene deductible = > adjusted payment

Outpatient PPS Error return codes:

30 = Missing, deleted or invalid APC

38 = Missing or invalid discount factor

40 = Invalid service indicator passed by the OCE

41 = Service indicator invalid for OPPS PRICER

42 = APC = '00000' or (packaging flag = 1 or 2)

43 = Payment indicator not = to 1 or 5 thru 9

44 = Service indicator = 'H' but payment indicator not = to 6

45 = Packaging flag not = to 0

46 = Line item denial/reject flag not = to 0 or line item denial/reject flag = to 1 and (APC not = 0033 or 0034 or 0322 or 0323 or 0324 or 0325 or 0373 or 0374)) or line item action flag not = to 1

47 = Line item action flag = 2 or 3

48 = Payment adjustment flag not valid

49 = Site of service flag not = to 0 or (APC 0033 is not on the claim and service indicator = 'P' or APC = 0322, 0325, 0373, 0374)

50 = Wage index not located

51 = Wage index equals zero

52 = Provider specific file wage index reclassification code invalid or missing

53 = Service from date not numeric or < 20000801

54 = Service from date < provider effective date or service from date > provider termination date

Inpatient Rehab Facility (IRF) Pricer Return Codes

IRF Payment return codes:

00 = Paid normal CMG payment without outlier

01 = Paid normal CMG payment with outlier

02 = Transfer paid on a per diem basis without outlier

03 = Transfer paid on a per diem basis with outlier

04 = Blended CMG payment -- 2/3 Federal PPS rate + 1/3 provider specific rate -- without outlier

05 = Blended CMG payment -- 2/3 Federal PPS rate + 1/3 provider specific rate -- with outlier

06 = Blended transfer payment -- 2/3 Federal PPS transfer rate + 1/3 provider specific rate - without outlier

07 = Blended transfer payment -- 2/3 Federal PPS transfer rate + 1/3 provider specific rate -- with outlier

PRCRRTRN (CLM_PRCR_RTRN_TB)	Claim Pricer Return Code Table

10 = Paid normal CMG payment with penalty without outlier
11 = Paid normal CMG payment with penalty with outlier
12 = Transfer paid on a per diem basis with penalty without outlier
13 = Transfer paid on a per diem basis with penalty with outlier
14 = Blended CMG payment -- 2/3 Federal PPS rate + 1/3 provider specific rate -- with penalty without outlier
15 = Blended CMG payment -- 2/3 Federal PPS rate + 1/3 provider specific rate -- with penalty with outlier
16 = Blended transfer payment -- 2/3 Federal PPS transfer rate + 1/3 provider specific rate -- with penalty without outlier
17 = Blended transfer payment -- 2/3 Federal PPS transfer rate + 1/3 provider specific rate -- with penalty with outlier

IRF Error return codes:
50 = Provider specific rate not numeric
51 = Provider record terminated
52 = Invalid wage index
53 = Waiver state - not calculated by PPS
54 = CMG on claim not found in table
55 = Discharge date < provider effective start date or discharge date < MSA effective start date for PPS
56 = Invalid length of stay
57 = Provider specific rate zero when blended payment requested
58 = Total covered charges not numeric
59 = Provider specific record not found
60 = MSA wage index record not found
61 = Lifetime reserve days not numeric or BILL-LTR-DAYS > 60
62 = Invalid number of covered days
65 = Operating cost-to-charge ratio not numeric
67 = Cost outlier with LOS > covered days or cost outlier threshold calculation
72 = Invalid blend indicator (not 3 or 4)
73 = Discharged before provider FY begin date
74 = Provider FY begin date not in 2002

Long Term Care Hospital (LTCH) Pricer Return Codes

LTCH Payment return codes:
00 = Normal DRG payment without outlier
01 = Normal DRG payment with outlier
02 = Short stay payment without outlier

PRCRRTRN (CLM_PRCR_RTRN_TB)	Claim Pricer Return Code Table

03 = Short stay payment with outlier

04 = Blend year 1 - 80% facility rate plus 20% normal DRG payment without outlier

05 = Blend year 1 - 80% facility rate plus 20% normal DRG payment with outlier

06 = Blend year 1 - 80% facility rate plus 20% short stay payment without outlier

07 = Blend year 1 - 80% facility rate plus 20% short stay payment with outlier

08 = Blend year 2 - 60% facility rate plus 40% normal DRG payment without outlier

09 = Blend year 2 - 60% facility rate plus 40% normal DRG payment with outlier

10 = Blend year 2 - 60% facility rate plus 40% short stay payment without outlier

11 = Blend year 2 - 60% facility rate plus 40% short stay payment with outlier

12 = Blend year 3 - 40% facility rate plus 60% normal DRG payment without outlier

13 = Blend year 3 - 40% facility rate plus 60% normal DRG payment with outlier

14 = Blend year 3 - 40% facility rate plus 60% short stay payment without outlier

15 = Blend year 3 - 40% facility rate plus 60% short stay payment with outlier

16 = Blend year 4 - 20% facility rate plus 80% normal DRG payment without outlier

17 = Blend year 4 - 20% facility rate plus 80% normal DRG payment with outlier

18 = Blend year 4 - 20% facility rate plus 80% short stay payment without outlier

19 = Blend year 4 - 20% facility rate plus 80% short stay payment with outlier

LTCH Error return codes:

50 = Provider specific rate not numeric

51 = Provider record terminated

52 = Invalid wage index

53 = Waiver state - not calculated by PPS

54 = DRG on claim not found in table

55 = Discharge date < provider effective start date or discharge date < MSA effective start date for PPS

56 = Invalid length of stay

57 = Provider specific rate zero when blended payment

PRCRRTRN (CLM_PRCR_RTRN_TB)	Claim Pricer Return Code Table
	requested 58 = Total covered charges not numeric 59 = Provider specific record not found 60 = MSA wage index record not found 61 = Lifetime reserve days not numeric or BILL-LTR-DAYS > 60 62 = Invalid number of covered days 65 = Operating cost-to-charge ratio not numeric 67 = Cost outlier with LOS > covered days or cost outlier threshold calculation 72 = Invalid blend indicator (not 1 thru 5) 73 = Discharged before provider FY begin date 74 = Provider FY begin date not in 2002 ***End Stage Renal Disease (ESRD) Pricer Return Codes*** ESRD Payment return codes: 00 = ESRD PPS payment calculated 01 = ESRD facility rate > zero ESRD Error return codes: 50 = ESRD facility rate not numeric 52 = Provider type not = '40' or '41' 53 = Special payment indicator not = '1' or blank 54 = Date of birth not numeric or = zero 55 = Patient weight not numeric or = zero 56 = Patient height not numeric or = zero 57 = Revenue center code not in range 58 = Condition code not = '73' or '74' or blank 60 = MSA wage adjusted rate record not found 98 = Claim through date before 4/1/2005 or not numeric
RLT_COND	Claim Related Condition Table 01 = Military service related - Medical condition incurred during military service. 02 = Employment related - Patient alleged that the medical condition causing this episode of care was due to environment/events resulting from employment. 03 = Patient covered by insurance not reflected here - Indicates that patient or patient representative has stated that coverage may exist beyond that reflected on this bill. 04 = Information Only Bill - Health Maintenance Organization (HMO) enrollee - Medicare beneficiary is enrolled in an HMO. Eff 9/93, hospital must also expect to receive payment from HMO.

RLT_COND	Claim Related Condition Table 05 = Lien has been filed - Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient. 06 = ESRD patient in 1st 30 months of entitlement covered by employer group health insurance - indicates Medicare may be secondary insurer. Eff 3/1/96, ESRD patient in 1st 30 months of entitlement covered by employer group health insurance. 07 = Treatment of nonterminal condition for hospice patient - The patient is a hospice enrollee, but the provider is not treating a terminal condition and is requesting Medicare reimbursement. 08 = Beneficiary would not provide information concerning other insurance coverage. 09 = Neither patient nor spouse is employed - Code indicates that in response to development questions, the patient and spouse have denied employment. 10 = Patient and/or spouse is employed but no EGHP coverage exists or (eff 9/93) other employer sponsored/provided health insurance covering patient. 11 = The disabled beneficiary and/or family member has no group coverage from a LGHP or (eff 9/93) other employer sponsored/provided health insurance covering patient. 12 = Payer code - Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them. 13 = Payer code - Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them. 14 = Payer code - Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them. 15 = Payer code - reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them. Prior to 3/07, clean claim (eff 10/92) OBSOLETE 16 = Payer code - reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them. Prior to 3/07. SNF transition exemption - An exemption from the post-hospital requirement applies for this SNF stay for the qualifying stay dates are more than 30 days prior to the admission date. OBSOLETE 17 = Patient is homeless (eff. 3/07). Prior to 3/07, code indicated Patient is over 100 years old - patient was over 100 years old at the date of admission. 18 = Maiden name retained - A dependent spouse entitled to benefits who does not use her husband's last name. 19 = Child retains mother's name - A patient who is a dependent child entitled to CHAMPVA benefits that does not have father's last name.

RLT_COND	Claim Related Condition Table 20 = Bene requested billing - Provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the bene has requested formal determination 21 = Billing for denial notice - The SNF or HHA realizes services are at a noncovered level of care or excluded, but requests a Medicare denial in order to bill medicaid or other insurer 22 = Patient on multiple drug regimen - A patient who is receiving Multiple intravenous drugs while on home IV therapy 23 = Homecaregiver available - The patient has a caregiver available to assist him or her during self-administration of an intravenous drug 24 = Home IV patient also receiving HHA services - the patient is under care of HHA while receiving home IV drug therapy services 25 = Patient is Non-U.S. resident 26 = VA eligible patient chooses to receive services in Medicare Certified facility rather than a VA facility (eff 3/92) 27 = Patient referred to a sole community hospital for a diagnostic laboratory test - (sole community hospital only). (eff 9/93) 28 = Patient and/or spouse's EGHP is secondary to Medicare - Qualifying EGHP for employers who have fewer than 20 employees. (eff 9/93) 29 = Disabled beneficiary and/or family member's LGHP is secondary to Medicare - Qualifying LGHP for employer having fewer than 100 full and part-time employees 30 = Qualifying Clinical Trials - Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial. 31 = Patient is student (full time - day) - Patient declares that he or she is enrolled as a full time day student. 32 = Patient is student (cooperative/work study program) 33 = Patient is student (full time - night) - Patient declares that he or she is enrolled as a full time night student. 34 = Patient is student (part time) - Patient declares that he or she is enrolled as a part time student. 36 = General care patient in a special unit - Patient is temporarily placed in special care unit bed because no general care beds were available. 37 = Ward accommodation is patient's request - Patient is assigned to ward accommodations at patient's request. 38 = Semi-private room not available - Indicates that either private or ward accommodations were assigned because semi-private accomodations were not available. 39 = Private room medically necessary - Patient needed a private room for medical reasons.

RLT_COND	Claim Related Condition Table 40 = Same day transfer - Patient transferred to another facility before midnight of the day of admission. 41 = Partial hospitalization - Eff 3/92, indicates claim is for partial hospitalization services. For OP services, this includes a variety of psych programs. 42 = Continuing Care Not Related to Inpatient Admission - continuing care not related to the condition or diagnosis for which the beneficiary received inpatient hospital services. (eff. 10/01) 43 = Continuing Care Not Provided Within Prescribed Postdischarge Window - continuing care was related to the inpatient admission but the prescribed care was not provided within the post-discharge window.(eff. 10/01) 44 = Inpatient Admission Changed to Outpatient - For use on outpatient claims only, when the physician ordered inpatient services, but upon internal review performed before the claim claim was initially submitted, the hospital determined the services did not meet its inpatient criteria. (eff. 4/1/04) 45 = Ambiguous Gender Category - claim indicates patient has ambiguous gender characteristics (e.g. transgendered or hermaphordite). 46 = Nonavailability statement on file for CHAMPUS claim for nonemergency IP care for CHAMPUS bene residing within the catchment area (usually a 40 mile radius) of a uniform services hospital. 47 = Transfer from another Home Health Agency. (eff. 7/1/10) 48 = Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs) 49 = Product Replacement within Product Lifecycle- replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly (eff. 4/2006) 50 = Product Replacement for Known Recall of a Product - Manufacturer or FDA has identified the product for recall and therefore replacement. (eff. 4/2006) 51 = Reserved for national assignment. 52 = Used to indicate a discharge due to the patient's unavailability/inability to receive hospice services from the hospice which has been responsible for the patient. (effective 7/2/12 - CR7677) 53 = Reserved for national assignment. 54 = Reserved for national assignment. 55 = SNF bed not available - The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.

RLT_COND	Claim Related Condition Table 56 = Medical appropriateness - Patient's SNF admission was delayed more than 30 days after hospital discharge because physical condition made it inappropriate to begin active care within that period 57 = SNF readmission - Patient previously received Medicare covered SNF care within 30 days of the current SNF admission. 58 = Payment of SNF claims for beneficiaries disenrolling from terminating M+C plans who have not met the 3-day hospital stay requirement (eff. 10/1/00) 59 = Non-primary ESRD facility - code indicates that ESRD that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other then his/her primary ESRD dialysis facility. 60 = Operating cost day outlier - A hospital is being paid under a prospective payment system (PPS) is reporting this stay as a day outlier. 61 = Operating cost outlier - A hospital is being paid under a prospective payment system (PPS) is requesting additional payment for this stay as a cost outlier. 62 = Payer Code - providers do not report this code. PIP bill - This bill is a periodic interim payment bill. Obsolete 63 = Payer Code - providers do not report this code. PRO denial received before batch clearance report - The HCSSACL receipt date is used on PRO adjustment if the PRO's notification is before orig bill's acceptance report. (Payer only code eff 9/93) 64 = Payer Code - providers do not report this code. Other than clean claim - the claim is not a 'clean claim'. Obsolete 65 = Payer Code - Providers do not report this code. Non-PPS code - The bill is not a prospective payment system bill. Obsolete 66 = Outlier not claimed - Bill may meet the criteria for cost outlier, but the hospital did not claim the cost outlier (PPS) 67 = Beneficiary elects not to use LTR days 68 = Beneficiary elects to use LTR days 69 = IME/DGME/N&AH Payment Only - providers request for supplemental IME/DGME/N&AH payment for each discharge of MCO enrollee, beginning 1/1/98, from teaching hospitals (facilities with approved medical residency training program); not stored in NCH. Exception: problem in startup year may have resulted in this special IME payment request being erroneously stored in NCH. If present, disregard claim as condition code '69' is not valid NCH claim. 70 = Self-administered EPO - Billing is for a home dialysis patient who self administers EPO. 71 = Full care in unit - Billing is for a patient who received staff assisted dialysis services in a hospital or renal dialysis facility.

RLT_COND	Claim Related Condition Table 72 = Self care in unit - Billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility. 73 = Self care training - Billing is for special dialysis services where the patient and helper (if necessary) were learning learning to perform dialysis. 74 = Home - Billing is for a patient who received dialysis services at home. 75 = Home 100% reimbursement - (not to be used for services after 4/15/90) The billing is for home dialysis patient using a dialysis machine that was purchased under the 100% program. 76 = Back-up facility - Billing is for a patient who received dialysis services in a back-up facility. 77 = Provider accepts or is obligated/required due to contractual agreement or law to accept payment by a primary payer as payment in full - Medicare pays nothing. 78 = New coverage not implemented by HMO - eff 3/92, indicates newly covered service under Medicare for which HMO does not pay. 79 = CORF services provided off site - Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site. 80 = Home Dialysis - Nursing Facility - Home dialysis furnished in a SNF or nursing facility. (eff. 4/4/05) 81 - 99 = Reserved for state assignment. A0 = TRICARE External Partnership Program - This code identifies TRICARE claims submitted under the External Partnership Program. A0 = Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (eff. 9/01) Obsolete A0 = CHAMPUS external partnership program special program indicator code. (eff 10/93) (obsolete) A1 = EPSDT/CHAP - Early and periodic screening diagnosis and treatment special program indicator code. (eff 10/93) A2 = Physically handicapped children's program - Services provided receive special funding through Title 8 of the Social Security Act or the CHAMPUS program for the handicapped. (eff 10/93) A3 = Special federal funding - Designed for uniform use by state uniform billing committees. Special program indicator code (eff 10/93) A4 = Family planning - Designed for uniform use by state uniform billing committees. Special program indicator code (eff 10/93) A5 = Disability - Designed for uniform use by state uniform billing committees. Special program indicator code (eff 10/93)

RLT_COND	Claim Related Condition Table
	A6 = PPV/Medicare 100% Payment - Identifies that pneumococcal pneumonia 100% payment vaccine (PPV) services should be reimbursed under a special Medicare program provision. Special program indicator code (eff 10/93)
	A7 = Induced abortion to avoid danger to woman's life. Special program indicator code (eff 10/93)
	A8 = Induced abortion - Victim of rape/incest. Special program indicator code (eff 10/93)
	A9 = Second opinion surgery - Services requested to support second Opinion on surgery. Part B deductible and coinsurance do not apply. Special program indicator code (eff 10/93)
	AA = Abortion Performed due to Rape (eff. 10/1/02)
	AB = Abortion Performed due to Incest (eff. 10/1/02)
	AC = Abortion Performed due to Serious Fetal Genetic Defect, Deformity or Abnormality (eff. 10/1/02)
	AD = Abortion Performed due to a Life Endangering Physical Condition Caused by, arising from or exacerbated by the Pregnancy itself (eff. 10/1/02)
	AE = Abortion Performed due to physical health of mother that is not life endangering (eff. 10/1/02)
	AF = Abortion Performed due to emotional/psychological health of mother (eff. 10/1/02)
	AG = Abortion performed due to social economic reasons (eff. 10/1/02)
	AH = Elective Abortion (eff. 10/1/02)
	AI = Sterilization (eff. 10/1/02)
	AJ = Payer Responsible for copayment (4/1/03)
	AK = Air Ambulance Required - For ambulance claims. Time needed to transport poses a threat. (eff. 10/16/03)
	AL = Specialized Treatment/bed Unavailable - For ambulance claims. Specialized treatment bed unavailable. Transported to alternate facility. (eff. 10/16/03)
	AM = Non-emergency Medically Necessary Stretcher Transport Required - For ambulance claims. Non-emergency medically necessary stretcher transport required. (eff. 10/16/03)
	AN = Preadmission Screening Not Required - person meets the criteria for an exemption from preadmission screening. (eff. 1/1/04)
	B0 = Medicare Coordinated Care Demonstration Program - patient is a participant in a Medicare Coordinated Care Demonstration (eff. 10/01)
	B1 = Beneficiary ineligible for demonstration program (eff. 10/01).
	B2 = Critical Access Hospital Ambulance Attestation - Attestation by CAH that it meets the criteria for exemption from the Ambulance Fee Schedule

RLT_COND

Claim Related Condition Table

B3 = Pregnancy Indicator - Indicates the patient is pregnant. Required when mandated by law. (eff. 10/16/03)

B4 = Admission Unrelated to Discharge - Admission unrelated to discharge on same day. This code is for discharges starting on January 1, 2004.
B5 = Special program indicator. Reserved for national assignment.
B6 = Special program indicator. Reserved for national assignment.
B7 = Special program indicator. Reserved for national assignment.
B8 = Special program indicator. Reserved for national assignment.
B9 = Special program indicator. Reserved for national assignment.

BP = Gulf Oil Spill of 2010 - The code identifies claims where the provision of all services on the claim are related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico and/or circumstances related to such spill, including but not limited to subsequent clean-up activites.

C0 = Reserved for national assignment.
C1 = Approved as billed - The services provided for this billing period have been reviewed by the QIO/UR or intermediary and are fully approved including any day or cost outlier. (eff 10/93) NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).

C2 = Automatic approval as billed based on focused review. (No longer used for Medicare) QIO approval indicator services (eff 10/93) NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
C3 = Partial approval - The services provided for this billing period have been reviewed by the QIO/UR or intermediary and some portion has been denied (days or services). (eff 10/93) NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).

C4 = Admission/services denied - Indicates that all of the services were denied by the QIO/UR. QIO approval indicator services (eff 10/93) NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).

RLT_COND	Claim Related Condition Table C5 = Postpayment review applicable - QIO/UR review to take place after payment. QIO approval indicator services (eff 10/93) NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X). C6 = Admission preauthorization - The QIO/UR authorized this admission/service but has not reviewed the services provided. QIO approval indicator services (eff 10/93) NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X). C7 = Extended authorization - the QIO has authorized these services for an extended length of time but has not reviewed the services provided. QIO approval indicator services (eff 10/93) NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X). C8 = Reserved for national assignment. QIO approval indicator services (eff 10/93) C9 = Reserved for national assignment. QIO approval indicator services (eff 10/93) D0 = Changes to service dates. Change condition (eff 10/93) D1 = Changes in charges. Change condition (eff 10/93) D2 = Changes in revenue codes/HCPCS/HIPPS Rate Code Change condition (eff 10/93) D3 = Second or subsequent interim PPS bill. Change condition (eff 10/93) D4 = Change in ICD-9-CM diagnosis and/or procedure code Change condition (eff 10/93) D5 = Cancel only to correct a beneficiary claim account number or provider identification number. Change condition (eff 10/93) D6 = Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an OP bill containing services required to be included on the IP bill). Change condition eff 10/93. D7 = Change to make Medicare the secondary payer. Change condition (eff 10/93) D8 = Change to make Medicare the primary payer. Change condition (eff 10/93) D9 = Any other change. Change condition (eff 10/93) DR = Disaster Relief (eff. 10/2005) - Code used to facilitate claims processing and track services and items provided to victims of Hurricane Katrina and any future disasters. E0 = Change in patient status. Change condition (eff 10/93) EY = National Emphysema Treatment Trial (NETT) or Lung Volume Reduction Surgery (LVRS) clinical study (eff. 11/97) Obsolete

RLT_COND	Claim Related Condition Table
	G0 = Multiple medical visits occur on the same day in the same revenue center but visits are distinct and constitute independent visits (allows for payment under outpatient PPS -- eff. 7/3/00).
	H0 = Delayed Filing, Statement of Intent Submitted -- statement of intent was submitted within the qualifying period to specifically identify the existence of another third party liability situation. (eff. 9/01)
	H2 = Discharge by a Hospice Provider for Cause (eff. 1/1/09).
	M0 = Reserved for national assignment.
	M0 = All inclusive rate for outpatient services. (payer only code). Obsolete
	M1 = Reserved for national assignment.
	M1 = Roster billed influenza virus vaccine. (payer only code) Eff 10/96, also includes pneumococcal pneumonia vaccine (PPV) Obsolete
	M2 = Reserved for national assignment.
	M2 = HH override code - home health total reimbursement exceeds the $150,000 cap or the number of total visits exceeds the 150 limitation. (eff 4/3/95) Obsolete (payer only code)
	P1 = Do Not Resuscitate Order (DNR) - for public health reporting only - code indicates that a DNR order was written at the time of or within the first 24 hours of the patient's admission to the hospital and is clearly documented in the patient's medical record.
	P7 = Direct Inpatient Admission from Emergency Room - for public health reporting only when required by state or federal law or regulations. Code indicates that patient was admitted directly from this facility's emergency room department. (eff. 7/1/10)
	W0 = United Mine Workers of America (UMWA) SNF demonstration indicator (eff 1/97); but no claims transmitted until 2/98)
	W2 = Duplicate of Original Bill - code indicates bill is exact duplicate of the original bill submitted. (eff. 10/1/08)
	W3 = Level I Appeal - code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (I) is specified/defined by the payer. (eff. 10/1/08)
	W4 = Level II Appeal - Code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (II) is specified/defined by the payer. (eff. 10/1/08)
	W5 = Level III Appeal - Code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (III) is specified/defined by the payer. (eff. 10/1/08)
	XX = Transgender/Hermaphrodite Beneficiaries (eff. 1/2/07) Obsolete

OCRNC_CD (CLM_RLT_OCRNC_TB)	Claim Related Occurrence Table

01 = Auto accident - The date of an auto accident.

02 = No-fault insurance involved, including auto accident/other - The date of an accident where the state has applicable no-fault liability laws, (i.e.,legal basis for settlement without admission or proof of guilt).

03 = Accident/tort liability - The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.

04 = Accident/employment related - The date of an accident relating to the patient's employment.

05 = Accident/No medical liability coverage - code indicating accident related injury for which there is no medical payment or third party liability coverage. Provide the date of accident/injury.

05 = Other accident - The date of an accident not described by the codes 01 thru 04. (obsolete)

06 = Crime victim - Code indicating the date on which a medical Condition resulted from alleged criminal action committed by one or more parties.

07 = Reserved for national assignment.

08 = Reserved for national assignment.

09 = Start of Infertility Treatment Cycle - code indicating the start date of infertility treatment cycle.

10 = Last Menstrual Period - code indicating the date of the last menstrual period; ONLY applies when patient is being treated for maternity related conditions.

11 = Onset of symptoms/illness - The date the patient first became aware of symptoms/illness.

12 = Date of onset for a chronically dependent individual - Code indicates the date the patient/bene became a chronically dependent individual.

13 = Reserved for national assignment.

14 = Reserved for national assignment.

15 = Reserved for national assignment.

16 = Date of Last Therapy - code denotes last day of therapy services (e.g., physical therapy, occupational therapy, speech therapy).

17 = Date outpatient occupational therapy plan established or last reviewed - Code indicating the date an occupational therapy plan was established or last reviewed (eff 3/93)

18 = Date of retirement (patient/bene) - Code indicates the date of retirement for the patient/bene.

19 = Date of retirement spouse - Code indicates the date of retirement for the patient's spouse.

OCRNC_CD (CLM_RLT_OCRNC_TB)	Claim Related Occurrence Table

20 = Guarantee of payment began - The date on which the provider began claiming Medicare payment under the guarantee of payment provision.

21 = UR notice received - Code indicating the date of receipt by the hospital & SNF of the UR committee's finding that the admission or future stay was not medically necessary.

22 = Active care ended - The date on which a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.

23 = Cancellation of Hospice benefits - The date the RHHI cancelled the hospice benefit. (eff. 10/00). NOTE: this will be different than the revocation of the hospice benefit by beneficiaries. Benefits exhausted - The last date for which for which benefits can be paid. (term 9/30/93; replaced by code A3)

24 = Date insurance denied - The date the insurer's denial of coverage was received by a higher priority payer.

25 = Date benefits terminated by primary payer - The date on which coverage (including worker's compensation benefits or no-fault coverage) is no longer available to the patient.

26 = Date skilled nursing facility (SNF) bed available - The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.

27 = Date of Hospice Certification or Re-Certification - code indicates the date of certification or recertification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods. (eff. 9/01)

27 = Date home health plan established or last reviewed - Code indicating the date a home health plan of treatment was established or last reviewed. (Obsolete) not used by hospital unless owner of facility

28 = Date comprehensive outpatient rehabilitation plan established or last reviewed - Code indicating the date a comprehensive outpatient rehabilitation plan was established or last reviewed. Not used by hospital unless owner of facility

29 = Date OPT plan established or last reviewed - the date a plan of treatment was established for outpatient physical therapy. Not used by hospital unless owner of facility

30 = Date speech pathology plan treatment established or last reviewed - The date a speech pathology plan of treatment was established or last reviewed. Not used by hospital unless owner of facility

OCRNC_CD (CLM_RLT_OCRNC_TB)	Claim Related Occurrence Table

31 = Date bene notified of intent to bill (accommodations) - The date of the notice provided to the patient by the hospital the hospital stating that he no longer required a covered level of IP care.

32 = Date bene notified of intent to bill (procedures or treatment) - The date of the notice provided to the patient by the hospital stating requested care (diagnostic procedures or treatments) is not considered reasonable or necessary.

33 = First day of the Medicare coordination period for ESRD bene - During which Medicare benefits are secondary to benefits payable under an EGHP. Required only for ESRD beneficiaries.

34 = Date of election of extended care facilities - The date the guest elected to receive extended care services (used by Religious Nonmedical Health Care Institutions only).

35 = Date treatment started for physical therapy - Code indicates the date services were initiated by the billing provider for physical therapy.

36 = Date of discharge for the IP hospital stay when patient received a transplant procedure - Hospital is billing for immunosuppressive drugs.

37 = The date of discharge for the IP hospital stay when patient received a noncovered transplant procedure - Hospital is billing for immunosuppresive drugs.

38 = Date treatment started for home IV therapy - Date the patient was first treated in his home for IV therapy.

39 = Date discharged on a continuous course of IV therapy - Date the patient was discharged from the hospital on a continuous course of IV therapy.

40 = Scheduled date of admission - The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)

41 = Date of First Test for Pre-admission Testing - The date on which the first outpatient diagnostic test was performed as performed as part of a pre-admission testing (PAT) program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s). (eff. 10/01)

42 = Date of discharge/termination of hospice care - for the final bill for hospice care. Eff 5/93, definition revised to apply only to date patient revoked hospice election.

43 = Scheduled Date of Canceled Surgery - date which ambulatory surgery was scheduled. (eff. 9/01)

44 = Date treatment started for occupational therapy - Code indicates the date services were initiated by the billing provider for occupational therapy.

OCRNC_CD (CLM_RLT_OCRNC_TB)	Claim Related Occurrence Table

45 = Date treatment started for speech therapy - Code indicates the date services were initiated by the billing provider for speech therapy.

46 = Date treatment started for cardiac rehabilitation - Code indicates the date services were initiated by the billing provider for cardiac rehabilitation.

47 = Date Cost Outlier Status Begins - code indicates that this is the first day the cost outlier threshold is reached. For Medicare purposes, a bene must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments. (eff. 9/01)

48 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.

49 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.
50 = Assessment Date - code indicating an assessment date as defined by the assessment instrument applicable to this provider type (e.g. Minimum Data Set (MDS) for skilled nursing). eff. 1/1/11

51 = Date of Last Kt/V Reading - for in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this date may be before the current billing period but should be within 4 months of the date of service. eff. 7/1/10

52 = Medical Certification/recertification date - the date of the most recent non-hospice medical certification or recertification of the patient. Use occurrence code 27 for Date of Hospice Certification or Recertification. eff. 1/1/11

54 = Physician Follow-up Date - Last date of a physician follow-up with the patient. eff. 1/1/11
55 = Used to report date of death. NOTE: The date of death will be present when the patient discharge status code is 20, 40, 41 or 42.

A1 = Birth date, Insured A - The birth date of the individual in whose name the insurance is carried. (Eff 10/93)

A2 = Effective date, Insured A policy - A code indicating the first date insurance is in force. (eff 10/93)

A3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer A. (eff 10/93)

A4 = Split Bill Date - date patient became eligible due to medically needy spend down (sometimes referred to as "Split Bill

OCRNC_CD (CLM_RLT_OCRNC_TB)	Claim Related Occurrence Table
	Date").
	B1 = Birth date, Insured B - The birth date of the individual in whose name the insurance is carried. (eff 10/93) B2 = Effective date, Insured B policy - A code indicating the first date insurance is in force. (eff 10/93) B3 = Benefits exhausted - code indicating the last date for which benefits are available and after which no payment can be made to payer B. (eff 10/93) C1 = Birth date, Insured C - The birth date of the individual in whose name the insurance is carried. (eff 10/93) C2 = Effective date, Insured C policy - A code indicating the first date insurance is in force. (eff 10/93) Obsolete C3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer C. (eff 10/93) Obsolete
ADMSRCE CLM_SRC_IP_ADMSN_TB	Claim Source Of Inpatient Admission Table
	For Inpatient/SNF Claims: 0 = ANOMALY: invalid value, if present, translate to '9' 1 = Non-Health Care Facility Point of Origin (Physician Referral) - The patient was admitted to this facility upon an order of a physician. 2 = Clinic referral - The patient was admitted upon the recommendation of this facility's clinic physician. 3 = HMO referral - Reserved for national assignment. (eff. 3/08) Prior to 3/08, HMO referral - The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician. 4 = Transfer from hospital (Different Facility) - The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient. 5 = Transfer from a skilled nursing facility (SNF) or Intermediate Care Facility (ICF) - The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident. 6 = Transfer from another health care facility - The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list where he or she was an inpatient. 7 = Emergency room - The patient was admitted to this facility after receiving services in this facility's emergency room department. Obsolete - eff. 7/1/10

ADMSRCE	Claim Source Of Inpatient Admission Table 8 = Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law a law enforcement agency's representative. Includes transfers from incarceration facilities. 9 = Information not available - The means by which the patient was admitted is not known. A = Reserved for National Assignment. (eff. 3/08) Prior to 3/08 defined as: Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital. B = Transfer from Another Home Health Agency - The patient was admitted to this home health agency as a transfer from another home health agency.(Discontinued July 1, 2010- See Condition Code 47) C = Readmission to Same Home Health Agency - The patient was re-admitted to this home health agency within the same home health episode period. (Discontinued July 1, 2010) D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer - The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer. E = Transfer from Ambulatory Surgery Center - The patient was admitted to this facility as a transfer from an ambulatory surgery center. (eff. 10/1/2007) F = Transfer from Hospice and is under a Hospice Plan of Care or Enrolled in a Hospice Program - The patient was admitted to this facility as a transfer from a hospice. (eff. 10/1/2007) **For Newborn Type of Admission** 1 = Normal delivery - A baby delivered without complications. Obsolete eff. 10/1/07 2 = Premature delivery - A baby delivered with time and/or weight factors qualifying it for premature status. Obsolete eff. 10/1/07 3 = Sick baby - A baby delivered with medical complications, other than those relating to premature status. Obsolete eff. 10/1/07 4 = Extramural birth - A baby delivered in a nonsterile environment. Obsolete eff. 10/1/07 5 = Born Inside this Hospital - eff. 10/1/07 6 = Born Outside of this Hospital - eff. 10/1/07 7-9 = Reserved for national assignment.
TYPESRVC (CLM_SRVC_CLSFCTN_TYPE_TB)	Claim Service Classification Type Table

TYPESRVC (CLM_SRVC_CLSFCTN_TYPE_TB)	Claim Service Classification Type Table

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) -- (Includes HHA medical and other health services not under a plan of treatment, hospital or SNF for diagnostic clinical laboratory services for 'nonpatients,' and referenced diagnostic services. For HHAs under PPS, indicates an osteoporosis claim.)

5 = Intermediate care - level I

6 = Intermediate care - level II

7 = Subacute Inpatient (revenue code 019X required) (formerly Intermediate care - level III)

NOTE: 17X & 27X are discontinued effective 10/1/05.

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 Clinic (RHC)

2 = Hospital based or independent renal dialysis facility

3 = Free-standing provider based federally qualified health center (FQHC) (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)

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

TYPESRVC (CLM_SRVC_CLSFCTN_TYPE_TB)	Claim Service Classification Type Table
	9 = Other
TRANS_CD (CLM_TRANS_TB)	Claim Transaction Table
	0 = Religious Non Medical 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 (obsolete 7/98) H = Hospice bill
HCFASPEC (CMS_PRVDR_SPCLTY_TB)	CMS Provider Specialty Table
	00 = Carrier wide 01 = General practice 02 = General surgery 03 = Allergy/immunology 04 = Otolaryngology 05 = Anesthesiology 06 = Cardiology 07 = Dermatology 08 = Family practice 09 = Interventional Pain Management (IPM) (eff. 4/1/03) 09 = Gynecology (osteopaths only) (discontinued 5/92 use code 16) 10 = Gastroenterology 11 = Internal medicine 12 = Osteopathic manipulative therapy 13 = Neurology 14 = Neurosurgery 15 = Speech Language Pathologists 15 = Obstetrics (osteopaths only) (discontinued 5/92 use code 16) 16 = Obstetrics/gynecology 17 = Hospice and Palliative Care

HCFASPEC (CMS_PRVDR_SPCLTY_TB)	CMS Provider Specialty Table

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 = Cardiac Electrophysiology

21 = Pathologic anatomy, clinical pathology (osteopaths only) (discontinued 5/92 use code 22)

22 = Pathology

23 = Sports medicine

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 = Geriatric Psychiatry Colorectal Surgery

27 = Psychiatry, neurology (osteopaths only) (discontinued 5/92 use code 86)

28 = Colorectal surgery (formerly proctology)

29 = Pulmonary disease

30 = Diagnostic radiology

31 = Intensive Cardiac Rehabilitation

31 = Roentgenology, radiology (osteopaths only) (discontinued 5/92 use code 30)

32 = Anesthesiologist Assistants (eff. 4/1/03 - previously grouped with Certified Registered Nurse Anesthetists (CRNA))

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 (eff. 1/87) (Anesthesiologist Assistants were removed from this specialty 4/1/03)

44 = Infectious disease

45 = Mammography screening center

HCFASPEC (CMS_PRVDR_SPCLTY_TB)	CMS Provider Specialty Table

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)

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 (private practice added 4/1/03) (independently practicing removed 4/1/03)

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

67 = Occupational therapist (private practice added 4/1/03) (independently practicing removed 4/1/03)

68 = Clinical psychologist

69 = Clinical laboratory (billing independently)

70 = Multispecialty clinic or group practice

71 = Registered Dietician/Nutrition Professional (eff. 1/1/02)

72 = Pain Management (eff. 1/1/02)

73 = Mass Immunization Roster Biller (eff. 4/1/03)

74 = Radiation Therapy Centers (added to differentiate them from Independent Diagnostic Testing Facilities (IDTF--eff. 4/1/03)

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

75 = Slide Preparation Facilities (added to differentiate them from Independent Diagnostic Testing Facilites (IDTFs -- eff. 4/1/03)

75 = Other medical care (GPPP) (not to 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 = Competitive Acquisition Program (CAP) Vendor (eff. 07/01/06). Prior to 07/01/06, known as 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)

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)

HCFASPEC (CMS_PRVDR_SPCLTY_TB)	CMS Provider Specialty Table
	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) A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital based facilities. DMERCs shall process claims submitted by IHS, tribe and non-tribal organizations for DMEPOS and drugs covered by the DMERCs. (eff. 1/2005) B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2/07) B2 = Pedorthic Personnel (eff. 10/2/07) B3 = Medical Supply Company with Pedorthic Personnel (eff. 10/2/07) B4 = Rehabilitation Agency (eff. 10/2/07) B5 = Ocularist C0 = Sleep medicine C1 = Centralized Flu
HCFATYPE (HCFA_TYPE_SRVC_TB)	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)

HCFATYPE (HCFA_TYPE_SRVC_TB)	HCFA Type of Service Table
	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)
Last Two digits in the HIC (CTGRY_EQTBL_BENE_IDENT_TB) NCH BIC	Category Equatable Beneficiary Identification Code (BIC) Table
	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)

Last Two digits in the HIC (CTGRY_EQTBL_BENE_IDENT_TB) NCH BIC	Category Equatable Beneficiary Identification Code (BIC) Table SSA Categories 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
SUP_TYPE (DMERC_LINE_SUPLR_TYPE_TB)	DMERC Line Supplier Type Table

SUP_TYPE (DMERC_LINE_SUPLR_TYPE_TB)	DMERC Line Supplier Type Table
	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.
ACTIONCD (FI_CLM_ACTN_TB)	Fiscal Intermediary Claim Action Table
	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.)
STATE_CD	State Table

(GEO_SSA_STATE_TB)

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
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

STATE_CD (GEO_SSA_STATE_TB)	State Table 45 = Texas 46 = Utah 47 = Vermont 48 = Virgin Islands 49 = Virginia 50 = Washington 51 = West Virginia 52 = Wisconsin 53 = Wyoming 54 = Africa 55 = California 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 = Commonwealth of the Northern Marianas Islands 67 = Texas 68 = Florida (eff. 10/2005) 69 = Florida (eff. 10/2005) 70 = Kansas (eff. 10/2005) 71 = Louisiana (eff. 10/2005) 72 = Ohio (eff. 10/2005) 73 = Pennsylvania (eff. 10/2005) 74 = Texas (eff. 10/2005) 80 = Maryland (eff. 8/2000) 97 = Northern Marianas 98 = Guam 99 = With 000 county code is American Samoa; otherwise unknown
DOCINDCD (LINE_ADDTNL_CLM_DCMTN_IND_TB)	Line Additional Claim Documentation Indicator Table 0 = No additional documentation 1 = Additional documentation submitted for non-DME EMC claim

DOCINDCD (LINE_ADDTNL_CLM_DCMTN_IND_TB)	Line Additional Claim Documentation Indicator Table
	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
DUP_CHK (LINE_DUP_CLM_CHK_IND_TB)	Line Duplicate Claim Check Indicator Table
	1 = Suspect duplicate review performed
PLCSRVC (LINE_PLC_SRVC_TB)	Line Place Of Service Table
	01 = Pharmacy (eff. 10/1/05) 03 = School (eff. 1/1/03 04 = Homeless Shelter (eff. 1/1/03) 09 = Prison/correctional facility setting (eff. 10/2006) 11 = Office 12 = Home 13 = Assisted Living Facility (eff. 10/1/2003) 14 = Group Home (eff. 10/1/2003) 15 = Mobile Unit (eff. 1/1/03) 18 = Place of Employment/Worksite 20 = Urgent Care Facility (eff. 1/1/03) 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

PLCSRVC (LINE_PLC_SRVC_TB)	Line Place Of Service Table
	42 = Ambulance - air or water 49 = Independent Care (eff. 10/1/2003) 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 57 = Non-residential substance abuse treatment facility (eff. 10/1/2003) 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
PROINDCD	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)

PROINDCD	Line Processing Indicator Table
	00= MSP cost avoided - COB Contractor 12= MSP cost avoided - BC/BS Voluntary Agreements 13= MSP cost avoided - Office of Personnel Management 14= MSP cost avoided - Workman's Compensation (WC) Datamatch 15= MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006) 16= MSP cost avoided - Liability Insurer VDSA (eff.4/2006) 17= MSP cost avoided - No-Fault Insurer VDSA (eff.4/2006) 18= MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement (eff.4/2006) 21= MSP cost avoided - MIR Group Health Plan (eff.1/2009) 22= MSP cost avoided - MIR non-Group Health Plan (eff.1/2009) 25= MSP cost avoided - Recovery Audit Contractor - California (eff.10/2005) 26= MSP cost avoided - Recovery Audit Contractor - Florida (eff.10/2005) NOTE: Effective 4/1/02, the Line Processing Indicator code was expanded to a 2-byte field. The NCH instituted a crosswalk from the 2-byte code to a 1-byte character code. Below are the character codes (found in NCH & NMUD). At some point, NMUD will carry the 2-byte code but NCH will continue to have the 1-byte character code. ! = MSP cost avoided - COB Contractor ('00' 2-byte code) @ = MSP cost avoided - BC/BS Voluntary Agreements ('12' 2-byte code) # = MSP cost avoided - Office of Personnel Management ('13' 2-byte code) $ = MSP cost avoided - Workman's Compensation (WC) Datamatch ('14' 2-byte code) * = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) ('15' 2-byte code) (eff. 4/2006) (= MSP cost avoided - Liability Insurer VDSA ('16' 2-byte code) (eff. 4/2006)) = MSP cost avoided - No-Fault Insurer VDSA ('17' 2-byte code) (eff. 4/2006) + = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement ('18' 2 -byte code) (eff. 4/2006) < = MSP cost avoided - MIR Group Health Plan ('21' 2-byte code) (eff. 1/2009) > = MSP cost avoided - MIR non-Group Health Plan ('22' 2-byte code) (eff. 1/2009)

PROINDCD	Line Processing Indicator Table % = MSP cost avoided - Recovery Audit Contractor - California ('25' 2-byte code) (eff. 10/2005) & = MSP cost avoided - Recovery Audit Contractor - Florida ('26' 2-byte code) (eff. 10/2005)
PRTCPTG (LINE_PRVDR_PRTCPTG_IND_TB)	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.
MCOPTN (MCO_OPTN_TB)	MCO Option Table *****For lock-in beneficiaries**** A = HCFA to process all provider bills B = MCO to process only in-plan C = MCO to process all Part A and Part B bills ***** For non-lock-in beneficiaries***** 1 = HCFA to process all provider bills 2 = MCO to process only in-plan Part A and Part B bills 4 = Cost Plan-Chronic Care Organizations (eff. 10/2005)
CLM_TYPE (NCH_CLM_TYPE_TB)	NCH Claim Type Table 10 = HHA claim 20 = Non swing bed SNF claim 30 = Swing bed SNF claim 40 = Outpatient claim 50 = Hospice claim 60 = Inpatient claim 61 = Inpatient 'Full-Encounter' claim

CLM_TYPE (NCH_CLM_TYPE_TB)	NCH Claim Type Table
	62 = Medicare Advantage IME/GME Claims 63 = Medicare Advantage (no-pay) claims 64 = Medicare Advantage (paid as FFS) claims 71 = RIC O local carrier non-DMEPOS claim 72 = RIC O local carrier DMEPOS claim 81 = RIC M DMERC non-DMEPOS claim 82 = RIC M DMERC DMEPOS claim NOTE: In the data element NCH_CLM_TYPE_CD (derivation rules) the numbers for these claim types need to be changed - dictionary reflects 61 for all three.
STUS_CD (PTNT_DSCHRG_STUS_TB)	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) with Medicare certification in anticipation of covered skilled care -- (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 a facility that provides custodial or supportive care (includes intermediate care facilities (ICF). Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to Assisted Living Facilities. 05 = Discharged/transferred to a designated cancer center or children's hospital (eff. 10/09). Prior to 10/1/09, discharged/transferred to another type of institution for inpatient care (including distinct parts). NOTE: Effective 1/2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is '65'. 06 = Discharged/transferred to home care of organized home health service organization in anticipation of covered skilled care. 07 = Left against medical advice or discontinued care. 08 = Discharged/transferred to home under care of a home IV drug therapy provider. (discontinued effective 10/1/05) 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

STUS_CD (PTNT_DSCHRG_STUS_TB)	Patient Discharge Status Table

21 = Discharged/transferred to Court/Law Enforcement.

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)

43 = Discharged/transferred to a federal hospital (eff. 10/1/03). Discharges and transfers to a government operated health facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the Destination at discharge is a federal health care facility, whether the patient lives there or not.

50 = Hospice - home (eff. 10/96)

51 = Hospice - medical facility (certified) providing hospice level of care

61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/01)

62 = Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital. (eff. 1/2002)

63 = Discharged/transferred to a Medicare certified long term care hospital. (eff. 1/2002)

64 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare (eff. 10/2002)

65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code). (eff. 1/2005).

66 = Discharged/transferred to a Critical Access Hospital (CAH) (eff. 1/1/06)

70 = Discharged/transferred to another type of health care institution not defined elsewhere in code list.

71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)

72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)

81 = Discharged to home or self-care with a planned acute care hospital inpatient (eff. 10/2013)

82 = Discharged/transferred to a short term general hospital for inpatient care readmission (eff. 10/2013)

83 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare (eff. 10/2013)

84 = Discharged/transferred to a facility that provides custodial supportative care with a planned acute care hospital inpatient

STUS_CD (PTNT_DSCHRG_STUS_TB)	Patient Discharge Status Table
	readmission certification with a planned acute care hospital inpatient readmission (eff. 10/2013) 85 = Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission (eff. 10/2013) 86 = Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission (eff. 10/2013) 87 = Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (eff. 10/2013) 88 = Discharged/transferred to a Federal health care facility with a planned acute care hospital inpatient readmission (eff. 10/2013) 89 = Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (eff. 10/2013) 90 = Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct units of a hospital with a planned acute care hospital inpatient readmission (eff. 10/2013) 91 = Discharged/transferred to a Medicare certified Long Term Care Hospital (LTCH) with a planned acute care hospital inpatient readmission (eff. 10/2013) 92 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (eff. 10/2013) 93 = Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (eff. 10/2013) 94 = Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (eff. 10/2013) 95 = Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission. (eff. 10/2013)
REVAN1 (REV_CNTR_ANSI_TB)	Revenue Center ANSI Code Table
	*******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES******* **********POSITIONS 1 & 2 OF ANSI CODE********** CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals -- this group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.

OA = Other Adjustments -- this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions -- this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility -- this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

**********Claim Adjustment Reason Codes**********

**********POSITIONS 3 through 5 of ANSI CODE**********

1 = Deductible Amount

2 = Coinsurance Amount

3 = Co-pay Amount

4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.

5 = The procedure code/bill type is inconsistent with the place of service.

6 = The procedure code is inconsistent with the patient's age.

7 = The procedure code is inconsistent with the patient's gender.

8 = The procedure code is inconsistent with the provider type.

9 = The diagnosis is inconsistent with the patient's age.

10 = The diagnosis is inconsistent with the patient's gender.

11 = The diagnosis is inconsistent with the procedure.

12 = The diagnosis is inconsistent with the provider type.

13 = the date of death precedes the date of service.

14 = The date of birth follows the date of service.

15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.

16 = Claim/service lacks information which is needed for adjudication.

17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.

18 = Duplicate claim/service.

19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.

20 = Claim denied because this injury/illness is covered by the liability carrier.

21 = Claim denied because this injury/illness is the liability of the no-fault carrier.

22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.

23 = Claim adjusted because charges have been paid by another payer.

24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.

25 = Payment denied. Your Stop loss deductible has not been met.

26 = Expenses incurred prior to coverage.

27 = Expenses incurred after coverage terminated.

28 = Coverage not in effect at the time the service was provided.

29 = The time limit for filing has expired.

30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.

31 = Claim denied as patient cannot be identified as our insured.

32 = Our records indicate that this dependent is not an eligible dependent as defined.

33 = Claim denied. Insured has no dependent coverage.

34 = Claim denied. Insured has no coverage for newborns.

35 = Benefit maximum has been reached.

36 = Balance does not exceed copayment amount.

37 = Balance does not exceed deductible amount.

38 = Services not provided or authorized by designated (network) providers.

39 = Services denied at the time authorization/pre-certification was requested.

40 = Charges do not meet qualifications for emergency/urgent care.

41 = Discount agreed to in Preferred Provider contract.

42 = Charges exceed our fee schedule or maximum allowable amount.

43 = Gramm-Rudman reduction.

44 = Prompt-pay discount.

45 = Charges exceed your contracted/legislated fee arrangement.

46 = This (these) service(s) is (are) not covered.

47 = This (these) diagnosis(es) is (are) not covered, missing, or are invalid.

48 = This (these) procedure(s) is (are) not covered.

49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.

50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.

51 = These are non-covered services because this a pre-existing condition.

52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.

53 = Services by an immediate relative or a member of the same household are not covered.

54 = Multiple physicians/assistants are not covered in this case.

55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.

56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.

57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.

58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.

60 = Charges for outpatient services with the proximity to inpatient services are not covered.

61 = Charges adjusted as penalty for failure to obtain second surgical opinion.

62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.

63 = Correction to a prior claim. INACTIVE

64 = Denial reversed per Medical Review. INACTIVE

65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE

66 = Blood Deductible.

67 = Lifetime reserve days. INACTIVE

68 = DRG weight. INACTIVE

69 = Day outlier amount.

70 = Cost outlier amount.

71 = Primary Payer amount.

72 = Coinsurance day. INACTIVE

73 = Administrative days. INACTIVE

74 = Indirect Medical Education Adjustment.

75 = Direct Medical Education Adjustment.

76 = Disproportionate Share Adjustment.
77 = Covered days. INACTIVE
78 = Non-covered days/room charge adjustment.
79 = Cost report days. INACTIVE
80 = Outlier days. INACTIVE
81 = Discharges. INACTIVE
82 = PIP days. INACTIVE
83 = Total visits. INACTIVE
84 = Capital adjustments. INACTIVE
85 = Interest amount. INACTIVE
86 = Statutory adjustment. INACTIVE
87 = Transfer amounts.
88 = Adjustment amount represents collection against receivable created in prior overpayment.
89 = Professional fees removed from charges.
90 = Ingredient cost adjustment.
91 = Dispensing fee adjustment.
92 = Claim paid in full. INACTIVE
93 = No claim level adjustment. INACTIVE
94 = Process in excess of charges.
95 = Benefits adjusted. Plan procedures not followed.
96 = Non-covered charges.
97 = Payment is included in allowance for another service/procedure.
98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE
99 = Medicare Secondary Payer Adjustment Amount. INACTIVE
100 = Payment made to patient/insured/responsible party.
101 = Predetermination: anticipated payment upon completion of services or claim adjudication.
102 = Major medical adjustment.
103 = Provider promotional discount (i.e. Senior citizen discount).
104 = Managed care withholding.
105 = Tax withholding.
106 = Patient payment option/election not in effect.
107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
108 = Claim/service reduced because rent/purchase guidelines were not met.
109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
110 = Billing date predates service date.
111 = Not covered unless the provider accepts assignment.

112 = Claim/service adjusted as not furnished directly to the patient and/or not documented.

113 = Claim denied because service/procedure was provided outside the United States or as a result of war.

114 = Procedure/Product not approved by the Food and Drug Administration.

115 = Claim/service adjusted as procedure postponed or canceled.

116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.

117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.

118 = Charges reduced for ESRD network support.

119 = Benefit maximum for this time period has been reached.

120 = Patient is covered by a managed care plan. INACTIVE

121 = Indemnification adjustment.

122 = Psychiatric reduction.

123 = Payer refund due to overpayment. INACTIVE

124 = Payer refund amount - not our patient. INACTIVE

125 = Claim/service adjusted due to a submission/billing error(s).

126 = Deductible - Major Medical.

127 = Coinsurance - Major Medical.

128 = Newborn's services are covered in the mother's allowance.

129 = Claim denied - prior processing information appears incorrect.

130 = Paper claim submission fee.

131 = Claim specific negotiated discount.

132 = Prearranged demonstration project adjustment.

133 = The disposition of this claim/service is pending further review.

134 = Technical fees removed from charges.

135 = Claim denied. Interim bills cannot be processed.

136 = Claim adjusted. Plan procedures of a prior payer were not followed.

137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.

138 = Claim/service denied. Appeal procedures not followed or time limits not met.

139 = Contracted funding agreement - subscriber is employed by the provider of services.

140 = Patient/Insured health identification number and name do not match.

141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.

142 = Claim adjusted by the monthly Medicaid patient liability amount.

A0 = Patient refund amount

A1 = Claim denied charges.

A2 = Contractual adjustment.

A3 = Medicare Secondary Payer liability met. INACTIVE

A4 = Medicare Claim PPS Capital Day Outlier Amount.

A5 = Medicare Claim PPS Capital Cost Outlier Amount.

A6 = Prior hospitalization or 30 day transfer requirement not met.

A7 = Presumptive Payment Adjustment.

A8 = Claim denied; ungroupable DRG.

B1 = Non-covered visits.

B2 = Covered visits. INACTIVE

B3 = Covered charges. INACTIVE

B4 = Late filing penalty.

B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.

B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.

B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.

B9 = Services not covered because the patient is enrolled in a Hospice.

B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.

B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.

B12 = Services not documented in patients' medical records.

B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.

B14 = Claim/service denied because only one visit or consultation per physician per day is covered.

B15 = Claim/service adjusted because this procedure/service is not paid separately.

B16 = Claim/service adjusted because 'New Patient' qualifications were not met.

REVAN1 (REV_CNTR_ANSI_TB)	Revenue Center ANSI Code Table
	B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current. B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission. B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider. B21 = The charges were reduced because the service/care was partially furnished by another physician. INACTIVE B22 = This claim/service is adjusted based on the diagnosis. B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program. W1 = Workers Compensation State Fee Schedule Adjustment.
DED (REV_CNTR_DDCTBL_COINSRNC_TB)	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)
DSCNTIND (REV_CNTR_DSCNT_IND_TB)	Revenue Center Discount Indicator Table
	DISCOUNTING FORMULAS 1 = 1.0 2 = (1.0+D(U-1))/U

DSCNTIND (REV_CNTR_DSCNT_IND_TB)	Revenue Center Discount Indicator Table
	3 = T/U 4 = (1+D)/U 5 = D 6 = TD/U 7 = D(1+D)/U 8 = 2.0/U NOTE: VALUES D, U & T REPRESENT THE FOLLOWING: D = Discounting fraction (currently 0.5) U = Number of units T = Terminated procedure discount (currently 0.5)
PMTMTHD (REV_CNTR_PMT_MTHD_IND_TB)	Revenue Center Payment Method Indicator Table
	NOTE: Prior to 10/2005, this table contained the valid values for both the payment indicator and status indicator. Effective 10/2005, the payment indicator codes will remain in this table and The status indicator code values will be reflected in the new table: REV_CNTR_STUS_IND_TB. Both the payment indicator and status indicator values have been expanded to 2-btyes. 1 = Paid standard hospital OPPS amount (status indicators K,S,T,V,X) 2 = Services not paid under OPPS (status indicator A, or no HCPCS code and not certain revenue center codes) 3 = Not paid (status indicator M,W,Y,E) or not paid under OPPS (status indicator B,C & Z) 4 = Paid at reasonable cost (status indicator F,L) 5 = Additional payment for drug or biological (status indicator G) 6 = Additional payment for device (status indicator H) 7 = Additional payment for new drug or new biological (status indicator J) 8 = Paid partial hospitalization per diem (status indicator P) 9 = No additional payment, payment included in line items with APCs (status indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy) or G0177 (partial hospitalization program services) *********VALUES PRIOR TO 10/3/2005********** **********Service Indicator**********

PMTMTHD (REV_CNTR_PMT_MTHD_IND_TB)	Revenue Center Payment Method Indicator Table
	********** 1st position ********** A = Services not paid under OPPS C = Inpatient procedure E = Noncovered items or services F = Corneal tissue acquisition G = Current drug or biological pass-through H = Device pass-through J = New drug or new biological pass-through N = Packaged incidental service P = Partial hospitalization services S = Significant procedure not subject to multiple procedure discounting T = Significant procedure subject to multiple procedure discounting V = Medical visit to clinic or emergency department X = Ancillary service **********Payment Indicator********** ********** 2nd position ********** 1 = Paid standard hospital OPPS amount (service indicators S,T,V,X) 2 = Services not paid under OPPS (service indicator A, or no HCPCS code and not certain revenue center codes) 3 = Not paid (service indicators C & E) 4 = Acquisition cost paid (service indicator F) 5 = Additional payment for current drug or biological (service indicator G) 6 = Additional payment for device (service indicator H) 7 = Additional payment for new drug or new biological (service indicator J) 8 = Paid partial hospitalization per diem (service indicator P) 9 = No additional payment, payment included in line items with APCs (service indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization training)
PRICING (REV_CNTR_PRICNG_IND_TB)	Revenue Center Pricing Indicator Table
	A = A valid HCPCS code not subject to a fee schedule payment. Reimbursement is calculated on provider submitted charges.

B = Valid HCPCS code subject to the fee schedule payment. For the provider billed charges. NOTE: There is an exception for Critical Access Hospitals (provider numbers XX1300-XX1399) with reimbursement method 'J' (all-inclusive method) and dates of service on or after 7/1/01. In these situations, reimbursement for professional services (revenue codes 96X, 97X, 98X) is always at the fee schedule amount of logic is not applicable.

C = Unlisted Rehabilitation Carrier Priced HCPCS

D = a valid radiology HCPCS code subject to the Radiology Pricer and the rate is reflected as zeroes on the HCPCS file and cost report. The Radiology Pricer treats this HCPCS as a non-covered service. Reimbursement is calculated on provider submitted charges.

E = A valid ASC HCPCS code subject to the ASC Pricer. The rate is reflected as zeroes on the HCPCS file. The ASC Pricer determines the ASC payment rate and is reported on the cost report.

F = A valid ESRD HCPCS code subject to the parameter rate. Reimbursement is the lesser of provider submitted charges or the fee schedule amount for non-dialysis HCPCS. Reimbursement is calculated on the provider file rates for dialysis HCPCS.

NOTE: The ESRD Pricing Indicator is used when processing the ESRD claim. The non-ESRD pricing indicator is used only for Inpatient claims as follows: valid Hemophilia HCPCS for inpatient claim only and code is summed to parameter rate.

G = A valid HCPCS, code is subject to a fee schedule, but the rate is no longer present on the HCPCS file. Reimbursement is calculated on provider submitted charges.

H = A valid DME HCPCS, code is subject to a fee schedule. The rates are reflected under the DME segment. Reimbursement is calculated either on a fee schedule, provider submitted charges or the lesser of provider submitted, or the fee schedule depending on the category of DME.

I = A valid DME category 5 HCPCS, HCPCS is not found on the DME history record, but a match was found on HIC, category and generic code. Claim must be reviewed by Medical Review before payment can be calculated.

J = A valid DME HCPCS, no DME history is present, and a prescription is required before delivery. Claim must be reviewed by Medical Review.

K = A valid DME HCPCS, prescribed has been reviewed, and fee schedule payment is approved as prescription was present before delivery.

PRICING (REV_CNTR_PRICNG_IND_TB)	Revenue Center Pricing Indicator Table
	L = A valid TENS HCPCS, rental period is six months or greater and must be reviewed by Medical Review. This code will be automatically set by the system. M = A valid TENS HCPCS, Medical Review has approved the rental charge in excess of five months. This must be set by Medical Review. This must be set by Medical Review when approved for payment. N = Paid based on the fee amount for non ESRD TOB's. NOTE: Fee amount is paid regardless of charges. Q = Manual pricing R = A valid radiology HCPCS code and is subject to APC. The rate is reported on the cost report. Reimbursement is calculated on provider submitted charges. S = Valid influenza/PPV HCPCS. A fee amount is not applicable. The amount payable is present in the covered charge field. This amount is not subject to the coinsurance and deductible. This charge is subject to the provider's reimbursement rate. T = Valid HCPCS. A fee amount is present. The amount payable should be the lower of the billed charge or fee amount. The system should compute the fee amount by multiplying the covered units times the rate. The fee amount is not subject to coinsurance and deductible or provider's reimbursement rate. U = Valid ambulance HCPCS. A fee amount is present. The amount payable is a blended amount based on a percentage of the fee schedule and a percentage of the reasonable cost. The fee amount is subject to coinsurance and deductible. X = Unclassified drug as subject to manual pricing.
QTYQLFR (REV_CNTR_NDC_QTY_QLFR_TB)	Revenue Center NDC Quantity Qualifier Code
	F2 = International Unit GR = Gram ML = Milliliter UN = Unit
PACKGIND (REV_CNTR_PACKG_IND_TB)	Revenue Center Packaging Indicator Table
	0 = Not packaged

PACKGIND (REV_CNTR_PACKG_IND_TB)	Revenue Center Packaging Indicator Table
	1 = Packaged service (service indicator N) 2 = Packaged as part of partial hospitalization per diem or daily mental health service per diem 3 = Artificial charges for surgical procedure(eff. 7/2004)
RSTUSIND (REV_CNTR_STUS_IND_TB)	Revenue Center Status Indicator Table
	A = Services not paid under OPPS B = Non-allowed item or service for OPPS C = Inpatient procedure E = Non-allowed item or service F = Corneal tissue acquisition and certain CRNA services G = Drug/biological pass-through H = Device pass-through J = New drug or new biological pass-through K = Non pass-through drug/biological, radio-pharmaceutical agent, certain brachytherapy sources L = Flu/PPV vaccines M = Service not billable to FI N = Packaged incidental service S = Significant procedure not subject to multiple procedure discounting T = Significant procedure subject to multiple procedure discounting V = Medical visit to clinic or emergency department W = Invalid HCPCS or invalid revenue code with blank HCPCS X = Ancillary service Y = Non-implantable DME, Therapeutic shoes Z = Valid revenue with blank HCPCS and no other SI assigned
CENTER (REV_CNTR_TB)	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.

CENTER (REV_CNTR_TB)	Revenue Center Table

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).

0024 = Inpatient Rehabilitation Facility services paid under PPS submitted as TOB 11X, effective for cost reporting periods beginning on or after 1/1/2002 (dates of service after 12/31/01). This code may appear only once on a claim.

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

CENTER (REV_CNTR_TB)

Revenue Center Table

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)
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)

CENTER (REV_CNTR_TB)

Revenue Center Table

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

CENTER (REV_CNTR_TB)

Revenue Center Table

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
0272 = Medical/surgical supplies-sterile supply
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

CENTER (REV_CNTR_TB)

Revenue Center Table

0311 = Laboratory pathological-cytology
0312 = Laboratory pathological-histology
0314 = Laboratory pathological-biopsy
0319 = Laboratory pathological-other
0320 = Radiology diagnostic-general classification
0321 = Radiology diagnostic-angiocardiography
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
0343 = Nuclear medicine-diagnostic radiopharmaceuticals
0344 = Nuclear medicine-therapeutic radiopharmaceuticals
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

CENTER (REV_CNTR_TB)

Revenue Center Table

0384 = Blood-platelets
0385 = Blood-leukocytes
0386 = Blood-other components
0387 = Blood-other derivatives (cryopricipatates)
0389 = Blood-other blood
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-emtala emergency medical screening services (eff 10/96)
0452 = Emergency room-ER beyond emtala screening (eff 10/96)

CENTER
(REV_CNTR_TB)

Revenue Center Table

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
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-Clinic visit by a member to RHC/FQHC (eff. 7/1/06). Prior to 7/1/06 - Rural Health-Clinic
0522 = Free-standing clinic-Home visit by RHC/FQHC practitioner (eff. 7/1/06). Prior to 7/1/06 - Rural Health-Home
0523 = Free-standing clinic-family practice
0524 = Free-standing clinic - visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF. (eff 7/1/06)
0525 = Free-standing clinic - visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility. (eff. 7/1/06)
0526 = Free-standing clinic-urgent care (eff 10/96)
0527 = Free-standing clinic-RHC/FQHC visiting nurse service(s) to a member's home when in a home health shortage area. (eff. 7/1/06)

CENTER
(REV_CNTR_TB)

Revenue Center Table

0528 = Free-standing clinic-visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g. scene of accident). (eff. 7/1/06)
0529 = Free-standing clinic-other
0530 = Osteopathic services-general classification
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/Home Health-general classification
0601 = Oxygen/Home Health-stat or port equip/supply or count
0602 = Oxygen/Home Health-stat/equip/under 1 LPM

CENTER (REV_CNTR_TB)

Revenue Center Table

0603 = Oxygen/Home Health-stat/equip/over 4 LPM

0604 = Oxygen/Home Health-stat/equip/portable add-on

0609 = Oxygen/Home Health - Other

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 MRT

0620 = Reserved (Use 0270 for general classification)

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 = Reserved (eff. 1/98)

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

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
0658 = Hospice services-Hospice Room & Board - Nursing Facility
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)
0663 = Respite care-daily respite care
0669 = Respite care-other respite care
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
0680 = Trauma Response-not used
0681 = Trauma response-Level I Trauma
0682 = Trauma response-Level II Trauma
0683 = Trauma response-Level III Trauma
0684 = Trauma response-Level IV Trauma
0689 = Trauma response-Other trauma response
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

CENTER (REV_CNTR_TB)

Revenue Center Table

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 moniter
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
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
0860 = Magnetoencephalography (MEG) - general classification
0861 = Magnetoencephalography (MEG) - MEG
0880 = Miscellaneous dialysis-general classification
0881 = Miscellaneous dialysis-ultrafiltration
0882 = Miscellaneous dialysis-home dialysis aide visit
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 = Behavior Health Treatment/Services - general classification (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-general classification

0901 = Behavior Health Treatment/Services - electroshock treatment (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-electroshock treatment

0902 = Behavior Health Treatment/Services - milieu therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-milieu therapy

0903 = Behavior Health Treatment/Services - play therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-play therapy

0904 = Behavior Health Treatment/Services - activity therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/Psychological treatments-activity therapy

0905 = Behavior Health Treatment/Services - intensive outpatient services-psychiatric (eff. 10/2004)

0906 = Behavior Health Treatment/Services - intensive outpatient services-chemical dependency (eff. 10/2004)

0907 = Behavior Health Treatment/Services - community behavioral health program-day treatment (eff. 10/2004)

0909 = Reserved for National Use (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological treatments-other

0910 = Behavioral Health Treatment/Services-Reserved for National Assignment (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-general classification

0911 = Behavioral Health Treatment/Services-rehabilitation (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-rehabilitation

0912 = Behavioral Health Treatment/Services-partial hospitalization -less intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-less intensive

0913 = Behavioral Health Treatment/Services-partial hospitalization-intensive (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-intensive

CENTER (REV_CNTR_TB)	Revenue Center Table

0914 = Behavioral Health Treatment/Services-individual therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/Psychological services-individual therapy

0915 = Behavioral Health Treatment/Services-group therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-group therapy (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-family therapy

0917 = Behavioral Health Treatment/Services-bio feedback (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-bio feedback

0918 = Behavioral Health Treatment/Services-testing (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-testing

0919 = Behavioral Health Treatment/Services-other (eff. 10/2004); prior to 10/2004 defined as Psychiatric/psychological services-other

0920 = Other diagnostic services-general classification

0921 = Other diagnostic services-peripheral vascular lab

0922 = Other diagnostic services-electromyelogram

0923 = Other diagnostic services-pap smear

0924 = Other diagnostic services-allergy test

0925 = Other diagnostic services-pregnancy test

0929 = Other diagnostic services-other

0931 = Medical Rehabilitation Day Program - Half Day

0932 = Medical Rehabilitation Day Program - Full Day

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 (extension of 094X)

0952 = Professional Fees-kinesiotherapy (extension of 094X)

0953 = Chemical Dependency (eff. 4/2013)

0960 = Professional fees-general classification

0961 = Professional fees-psychiatric

0962 = Professional fees-ophthalmology

0963 = Professional fees-anesthesiologist (MD)

CENTER (REV_CNTR_TB)	Revenue Center Table

0964 = Professional fees-anesthetist (CRNA)
0969 = Professional fees-other NOTE: 097X is an extension of 096X
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 NOTE: 098X is an extension of 096X & 097X
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/telecom
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
1000 = Behavioral Health Accommodations - general classification
1001 = Behavioral Health Accommodations - residential treatment -Psychiatric
1002 = Behavioral Health Accommodations - residential treatment - chemical dependency
1003 = Behavioral Health Accommodations - supervised living
1004 = Behavioral Health Accommodations - halfway house
1005 = Behavioral Health Accommodations - group home
2100 = Alternative Therapy Services - general classification
2101 = Alternative Therapy Services - Acupuncture

CENTER
(REV_CNTR_TB)

Revenue Center Table

2102 = Alternative Therapy Services - Acupressure
2103 = Alternative Therapy Services - massage
2104 = Alternative Therapy Services - reflexology
2105 = Alternative Therapy Services - biofeedback
2106 = Alternative Therapy Services - hypnosis
2109 = Alternative Therapy Services - other alternative therapy service
3100 = Adult Care - Reserved
3101 = Adult Care - adult day care, medical and social hourly
3102 = Adult Care - adult day care, social-hourly
3103 = Adult Care - adult day care, medical and social - daily
3104 = Adult Care - adult day care, social - daily
3105 = Adult Care - adult foster care daily
3109 = Adult Care - other adult care

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

CENTER (REV_CNTR_TB)	Revenue Center Table
	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
PAYINDCD (LINE_PMT_IND_TB)	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)
OP_RFRL (CLM_OP_RFRL_TB)	Claim Outpatient Referral Table
	* For Outpatient Claims: Effective 3/91 * 1 = Non-Health Care Facility Point of Origin (Physician Referral)- The patient presents to the facility an order from a physician for services or seeks scheduled services for which an order is not required (e.g. mammography). Includes non-emergent self referrals. NOTE; Includes patients coming from home, a physician’s office or work-place. 2 = Clinical referral - The patients was referred to this facility for outpatient or referenced diagnostic services by this facility’s clinic or other outpatient department physician.

3 = Reserved for national assignment. (eff. 10/1/07). Prior to 10/1/07, HMO referral - The patient referenced diagnostic services by a HMO physician.

4 = Transfer from a hospital (Different Facility) - The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an outpatient. NOTE: Excludes transfers from Hospital Inpatient in the same facility (see code D).

5 = Transfer from a SNF for Intermediate Care Facility (ICF) - The Patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF or ICF where he or she was a resident.

6 = Transfer from another health care facility - The patient was referred to this facility for services by (a physician of) another type of health care facility not defined elsewhere in this code list where he or she was an outpatient.
7 = Emergency room - The patient received unscheduled services in this facility's emergency department and discharged without an inpatient admission. Includes self referrals in emergency situations that require immediate medical attention. OBSOLETE - 7/1/10

8 = Court/law enforcement - The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.

9 = Information not available - For Medicare outpatient claims this is not a valid code.

A = Reserved for National Assignment. (eff. 10/1/07) Prior to 10/07, defined as: Transfer from a Critical Access Hospital (CAH) - The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the CAH where the patient is an inpatient.

B = Transfer from Another Home Health Agency - The patient was admitted to this home health agency as a transfer from another home health agency. Discontinued 7/1/10 - replaced with condition code 47.

C = Readmission to Same Home Health Agency - The patient was readmitted to this home health agency as a transfer from another home health agency. Discontinued 7/1/10

D = Transfer from hospital inpatient in the same facility resulting in separate claims to the payer.
E = Transfer from Ambulatory Surgery Center - The patient received outpatient services in this facility for outpatient or referenced diagnostic services from an ambulatory surgery center.

OP_RFRL (CLM_OP_RFRL_TB)	Claim Outpatient Referral Table
	F = Transfer from Hospice and is under a Hospice plan of care or enrolled in a Hospice program - the patient was referred to this facility for outpatient or referenced diagnostic services from hospice.
HSCRCTY (HPSA_SCRCTY_IND_TB)	HPSA/Scarcity Indicator Table
	1 = Health Professional Shortage Areas (HPSA) 2 = PSA (Scarcity) 3 = HPSA and PSA 4 = HPSA Surgical Incentive Payment Program (HSIP) eff. 1/2011 5 = HPSA and HSIP 6 = Primary Care Incentive Payment Program (PCIP) eff. 1/2011 7 = HPSA and PCIP Space = Not applicable