COL	FIELD	LENGTH	NOTES
1	NEAR-LINE RECORD IDENTIFICATION CODE (3) **(ric_cd)**	1	Claim Near-Line Record Identification Code O - Part B (CWFB) Physician/Supplier Claim Record 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) M - Part B (CWFB) DMEPOS claim record (Effective 10/93) U - Both Part A and B institutional HHA claim records – due to HHPPS and HHA A/B split. (eff. 10/00)
2	NEAR-LINE RECORD VERSION (2) **(rec_lvl)**	1	Record version of Near-Line file storing Institutional or CWFB claims data. Record format as of: A - January 1991 B - April 1991 C - May 1991 D - January 1992 E - March 1992 F - May 1992 G - October 1993 H - September 1998 I - July 2000
3	ID **(regcase)**	11	Use first 10 characters only for SEER Cases
	SEER Cases		
3	REGISTRY	2	02 - Connecticut 20 - Detroit 21 - Hawaii 22 - Iowa 23 - New Mexico 25 - Seattle 26 - Utah 27 - Atlanta 33 - Arizona Indians 37 - Rural Georgia 42 - Kentucky 43 - Louisiana 44 - New Jersey 88 - California

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COL	FIELD	LENGTH	NOTES
5	CASE NUMBER	8	Encrypted SEER case #
13	FILLER	1	
	Non-cancer Patients		
3	HIC **(hicbic)**	11	
14	BENEFICIARY IDENTIFICATION CODE (BIC) (8) **(bic)**	2	Relationship between an individual and a primary Beneficiary. (Refer to Appendix table BIC)
16	SSA STANDARD STATE CODE (10) **(state_cd)**	2	State of Beneficiary's residence, SSA Standard Code. (Refer to Appendix table STATE_CD)
18	SSA STANDARD COUNTY CODE (30) **(cnty_cd)**	3	County of Beneficiary's residence, SSA Standard Code.
21	STATE SEGMENT CODE (9) **(st_sgmt)**	1	Segment of Near-Line file with Beneficiary's record for a specific service year. By ranges of county codes within the residence state.
22	MAILING CONTACT ZIP CODE (37) **(bene_zip)**	9	Beneficiary's mailing address zip code. *** Special Permission Required.**
31	SEX (38) **(sex)**	1	Sex of a Beneficiary. 1 - Male 2 - Female 0 - Unknown
32	RACE (39) **(race)**	1	Race of a Beneficiary. 1 - White 2 - Black 3 - Other 4 - Asian 5 - Hispanic 6 - North American Native 0 - Unknown
41	CWF BENEFICIARY MEDICARE STATUS (41) **(ms_cd)**	2	Medicare entitlement reason. 10 - Aged without ESRD 11 - Aged with ESRD 20 - Disabled without ESRD 21 - Disabled with ESRD 31 - ESRD only
51	CLAIM FROM DATE (11)	8	For Institutional or CWFB Claim,

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COL	FIELD	LENGTH	NOTES
	(from_dtm, from_dtd, from_dty)		firstday of Provider's or Physician/Supplier's billing statement. MMDDYYYY
59	CLAIM THROUGH DATE (12) **(thru_dtm,thru_dtd, thru_dty)**	8	Last day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
67	BENEFICIARY CWF LOCATION CODE (45) **(cwfloccd)**	1	Location where maintenance of Beneficiary's record, Common Working File (CWF), takes place. B - Mid-Atlantic C - Southwest D - Northeast E - Great Lakes F - Great Western G - Keystone H - Southeast I - South J - Pacific
68	CWF CLAIM ACCRETION DATE (14) **(acrtn_dtm, acrtn_dtd, acrtn_dty)**	8	Date claim is posted to the master record and payment is authorized. MMDDYYYY
76	CWF CLAIM ACCRETION NUMBER (15) **(acrtn_nm)**	4	Assigned to claim when posted. Indicates position of the claim within that day'sprocessing at the CWF host.
80	CLAIM DISPOSITION CODE (27) **(disp_cd)**	2	Outcome of Institutional processing. 01- Debit Accepted 02- Debit Accepted (Automatic Adjustment) 03- Void (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
82	CARRIER NUMBER (34) **(fi_num)**	5	Fiscal Intermediary/Carrier Identification Number. Assigned by HCFA to an Intermediary authorized to process claims from Providers or to a Carrier

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I file documentation.

COL	FIELD	LENGTH	NOTES
			authorized to process claims from Physician/Suppliers. (Refer to Appendix Table fi_num for NCH and DME)
102	CARRIER CLAIM RECEIPT DATE (31) **(rcpt_dtm, rcpt_dtd, rcpt_dty)**	8	Date claim received from the Provider or Physician/Supplier. MMDDYYYY
110	CARRIER CLAIM SCHEDULED PAYMENT DATE (32) **(schl_dtm, schl_dtd, schl_dty)**	8	Scheduled date of payment to the Provider, Physician or Supplier, as appearing on the original Institutional or CWFB claim sent to the CWF host. This date is considered to be the date paid. MMDDYYYY
118	CARRIER CLAIM ENTRY CODE (25) **(entry_cd)**	1	Generated by Carrier. 1 - *Original Debt 3 - Full Credit 5 - Replacement Debit 9 - Accrete bill history only (Internal; effective 2/22/91) *if Claim Disposition Code = 3,Entry Code = 1 means original debit was voided.
119	CARRIER CLAIM PAYMENT DENIAL CODE (48) **(pmtdnlcd)**	1	Indicates to whom payment was made, or if a claim was denied. (Refer to Appendix table PMTDNLCD)
120	CARRIER CLAIM PROVIDER ASSIGNMENT INDICATOR SWITCH(55) **(asgmntcd)**	1	Whether the provider accepts assignment for the INDICATOR SWITCH claim. A - Assigned claim N - Non-assigned claim
121	DMERC CLAIM ORDERING PHYSICIAN UPIN NUMBER (53) **(ord_upin)**	6	Unique Physician Identification Number (UPIN) UPIN NUMBER of physician ordering the Part B services/DMEPOS item. **Encrypted data. * Special permission required for unencrypted data.**
127	LINE HCFA PROVIDER SPEC CODE (101) **(hcfaspec)**	2	HCFA Specialty code used for pricing the service for this line item on the CWFB claim.

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I file documentation.

COL	FIELD	LENGTH	NOTES
			(Refer to Appendix table HCFASPEC)
129	LINE PROVIDER PART. INDICATOR CODE (102) **(prtcptg)**	1	Code indicating whether or not a provider is participating or accepting assignment for this line item on the Part B claim. 1 - Participating 2 - All or some covered and allowed expenses applied to deductible participating 3 - Assignment accepted/non participating 4 - Assignment not accepted/ non-participating 5 - Assignment accepted but all or some covered and allowed expenses applied to deductible non-participation 6 - Assignment not accepted and all covered and allowed expenses applied to deductible non-participating 7 - Participating provider not accepting assignment
130	LINE PROCESSING INDICATOR CODE (131) **(proindcd)**	1	The code indicating the reason a line item on the CWFB claim was allowed or denied. A - Allowed B - Benefits exhausted C - Non-covered care D - Denied (existed prior to 91 from BMAD) I - Invalid data L - CLIA (eff 9/92) M - Multiple submittal – duplicate line item N - Medically unnecessary O - Other P - Physician ownership denial (eff 3/92) Q - MSP cost avoided (contractor #88888) - voluntary agreement (eff 1/98) R - Reprocessed--adjustments based on subsequent reprocessing of claim S - Secondary payer T - MSP cost avoided - IEQ

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COL	FIELD	LENGTH	NOTES
			contractor U - MSP cost avoided - HMO rate cell adjustment (eff 7/96) V - MSP cost avoided - litigation settlement (eff 7/96) X - MSP cost avoided - generic Y - MSP cost avoided - IRS/SSA data match project Z - Zero payment; allowed tests (eff 1/1/98)
131	LINE PAYMENT 80/100% CODE (132) **(pay80cd)**	1	The code indicating that the amount shown in the payment field on the CWFB claim represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only. 0 - 80% 1 - 100% 3 - 100% limitation of liability only
132	LINE SERVICE DEDUCTIBLE INDICATOR SWITCH (133) **(dedind)**	1	Switch indicating whether or not the service reflected on the line item on the CWFB claim is subject to deductible. 0 - Service subject to deductible 1 - Service not subject to deductible
133	LINE PAYMENT INDICATOR CODE(134) **(payindcd)**	1	Code that indicates the payment screen used to determine the allowed charge for the line item on the CWFB claim. 1 - Actual charge 2 - Customary charge 3 - Prevailing charge 4 - Other 5 - Lab fee schedule 6 - Physician fee schedule (full fee schedule amt) 7 - Physician fee schedule (transition) 8 - Clinical psychologist fee schedule 9 - DME and prosthetics/ orthotics fee schedule (eff 4/97)
134	CARRIER MILES/TIME/UNITS/		

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COL	FIELD	LENGTH	NOTES
	SERVICES COUNT (135) **(mtuscnt)**	8	The count of the total units associated with services needing unit reporting such as transportation, miles, anesthesia time units, number of services, volume of oxygen or blood units. This is a line item on the CWFB claim and is used for both allowed and denied services.
142	CARRIER MILES/TIME/UNITS/SERVICES INDICATOR CODE (136) **(mtusind)**	1	Code indicating the units associated with services needing unit reporting on the line item for the CWFB claim. 0 - Values reported as zero 3 - Number of Services 4 - Oxygen volume units 6 - Drug Dosage
143	LINE HCPCS CODE (108) **(hcpcs)**	5	Health Care Financing Administration Common Procedure Coding System (HCPCS) code. Procedures, supplies, products or services provided to Medicare Beneficiaries. (Refer to Appendix table HCPCS)
148	LINE HCPCS INITIAL MODIFIER CODE (109) **(mfrcd1)**	2	First modifier to the procedure code to enable a more specific procedure ID for the claim. (Carrier Information file)
150	LINE HCPCS SECOND MODIFIER CODE (110) **(mfrcd2)**	2	Second modifier to enable a more specific procedure ID. (Carrier Information file)
152	LINE HCPCS THIRD MODIFIER CODE (111) **(mfrcd3)**	2	Third modifier to the HCPCS procedure code used to process the DMERC line item.
154	LINE HCPCS FOURTH MODIFIER CODE (112) **(mfrcd4)**	2	Fourth modifier to the HCPCS procedure code used to process the DMERC line item.
156	LINE SUBMITTED CHARGE AMOUNT (127) **(submamt)**	15.2	The amount of submitted charges reported on the line item on the CWFB claim.
171	LINE ALLOWED CHARGE	15.2	The amount of allowed charges

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COL	FIELD	LENGTH	NOTES
	AMOUNT (128) **(alowamt)**		reported on the line item on the CWFB claim.
192	LINE HCFA TYPE OF SERVICE CODE (104) **(hcfatype)**	1	Carrier's type of service code (usually different from HCFA's) used for pricing this service.
193	LINE PLACE OF SERVICE CODE (105) **(plcsrvc)**	2	Place of service for this procedure code. (Refer to Appendix table PLCSRVC)
195	LINE FIRST EXPENSE DATE (106) **(frexpenm, frexpend, frexpeny)**	8	Beginning date for this service. MMDDYYYY
203	LINE LAST EXPENSE DATE (107) **(lsexpenm, lsexpend, lsexpeny)**	8	Ending date for this service. MMDDYYYY
211	LINE SERVICE COUNT (103) **(srvc_cnt)**	4	Count of the total number of services processed.
215	LINE DIAGNOSIS CODE (137) **(linediag)**	5	ICD-9-CM code indicating diagnosis supporting this procedure/service.
220	LINE PAYMENT AMOUNT (117) **(linepmt)**	15.2	Amount of payment made to provider and/or beneficiary for the services covered
235	LINE BENEFICIARY PART B DEDUCTIBLE AMOUNT (120) **(ldedamt)**	15.2	The amount of money for which the intermediary or carrier has determined that the beneficiary is liable for the Part B deductible on the CWFB claim.
250	LINE BENEFICIARY PRIMARY PAYER PAID AMOUNT (122) **(lprpayat)**	15.2	Amount of a payment made on behalf of a medicare bene by a primary payer other than medicare, that the provider is applying to covered medicare charges on an CWFB claim.
265	LINE BENEFICIARY PRIMARY PAYER CODE (121) **(lprpaycd)**	1	Specifies a federal non-medicare program or other source that has primary responsibility for the payment of the medicare bene's medical bills.(Refer to Appendix

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COL	FIELD	LENGTH	NOTES
			table PRPAY_CD)
266	LINE INTEREST AMOUNT (124) **(lintamt)**	15.2	Amount of interest to be paid on this line item.
281	LINE ADDITIONAL CLAIM DOCUMENTATION INDICATOR CODE (139) **(docindcd)**	1	Code indicating additional claim documentation was submitted 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 - Re-certification CMN/ prescription/other documentation
282	CLAIM DIAGNOSIS CODES (92) (**dgnscd1-dgnscd4**)	5*4	Up to four 5 digit ICD-9 diagnosis codes. For persons with less than four codes the columns are blank filled.
302	BETOS CODE (113) **(betos)**	3	Berenson-Eggers type of service (Betos) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services. (Refer to Appendix table BETOS)
305	LINE NATIONAL DRUG CODE **(ndc_cd)**	11	The National drug code identifies the oral anti-cancer drugs.
316	YEAR OF FILE **(year)**	4	Year of the File.
320	SEGMENT LINK NUMBER (19)	10	An IMS generated number used

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COL	FIELD	LENGTH	NOTES
	(link_num)		to keep records/segments belonging to a specific claim together.
330	TOTAL SEGMENT COUNT (20) **(tot_seg)**	2	Total number of segments for each claim. (corresponds to the total number of original variable-length records for each claim. Max = 10).
332	SEGMENT NUMBER (21) **(seg_num)**	2	Number of each segment. (corresponds to original var-length record for this claim. Values 1 to 10).
334	TOTAL LINE COUNT (22) **(tot_line)**	3	The total number of Revenue Center lines associated with the claim.
337	DMERC LINE SUPPLIER TYPE CODE (99) **(sup_type)**	1	Code identifying the type of supplier furnishing the line item service on the DMERC claim. (Refer to Appendix table SUP_TYPE)
338	RECORD COUNT **(rec_count)**	3	Record count for claim
341	filler	1	

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