Appendix for SEER-Medicare 1/2009 Claims Files

BIC

(BENE_IDENT_CD)

Beneficiary Identification Code (BIC) Table

Social Security Administration:

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

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

BIC

(BENE_IDENT_CD)

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

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

BIC

(BENE_IDENT_CD)

Beneficiary Identification Code (BIC) Table
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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_CD)

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
C = Conditional payment by Medicare; future reimbursement expected
D = Automobile no-fault (eff. 4/97; Prior to 3/94, also included any liability insurance)
E = Workers' compensation
F = Public Health Service or other federal agency (other than Dept. of Veterans Affairs)
G = Working disabled bene (under age 65 with LGHP)
H = Black Lung
I = Dept. of Veterans Affairs
J = Any liability insurance (eff. 3/94 - 3/97)
L = Any liability insurance (eff. 4/97) (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)

M = Override code: EGHP services involved (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)

N = Override code: non-EGHP services involved (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)

BLANK = Medicare is primary payer (not sure of effective date: in use 1/91, if not earlier)

T = MSP cost avoided - IEQ contractor (eff. 7/96 carrier claims only)
U = MSP cost avoided - HMO rate cell adjustment contractor (eff. 7/96 carrier claims only)
V = MSP cost avoided - litigation settlement contractor (eff. 7/96 carrier claims only)

X = MSP cost avoided override code (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)

PRPAY_CD

(BENE_PRMRY_PYR_CD)

Beneficiary Primary Payer Table

Prior to 12/90

Y = Other secondary payer investigation shows Medicare as primary payer

Z = Medicare is primary payer

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

PMTDNLCD

(CARR_CLM_PMT_DNL_CD)

Carrier Claim Payment Denial Table

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

PRV_TYPE

(CARR_LINE_PRVDR_TYPE_CD)

Carrier Line Provider Type Table

For Physician/Supplier (RIC O) Claims:

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

PRV_TYPE

(CARR_LINE_PRVDR_TYPE_CD)

Carrier Line Provider Type Table

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

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

ASTNT_CD

(CARR_LINE_RDCD_PHYSN_ASTNT_CD)

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_CD)

Carrier Number Table

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

FI_NUM (IN NCH, DME)

Carrier Number Table

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

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

DISP_CD — Claim Disposition Table

(CLM_DISP_CD)

01 = Debit accepted
02 = Debit accepted (automatic adjustment) applicable through 4/4/93
03 = Cancel accepted
61 = *Conversion code: debit accepted
62 = *Conversion code: debit accepted (automatic adjustment)
63 = *Conversion code: cancel accepted

*Used only during conversion period: 1/1/91 - 2/21/91

FAC_TYPE — Claim Facility Type Table

(CLM_FAC_TYPE_CD)

1 = Hospital
2 = Skilled nursing facility (SNF)
3 = Home health agency (HHA)
4 = Religious Nonmedical (Hospital) (eff. 8/1/00); prior to 8/00 referenced Christian Science (CS)
5 = Religious Nonmedical (Extended Care) (eff. 8/1/00); prior to 8/00 referenced CS
6 = Intermediate care
7 = Clinic or hospital-based renal dialysis facility
8 = Special facility or ASC surgery
9 = Reserved

FREQ_CD — Claim Frequency Table

(CLM_FREQ_CD)

0 = Non-payment/zero claims
1 = Admit thru discharge claim
2 = Interim - first claim
3 = Interim - continuing claim
4 = Interim - last claim
5 = Late charge(s) only claim
6 = Adjustment of prior claim
7 = Replacement of prior claim; eff 10/93, provider debit
8 = Void/cancel prior claim. eff 10/93, provider cancel
9 = Final claim -- used in an HH PPS episode to indicate the claim should be processed like debit/ credit adjustment to RAP (initial claim) (eff. 10/00)

FREQ_CD — Claim Frequency Table

(CLM_FREQ_CD)

A = Admission notice - used when hospice is submitting the HCFA-1450 as an admission notice - hospice NOE only
B = Hospice termination/revocation notice - hospice NOE only (eff 9/93)
C = Hospice change of provider notice - hospice NOE only (eff 9/93)
D = Hospice election void/cancel - hospice NOE only (eff 9/93)
E = Hospice change of ownership - hospice NOE only (eff 1/97)
F = Beneficiary initiated adjustment (eff 10/93)
G = CWF generated adjustment (eff 10/93)
H = HCFA generated adjustment (eff 10/93)
I = Misc adjustment claim (other than PRO or provider) - used to identify a debit adjustment initiated by HCFA or an intermediary - eff 10/93, used to identify intermediary initiated adjustment only
J = Other adjustment request (eff 10/93)
K = OIG initiated adjustment (eff 10/93)
M = MSP adjustment (eff 10/93)
P = Adjustment required by peer review organization (PRO)
X = Special adjustment processing - used for QA editing (eff 8/92)
Z = Hospital Encounter Data alternate submission (TOB '11Z') used for MCO enrollee hospital discharges 7/1/97-12/31/98; not stored in NCH. Exception: Problem in startup months may have resulted in this abbreviated UB-92 being erroneously stored in NCH.

TYPESRVC — Claim Service Classification Type Table

(CLM_SRVC_CLSFCTN_TYPE_CD)

For facility type code 1 thru 6, and 9

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

For facility type code 7

1 = Rural health
2 = Hospital based or independent renal dialysis facility
3 = Free-standing provider based federally qualified health center (eff 10/91)
4 = Other Rehabilitation Facility (ORF) and Community Mental Health Center (CMHC) (eff 10/91 - 3/97); ORF only (eff. 4/97)
5 = Comprehensive Rehabilitation Center (CORF)
6 = Community Mental Health Center (CMHC) (eff 4/97)
7-8 = Reserved for national assignment
9 = Other

For facility type code 8

1 = Hospice (non-hospital based)
2 = Hospice (hospital based)

TYPESRVC — Claim Service Classification Type Table

(CLM_SRVC_CLSFCTN_TYPE_CD)

3 = Ambulatory surgical center in hospital outpatient department
4 = Freestanding birthing center
5 = Critical Access Hospital (eff. 10/99) formerly Rural primary care hospital (eff. 10/94)
6-8 = Reserved for national use
9 = Other

TRANS_CD — Claim Transaction Table

(CLM_TRANS_CD)

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

Last Two digits in the HIC — Category Equatable Beneficiary Identification Code (BIC) Table

(CTGRY_EQTBL_BENE_IDENT_CD)

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

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

ACTIONCD — Fiscal Intermediary Claim Action Table

(FI_CLM_ACTN_CD)

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

FI_NUM(In Outpat.,HHA,Hosp) Fiscal Intermediary Number Table

(FI_NUM_CD)

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

FI_NUM(In Outpat.,HHA,Hosp) Fiscal Intermediary Number Table

(FI_NUM_CD)

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

CANCELCD

Claim Cancel Reason Code Table

(FI_RQST_CLM_CNCL_RSN_CD)

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

STATE_CD

State Table

(GEO_SSA_STATE_CD)

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

STATE_CD

State Table

(GEO_SSA_STATE_CD)

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

HCFASPEC — HCFA Provider Specialty Table

(HCFA_PRVDR_SPCLTY_CD)

Prior to 5/92

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

HCFASPEC — HCFA Provider Specialty Table

(HCFA_PRVDR_SPCLTY_CD)

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

HCFASPEC — HCFA Provider Specialty Table

(HCFA_PRVDR_SPCLTY_CD)

62 = Psychologist--billing independently
63 = Portable X-ray supplier--billing independently (revised 10/91 to mean portable X-ray supplier)
64 = Audiologist (billing independently)
65 = Physical therapist (independent practice)
66 = Rheumatology (added 10/91)
67 = Occupational therapist--independent practice
68 = Clinical psychologist
69 = Independent laboratory--billing independently (revised 10/91 to mean independent clinical laboratory -- billing independently)
70 = Clinic or other group practice, except Group Practice Prepayment Plan (GPPP)
71 = Group Practice Prepayment Plan - diagnostic X-ray (do not use after 1/92)
72 = Group Practice Prepayment Plan - diagnostic laboratory (do not use after 1/92)
73 = Group Practice Prepayment Plan - physiotherapy (do not use after 1/92)
74 = Group Practice Prepayment Plan - occupational therapy (do not use after 1/92)
75 = Group Practice Prepayment Plan - other medical care (do not use after 1/92)
76 = Peripheral vascular disease (added 10/91)
77 = Vascular surgery (added 10/91)
78 = Cardiac surgery (added 10/91)
79 = Addiction medicine (added 10/91)
8O = Clinical social worker (1991)
81 = Critical care-intensivists (added 10/91)
82 = Ophthalmology, cataracts specialty (added 10/91; used only until 5/92)
83 = Hematology/oncology (added 10/91)
84 = Preventive medicine (added 10/91)
85 = Maxillofacial surgery (added 10/91)
86 = Neuropsychiatry (added 10/91)
87 = All other (e.g. drug and department stores) (revised 10/91 to mean all other suppliers)
88 = Unknown (revised 10/91 to mean physician assistant)
90 = Medical oncology (added 10/91)
91 = Surgical oncology (added 10/91)
92 = Radiation oncology (added 10/91)
93 = Emergency medicine (added 10/91)
94 = Interventional radiology (added 10/91)
95 = Independent physiological laboratory (added 10/91)
96 = Unknown physician specialty (added 10/91)
99 = Unknown--incl. social worker's psychiatric services (revised 10/91 to mean unknown supplier/provider)

Effective 5/92

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

HCFASPEC HCFA Provider Specialty Table

(HCFA_PRVDR_SPCLTY_CD)

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

HCFASPEC

(HCFA_PRVDR_SPCLTY_CD)

HCFA Provider Specialty Table
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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 Associiation, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier
64 = Audiologist (billing independently)
65 = Physical therapist (independently practicing)
66 = Rheumatology (eff 5/92)
Note: during 93/94 DMERC also used this to mean medical supply company with respiratory therapist
67 = Occupational therapist (independently practicing)
68 = Clinical psychologist
69 = Clinical laboratory (billing independently)
70 = Multispecialty clinic or group practice
71 = Diagnostic X-ray (GPPP) (not to be assigned after 5/92)
72 = Diagnostic laboratory (GPPP) (not to be assigned after 5/92)
73 = Physiotherapy (GPPP) (not to be assigned after 5/92)
74 = Occupational therapy (GPPP) (not to be assigned after 5/92)
75 = Other medical care (GPPP) (not to assigned after 5/92)
76 = Peripheral vascular disease (eff 5/92)
77 = Vascular surgery (eff 5/92)
78 = Cardiac surgery (eff 5/92)
79 = Addiction medicine (eff 5/92)
80 = Licensed clinical social worker
81 = Critical care (intensivists) (eff 5/92)
82 = Hematology (eff 5/92)
83 = Hematology/oncology (eff 5/92)
84 = Preventive medicine (eff 5/92)
85 = Maxillofacial surgery (eff 5/92)
86 = Neuropsychiatry (eff 5/92)
87 = All other suppliers (e.g. drug and department stores) (note: DMERC used 87 to mean department store from 10/93 through 9/94; recoded eff 10/94 to A7; NCH cross-walked DMERC reported 87 to A7.
88 = Unknown supplier/provider specialty (note: DMERC used 87 to mean grocery store from 10/93 - 9/94; recoded eff 10/94 to A8; NCH cross-walked DMERC reported 88 to A8.
89 = Certified clinical nurse specialist
90 = Medical oncology (eff 5/92)
91 = Surgical oncology (eff 5/92)
92 = Radiation oncology (eff 5/92)
93 = Emergency medicine (eff 5/92)
94 = Interventional radiology (eff 5/92)
95 = Independent physiological laboratory (eff 5/92)
96 = Optician (eff 10/93)
97 = Physician assistant (eff 5/92)
98 = Gynecologist/oncologist (eff 10/94)
99 = Unknown physician specialty
A0 = Hospital (eff 10/93) (DMERCs only)
A1 = SNF (eff 10/93) (DMERCs only)
A2 = Intermediate care nursing facility (eff 10/93) (DMERCs only)
A3 = Nursing facility, other (eff 10/93) (DMERCs only)

HCFASPEC

(HCFA_PRVDR_SPCLTY_CD)

HCFA Provider Specialty Table

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

HCFATYPE — HCFA Type of Service Table
(HCFA_TYPE_SRVC_CD)

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

DOCINDCD — Line Additional Claim Documentation Indicator Table
(LINE_ADDTNL_CLM_DCMTN_IND_CD)

0 = No additional documentation
1 = Additional documentation submitted for non-DME EMC claim
2 = CMN/prescription/other documentation submitted
which justifies medical necessity
3 = Prior authorization obtained and approved
4 = Prior authorization requested but not approved
5 = CMN/prescription/other documentation submitted
but did not justify medical necessity
6 = CMN/prescription/other documentation submitted
and approved after prior authorization rejected
7 = Recertification CMN/prescription/other documentation

PLCSRVC — Line Place Of Service Table
(LINE_PLC_SRVC_CD)

Prior To 1/92

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

Effective 1/92

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

PAYINDCD

(LINE_PMT_IND_CD)

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

PROINDCD

(LINE_PRCSG_IND_CD)

Line Processing Indicator Table

A = Allowed

B = Benefits exhausted
C = Noncovered care
D = Denied (existed prior to 1991; from BMAD)
I = Invalid data
L = CLIA (eff 9/92)
M = Multiple submittal--duplicate line item
N = Medically unnecessary
O = Other
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided (contractor #88888) - voluntary agreement (eff. 1/98)
R = Reprocessed--adjustments based on subsequent reprocessing of claim
S = Secondary payer
T = MSP cost avoided - IEQ contractor (eff. 7/76)
U = MSP cost avoided - HMO rate cell adjustment (eff. 7/96)
V = MSP cost avoided - litigation settlement (eff. 7/96)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data match project
Z = Bundled test, no payment (eff. 1/1/98)

PRTCPTG
(LINE_PRVDR_PRTGPTG_IND_CD)

Line Provider Participating Indicator Table

1 = Participating
2 = All or some covered and allowed expenses applied to deductible Participating
3 = Assignment accepted/non-participating
4 = Assignment not accepted/non-participating
5 = Assignment accepted but all or some covered and allowed expenses applied to deductible Non-participating.
6 = Assignment not accepted and all covered and allowed expenses applied to deductible non-participating.
7 = Participating provider not accepting assignment.

RIC_CD
(NCH_NEAR_LINE_RIC_CD)

NCH Near-Line Record Identification Code Table

O = Part B physician/supplier claim record (processed by local carriers; can include DMEPOS services)
V = Part A institutional claim record (inpatient (IP), skilled nursing facility (SNF), christian science (CS), home health agency (HHA), or hospice)
W = Part B institutional claim record (outpatient (OP), HHA)
U = Both Part A and B institutional home health agency (HHA) claim records -- due to HHPPS and HHA A/B split. (effective 10/00)
M = Part B DMEPOS claim record (processed by DME Regional Carrier) (effective 10/93)

STUS_CD
(PTNT_DSCHRG_STUS_CD)

Patient Discharge Status Table

01 = Discharged to home/self care (routine

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

DED

(REV_CNTR_DDCTBL_COINSRNC_CD)

Revenue Center Deductible Coinsurance Code
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0 = Charges are subject to deductible and coinsurance
1 = Charges are not subject to deductible
2 = Charges are not subject to coinsurance
3 = Charges are not subject to deductible or coinsurance
4 = No charge or units associated with this revenue center code. (For multiple HCPCS per single revenue center code)

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

M = Override code; EGHP services involved (eff 12/90 for non-institutional claims; 10/93 for institutional claims)
N = Override code; non-EGHP services involved (eff 12/90 for non-institutional claims; 10/93 for institutional claims)
X = Override code: MSP cost avoided (eff 12/90 for non-institutional claims; 10/93 for institutional claims)

CEN

(REV_CNTR_CD)

Revenue Center Table

0001 = Total charge

0022 = SNF claim paid under PPS submitted as TOB 21X, effective for cost reporting periods beginning on or after 7/1/98 (dates of service after 6/30/98). NOTE: This code may appear multiple times on a claim to identify different HIPPS Rate Code/assessment periods.
0023 = Home Health services paid under PPS submitted as TOB 32X and 33X, effective 10/00. This code may appear multiple times on a claim to identify different HIPPS/Home Health Resource Groups (HRG).
0100 = All inclusive rate-room and board plus ancillary
0101 = All inclusive rate-room and board
0110 = Private medical or general-general classification
0111 = Private medical or general-medical/surgical/GYN
0112 = Private medical or general-OB
0113 = Private medical or general-pediatric
0114 = Private medical or general-psychiatric
0115 = Private medical or general-hospice
0116 = Private medical or general-detoxification
0117 = Private medical or general-oncology
0118 = Private medical or general-rehabilitation
0119 = Private medical or general-other
0120 = Semi-private 2 bed (medical or general) general classification
0121 = Semi-private 2 bed (medical or general) medical/surgical/GYN
0122 = Semi-private 2 bed (medical or general)-OB
0123 = Semi-private 2 bed (medical or general)-pediatric
0124 = Semi-private 2 bed (medical or general)-psychiatric
0125 = Semi-private 2 bed (medical or general)-hospice
0126 = Semi-private 2 bed (medical or general) detoxification
0127 = Semi-private 2 bed (medical or general)-oncology
0128 = Semi-private 2 bed (medical or general) rehabilitation
0129 = Semi-private 2 bed (medical or general)-other
0130 = Semi-private 3 and 4 beds-general classification
0131 = Semi-private 3 and 4 beds-medical/surgical/GYN
0132 = Semi-private 3 and 4 beds-OB
0133 = Semi-private 3 and 4 beds-pediatric
0134 = Semi-private 3 and 4 beds-psychiatric
0135 = Semi-private 3 and 4 beds-hospice
0136 = Semi-private 3 and 4 beds-detoxification
0137 = Semi-private 3 and 4 beds-oncology
0138 = Semi_private 3 and 4 beds-rehabilitation
0139 = Semi-private 3 and 4 beds-other
0140 = Private (deluxe)-general classification
0141 = Private (deluxe)-medical/surgical/GYN
0142 = Private (deluxe)-OB
0143 = Private (deluxe)-pediatric
0144 = Private (deluxe)-psychiatric
0145 = Private (deluxe)-hospice
0146 = Private (deluxe)-detoxification
0147 = Private (deluxe)-oncology
0148 = Private (deluxe)-rehabilitation
0149 = Private (deluxe)-other
0150 = Room&Board ward (medical or general) general classification
0151 = Room&Board ward (medical or general) medical/surgical/GYN
0152 = Room&Board ward (medical or general)-OB
0153 = Room&Board ward (medical or general)-pediatric
0154 = Room&Board ward (medical or general)-psychiatric
0155 = Room&Board ward (medical or general)-hospice
0156 = Room&Board ward (medical or general)-detoxification
0157 = Room&Board ward (medical or general)-oncology
0158 = Room&Board ward (medical or general)-rehabilitation
0159 = Room&Board ward (medical or general)-other
0160 = Other Room&Board-general classification
0164 = Other Room&Board-sterile environment
0167 = Other Room&Board-self care
0169 = Other Room&Board-other
0170 = Nursery-general classification
0171 = Nursery-newborn level I (routine)
0172 = Nursery-premature newborn-level II (continuing care)

CEN — Revenue Center Table

(REV_CNTR_CD)

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

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

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
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
0349 = Nuclear medicine-other
0350 = Computed tomographic (CT) scan-general classification
0351 = CT scan-head scan
0352 = CT scan-body scan
0359 = CT scan-other CT scans
0360 = Operating room services-general classification
0361 = Operating room services-minor surgery
0362 = Operating room services-organ transplant, other than kidney
0367 = Operating room services-kidney transplant
0369 = Operating room services-other operating room services
0370 = Anesthesia-general classification
0371 = Anesthesia-incident to RAD and subject to the payment limit
0372 = Anesthesia-incident to other diagnostic service and subject to the payment limit
0374 = Anesthesia-acupuncture
0379 = Anesthesia-other anesthesia
0380 = Blood-general classification
0381 = Blood-packed red cells
0382 = Blood-whole blood
0383 = Blood-plasma
0384 = Blood-platelets
0385 = Blood-leukocytes
0386 = Blood-other components
0387 = Blood-other derivatives (cryopricipatates)
0389 = Blood-other blood

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(REV_CNTR_CD)

Revenue Center Table

0390 = Blood storage and processing-general

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

CEN Revenue Center Table
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(REV_CNTR_CD)

0531 = Osteopathic services-osteopathic therapy

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

CEN Revenue Center Table
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(REV_CNTR_CD)

0640 = Home IV therapy-general classification

(eff 10/94)
0641 = Home IV therapy-nonroutine nursing
(eff 10/94)
0642 = Home IV therapy-IV site care, central line
(eff 10/94)
0643 = Home IV therapy-IV start/change peripheral line
(eff 10/94)
0644 = Home IV therapy-nonroutine nursing, peripheral line
(eff 10/94)
0645 = Home IV therapy-train patient/caregiver, central
line (eff 10/94)
0646 = Home IV therapy-train disabled patient, central
line (eff 10/94)
0647 = Home IV therapy-train patient/caregiver, peripheral
line (eff 10/94)
0648 = Home IV therapy-train disabled patient, peripheral
line (eff 10/94)
0649 = Home IV therapy-other IV therapy services
(eff 10/94)
0650 = Hospice services-general classification
0651 = Hospice services-routine home care
0652 = Hospice services-continuous home care-1/2
0655 = Hospice services-inpatient care
0656 = Hospice services-general inpatient care
(non-respite)
0657 = Hospice services-physician services
0659 = Hospice services-other
0660 = Respite care (HHA)-general classification
(eff 9/93)
0661 = Respite care (HHA)-hourly charge/skilled nursing
(eff 9/93)
0662 = Respite care (HHA)-hourly charge/home health aide/
homemaker (eff 9/93)
0670 = OP special residence charges - general
classification
0671 = OP special residence charges - hospital based
0672 = OP special residence charges - contracted
0679 = OP special residence charges - other special
residence charges
0700 = Cast room-general classification
0709 = Cast room-other
0710 = Recovery room-general classification
0719 = Recovery room-other
0720 = Labor room/delivery-general classification
0721 = Labor room/delivery-labor
0722 = Labor room/delivery-delivery
0723 = Labor room/delivery-circumcision
0724 = Labor room/delivery-birthing center
0729 = Labor room/delivery-other
0730 = EKG/ECG-general classification
0731 = EKG/ECG-Holter moniter
0732 = EKG/ECG-telemetry (include fetal monitering 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

CEN Revenue Center Table
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(REV_CNTR_CD)

0802 = Inpatient renal dialysis-inpatient peritoneal

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

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0904 = Psychiatric/psychological treatments-activity

therapy (eff 4/94)
0909 = Psychiatric/psychological treatments-other
0910 = Psychiatric/psychological services-general classification
0911 = Psychiatric/psychological services-rehabilitation
0912 = Psychiatric/psychological services-day care-redefined 10/97 to less Intensive
0913 = Psychiatric/psychological services-night care redefined 10/97 to Intensive
0914 = Psychiatric/psychological services-individual therapy
0915 = Psychiatric/psychological services-group therapy
0916 = Psychiatric/psychological services-family therapy
0917 = Psychiatric/psychological services-biofeedback
0918 = Psychiatric/psychological services-testing
0919 = Psychiatric/psychological services-other
0920 = Other diagnostic services-general classification
0921 = Other diagnostic services-peripheral vascular lab
0922 = Other diagnostic services-electromyelogram
0923 = Other diagnostic services-pap smear
0924 = Other diagnostic services-allergy test
0925 = Other diagnostic services-pregnancy test
0929 = Other diagnostic services-other
0940 = Other therapeutic services-general classification
0941 = Other therapeutic services-recreational therapy
0942 = Other therapeutic services-education/training (include diabetes diet training)
0943 = Other therapeutic services-cardiac rehabilitation
0944 = Other therapeutic services-drug rehabilitation
0945 = Other therapeutic services-alcohol rehabilitation
0946 = Other therapeutic services-routine complex medical equipment
0947 = Other therapeutic services-ancillary complex medical equipment (eff 3/92)
0949 = Other therapeutic services-other
0951 = Professional Fees-athletic training
0952 = Professional Fees-kinesiotherapy
0960 = Professional fees-general classification
0961 = Professional fees-psychiatric
0962 = Professional fees-ophthalmology
0963 = Professional fees-anesthesiologist (MD)
0964 = Professional fees-anesthetist (CRNA)
0969 = Professional fees-other
0971 = Professional fees-laboratory
0972 = Professional fees-radiology diagnostic
0973 = Professional fees-radiology therapeutic
0974 = Professional fees-nuclear medicine
0975 = Professional fees-operating room
0976 = Professional fees-respiratory therapy
0977 = Professional fees-physical therapy
0978 = Professional fees-occupational therapy
0979 = Professional fees-speech pathology
0981 = Professional fees-emergency room
0982 = Professional fees-outpatient services
0983 = Professional fees-clinic
0984 = Professional fees-medical social services
0985 = Professional fees-EKG
0986 = Professional fees-EEG
0987 = Professional fees-hospital visit
0988 = Professional fees-consultation
0989 = Professional fees-private duty nurse
0990 = Patient convenience items-general classification
0991 = Patient convenience items-cafeteria/guest tray
0992 = Patient convenience items-private linen service
0993 = Patient convenience items-telephone/telegraph
0994 = Patient convenience items-tv/radio
0995 = Patient convenience items-nonpatient room rentals
0996 = Patient convenience items-late discharge charge
0997 = Patient convenience items-admission kits
0998 = Patient convenience items-beauty shop/barber
0999 = Patient convenience items-other

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(REV_CNTR_CD)

Revenue Center Table

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

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

Changes effective for providers entering
RUGS Demo Phase III as of 1/1/97 or later
9019 = Clinically complex- RUGS CA1/ADL index of 11
9020 = Clinically complex- RUGS CA2/ADL index of 11D
9021 = Clinically complex- RUGS CB1/ADL index of 12-16
9022 = Clinically complex- RUGS CB2/ADL index of 12-16D
9023 = Clinically complex- RUGS CC1/ADL index of 17-18
9024 = Clinically complex- RUGS CC2/ADL index of 17-18D
9025 = Special care- RUGS SSA/ADL index of 14
9026 = Special care- RUGS SSB/ADL index of 15-16
9027 = Special care- RUGS SSC/ADL index of 17-18
9028 = Extensive services- RUGS SE1/ADL index 7-18/1 procedure
9029 = Extensive services- RUGS SE2/ADL index 7-18/2 procedures
9030 = Extensive services- RUGS SE3/ADL index 7-18/3 procedures
9031 = Low rehabilitation- RUGS RLA/ADL index of 4-13
9032 = Low rehabilitation- RUGS RLB/ADL index of 14-18
9033 = Medium rehabilitation- RUGS RMA/ADL index of 4-7
9034 = Medium rehabilitation- RUGS RMB/ADL index of 8-14
9035 = Medium rehabilitation- RUGS RMC/ADL index of 15-18
9036 = High rehabilitation- RUGS RHA/ADL index of 4-7
9037 = High rehabilitation- RUGS RHB/ADL index of 8-12
9038 = High rehabilitation- RUGS RHC/ADL index of 13-18
9039 = Very High rehabilitation- RUGS RVA/ADL index of 4-8
9040 = Very high rehabilitation- RUGS RVB/ADL index of 9-15
9041 = Very high rehabilitation- RUGS RVC/ADL index of 16
9042 = Very high rehabilitation- RUGS RUA/ADL index of 4-8
9043 = Very high rehabilitation- RUGS RUB/ADL index of 9-15
9044 = Ultra high rehabilitation- RUGS RUC/ADL index of 16-18

BETOS

(BETOS_TB)

BETOS Table

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

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

BETOS

(BETOS_TB)

BETOS Table

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

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

SUP_TYPE — DMERC Line Supplier Type Table

DMERC_LINE_SUPLR_TYPE_TB

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

HCPCS — Claim SNF & HHA Health Insurance PPS Table

(CLM_HIPPS_TB)

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

AAA = Default: No assessment

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

CA1,CA2,CB1,CB2 = Clinically-complex conditions
CC1,CC2 (e.g., chemo, dialysis)

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

PA1,PA2,PB1,PB2 = Reduced physical functions
PC1,PC2,PD1,PD2
PE1,PE2

RHA,RHB,RHC,RLA = Low/medium/high rehabilitation
RLB,RMA,RMB,RMC

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

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

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

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

00 = No assessment completed
01 = Medicare 5-day full assessment/not an initial admission assessment
02 = Medicare 30-day full assessment
03 = Medicare 60-day full assessment
04 = Medicare 90-day full assessment
05 = Medicare Readmission/Return required assessment (eff. 10/2000)
07 = Medicare 14-day full or comprehensive assessment/ not an initial admission assessment
08 = Off-cycle Other Medicare Required Assessment (OMRA)
11 = Admission assessment AND Medicare 5-day (or readmission/return) assessment
17 = Medicare 14-day required assessment AND initial admission assessment (eff. 10/2000)
18 = OMRA replacing Medicare 5-day required assessment (eff. 10/2000)
28 = OMRA replacing Medicare 30-day required assessment (eff. 10/2000)
30 = Off-cycle significant change assessment (outside assessment window) (eff. 10/2000)
31 = Significant change assessment replaces Medicare 5-day assessment (eff. 10/2000)
32 = Significant change assessment replaces Medicare 30-day assessment
33 = Significant change assessment replaces Medicare 6--day assessment
34 = Significant change assessment replaces Medicare 90-day assessment
35 = Significant change assessment replaces a Medicare readmission/return assessment
37 = Significant change assessment replaces Medicare 14-day assessment
38 = OMRA replacing Medicare 60-day required assessment
40 = Off-cycle significant correction assessment of a prior assessment (outside assessment window) (eff. 10/2000)
41 = Significant correction of prior full assessment replaces a Medicare 5-day assessment
42 = Significant correction of prior full assessment replaces a Medicare 30-day assessment
43 = Significant correction of prior full assessment replaces a Medicare 60-day assessment

HCPCS Claim SNF & HHA Health Insurance PPS Table

(CLM_HIPPS_TB)

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

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

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**********Claim Home Health PPS HIPPS Table**********
********** KEY **********
Position 1 = 'H'
Position 2 = Clinical (A = MIN, B = LOW, C = MOD, D =HIGH)
Position 3 = Functional (E = MIN, F = LOW, G = MOD, H = HIGH, I = MAX)
Position 4 = Service (J = MIN, K = LOW, L = MOD, M = HIGH)
Position 5 = identifies which elements of the code were
computed or derived:
1 = 2nd, 3rd, 4th positions computed
2 = 2nd position derived
3 = 3rd position derived
4 = 4th position derived
5 = 2nd & 3rd positions derived
6 = 3rd & 4th positions derived
7 = 2nd & 4th positions derived
8 = 2nd, 3rd, 4th positions derived
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1 NOPAY_CD Claim Medicare Non-Payment Reason Table
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CLM_MDCR_NPMT_RSN_TB

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)
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)

1 ADMSRCE — Claim Source Of Inpatient Admission Table

CLM_SRC_IP_ADMSN_TB

For Inpatient/SNF Claims:

0 = ANOMALY: invalid value, if present, translate to '9'
1 = Physician referral - The patient was admitted upon the recommendation of a personal physician.
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 physician.
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.

For Newborn Type of Admission

1 = Normal delivery - A baby delivered with out complications.
2 = Premature delivery - A baby delivered with time and/or weight factors qualifying it for premature status.
3 = Sick baby - A baby delivered with medical complications, other than those relating to premature status.
4 = Extramural birth - A baby delivered in a nonsterile environment.
5-8 = Reserved for national assignment.
9 = Information not available.

1 ADMTYPE — Claim Inpatient Admission Type Table

CLM_IP_ADMSN_TYPE_TB

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.
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.