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 individual and a primary Social Security Administration 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 (36) **(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 (43) **(bene_zip)**	9	Beneficiary's mailing address zip code. *** Special Permission Required.**
31	SEX (44) **(sex)**	1	Sex of a Beneficiary. 1 - Male 2 - Female 0 - Unknown
32	RACE (45) **(race)**	1	Race of a Beneficiary. 1 - White 2 - Black 3 - Other 4 - Asian 5 - Hispanic 6 - North American Native 0 - Unknown
41	CWF MEDICARE STATUS (47) **(ms_cd)**	2	Medicare entitlement reason 10- Aged without ESRD 11- Aged with ESRD 20- Disabled without ESRD 21- Disabled with ESRD 31- ESRD only

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COL	FIELD	LENGTH	NOTES
43	DAILY PROCESS DATE (20) **(daily_dtm, daily_dtd, daily_dty)**	8	The date the claim record was processed by CMS's CWFMQA system. This date is used in conjunction with the Segment Link Number to keep claims with multiple records/segments together. MMDDYYYY
51	CLAIM FROM DATE (11) **(from_dtm, from_dtd from_dty)**	8	For Institutional or CWFB Claim, first day of Provider's or Physician/ Supplier's billing statement. MMDDYYYY
59	CLAIM THROUGH DATE (12) **(thru_dtm, thru_dtd thru_dtm)**	8	Last day of Provider's or Physician/Supplier's billing statement. MMDDYYYY
67	CWF LOCATION CODE(51) **(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) **(acrt_dtm, acrt_dtd, acrt_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's processing at the CWF host.
80	CLAIM DISPOSITION CODE (33) **(disp_cd)**	2	Outcome of Institutional processing 01- Debit Accepted 02- Debit Accepted(Automatic Adjustment) Applicable through April 4, 1993 03- Cancel Accepted 61- *Conversion Code: Debit Accepted

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COL	FIELD	LENGTH	NOTES
			62- *Conversion Code: Debit Accepted (Automatic Adjustment) 63- *Conversion Code: Cancel Accepted *used only during Conversion Period: 1/1/91 - 2/21/91
82	FI NUMBER (40) **(fi_num)**	5	Assigned by HCFA to an Intermediary or Carrier authorized to process claims from Providers or Physician/Suppliers. (Refer to Appendix table FI_NUM for HHA)
87	FI CLAIM RECEIPT DATE (37) **(rcpt_dtm, rcpt_dtd,rcpt_dty)**	8	Date claim received from the Provider or Physician/Supplier. MMDDYYYY
95	CLAIM PROCESS DATE (61) **(aprv_dtm, aprv_dtd, aprv_dty)**	8	Date processing completed and claim is released to the CWF host. MMDDYYYY
103	FI CLAIM SCHEDULED PAYMENT DATE (38) **(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
111	PROVIDER NUMBER (19) **(provider)**	6	ID of Medicare Provider certified to provide services to the Beneficiary. **Encrypted data. * Special permission required for unencrypted data.**
117	CLAIM QUERY CODE (18) **(query_cd)**	1	Payment type of claim being processed. 0 - Credit adjustment 1 - Interim bill 2 - Home Health Agency benefits exhausted (obsolete 7/98) 3 - Final bill 4 - Discharge notice (obsolete 7/98) 5 - Debit adjustment
118	CLAIM FACILITY TYPE CODE (28) **(fac_type)**	1	Facility that provided care. 1 - Hospital 2 - Skilled Nursing Facility (SNF) 3 - Home Health Association (HHA) 4 - Religious Nonmedical (Hospital) (eff. 8/1/00); prior to 8/00

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COL	FIELD	LENGTH	NOTES
			referenced Christian Science (CS) 5 - Religious Nonmedical Extended Care (eff. 8/1/00); prior to 8/00 referenced CS extended care 6 - Intermediate Care 7 - Clinic (Requires special informationin Service Classification Code) 8 - Special Facility or ASC Surgery (Requires special information in Service Classification Code) 9 - Reserved
119	CLAIM SERVICE CLASSIFICATION TYPE CODE (29) **(typesrvc)**	1	Classification of type of service provided to the Beneficiary. For facility type code 1-6 and 9 1 - Inpatient(including Part A) 2 - Inpatient(Part B only) or Home Health visits under Part B. 3 - Outpatient (HHA-A also) 4 - Other(Part B) 5 - Intermediate care - level 1 6 - Intermediate care - level 2 7 - Intermediate care - level 3 8 - Swing beds 9 - Reserved for national assignment. For facility type code 7 1 - Rural health 2 - Hospital based of independent renal dialysis facility 3 - Independent 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

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COL	FIELD	LENGTH	NOTES
			For facility type code 8 1 - Hospice (non-hospital based) 2 - Hospice (hospital based) 3 - Ambulatory surgical center 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
120	CLAIM FREQUENCY CODE (30) **(freq_cd)**	1	Sequence of claim in the Beneficiary's current episode of care associated with a given facility. 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 HHPPS episode to indicate the claim should be processed like debit/ credit adjustment to RAP (initial claim) (eff. 10/00) 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)

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COL	FIELD	LENGTH	NOTES
			I - Misc adjustment claim (other than PRO or provider) - used to identify a debit adjustment initiated by HCFA or an intermediary(eff 10/93) 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 used for MCO enrollee hospital discharges 7/1/97-12/31/98
121	PAYMENT AND EDIT RIC (26) **(pe_ric)**	1	Institutional claim originated on this type of form. C - Inpatient Hospital, SNF D - Outpatient E - Christian Science F - Home Health Agency (HHA) G - Discharge Notice I - Hospice
122	CLAIM TRANSACTION CODE(27) **(trans_cd)**	1	Type of claim submitted by Institutional Provider. 0 - Religious Nonmedical Health Care Institutions (RNHCI) bill (prior to 8/00, CS or state buy-in bill) 1 - Psychiatric or Dummy Psychiatric Hospital Facility bill 2 - Tuberculosis Hospital Facility bill 3 - General Care Hospital Facility bill or Dummy Lifetime Reserve Days (LRD) 4 - Regular SNF bill 5 - HHA bill 6 - Outpatient Hospital bill C - Comprehensive Rehabilitation Facility bill (CORF) - in the Home Health bill format (obsoleted 7/98) H - Hospice bill

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COL	FIELD	LENGTH	NOTES
136	CLAIM PAYMENT AMOUNT (56) **(pmt_amt)**	15.2	Made to Provider and/or Beneficiary from trust fund (after deductible and coinsurance amounts) for services covered by Institutional claim (does not include pass-through per diem or organ acquisition), or for services included as line item on CWFB Physician/Supplier claim. Does not include automatic adjustments.
151	CLAIM TOTAL CHARGE AMOUNT (91) **(tot_chrg)**	15.2	Total charges for all services included on the institutional claim.
203	CLAIM TREATMENT AUTHORIZATION NUMBER (82) **(authrztn)**	18	Assigned by medical reviewer and reported by Provider action taken after review of case. Designates treatment covered by bill has been authorized by the payer. Used by the intermediary and the Peer Review Organization.
221	PRIMARY PAYER CODE (58) **(prpay_cd)**	1	Federal non-Medicaid program or other source with primary responsibility for payment of Beneficiary's medical bills.(Refer to Appendix table PRPAY_CD)
222	PRIMARY PAYER CLAIM PAID AMOUNT (57) **(prpayamt)**	15.2	Made on behalf of Beneficiary by a primary payer other than Medicare. Provider is applying to covered Medicare charges on Institutional or CWFB claim.
237	FI CLAIM ACTION CODE (60) **(actioncd)**	1	Action requested by Intermediary to be taken on an Institutional claim. 1 - Original debit action (includes non-adjustment RTI correction items) - all regular bills. 2 - Cancel by credit adjustment - only in credit/debit pairs. 3 - Secondary debit adjustment - only in credit/debit pairs. 4 - Cancel only adjustment. 5 - Force action code 3. 6 - Force action code 2.

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COL	FIELD	LENGTH	NOTES
			8 - Benefits refused (For inpatient bills, 'R' Nonpayment Code must also be present). 9 - Payment requested (Bills that replace previously-submitted benefits-refused bills, action code 8. Debit/credit pair is not required. Inpatient bills should have 'P' Nonpayment Code).
238	FI REQUESTED CLAIM CANCEL REASON CODE (59) **(cancelcd)**	1	Reason an intermediary requested canceling a previously submitted institutional claim. C - Coverage transfer D - Duplicate billing H - Other or blank L - Combining 2 benefit periods or 2 Beneficiary master records P - Plan transfer S - Scramble For action code 4(eff. w/HHPPS 10/00) A - RAP/Final claim/LUPA is cancelled by intermediary. Does not delete episode. Do not set cancellation indicator. B - RAP/Final claim/LUPA is cancelled by intermediary. Does not delete episode. Set cancellation indicator to 1. E - RAP/Final claim/LUPA is cancelled by intermediary. Remove episode. F - RAP/Final claim/LUPA is cancelled by Provider. Remove episode.
239	CLAIM ATTENDING PHYSICIAN UPIN NUMBER(64) **(at_upin)**	6	Institutional claim's state license number or other identifier (like UPIN, required since 1/92) of Physician expected to certify medical necessity of services rendered and/or has primary responsibility for Beneficiary's medical care and treatment. **Encrypted data. * Special permission required for unencrypted data.**

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COL	FIELD	LENGTH	NOTES
245	PATIENT DISCHARGE STATUS CODE (87) **(stus_cd)**	2	Status of Beneficiary as of Service Through Date on a claim. 01- Discharge to home/self care 02- Discharge/transferred to other short term general hospital for inpatient care. 03- Discharged/transferred to skilled SNF. 04- Discharged/transferred to intermediate care facility. 05- Discharged/transferred to another type of institution. 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 home IV drug therapy provider. 09- Admitted as an inpatient to this hospital. 20- Expired. 30- Still patient. 40- Expired at home. 41- Expired in medical facility. 42- Expired - place unknown. 50- Hospice - home. 51- Hospice - medical facility. 61- Discharged/transferred within this institution to a hospital-based Medicare approved swing bed. 71- Discharged/transferred/referred to another institution for outpatient services. 72- Discharged/transferred/referred to this institution for outpatient services.
247	CLAIM TOTAL LINE COUNT (24) **(hhrevcnt)**	3	The total number of Revenue Center lines associated with the claim.
250	REVENUE CENTER CODE (147) **(center)**	4	Cost center (division or unit within a hospital) for which a separate charge is billed (type of accommodation or ancillary). Assigned by Provider.(Refer to

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COL	FIELD	LENGTH	NOTES
			Appendix table CEN)
254	HCPCS CODE (154) **(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)
259	HCPCS INITIAL MODIFIER CODE (155) **(mf1)**	2	First modifier to the procedure code to enable a more specific procedure ID for the claim. (Carrier Information file)
261	HCPCS SECOND MODIFIER CODE (156) **(mf2)**	2	Second modifier to enable a more specific procedure ID. (Carrier Information file)
263	REVENUE CENTER UNIT COUNT (167) **(unit)**	8	A quantitative measure (unit) of services provided to a beneficiary associated with accommodation and ancillary revenue centers described on an institutional claim.
271	REVENUE CENTER RATE AMOUNT (168) **(rate)**	15.2	Charges relating to unit cost associated with the revenue center code.
286	REVENUE CENTER TOTAL CHARGE AMOUNT (180) **(charge)**	15.2	Total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided.
301	REVENUE CENTER DEDUCTIBLE COINSURANCE CODE (182) **(ded)**	1	Code indicating whether the revenue center charges are subject to deductible and/or coinsurance. 0 - Charges are subject to deductible and coinsurance 1 - Charges are not subject to deductible 2 - Charges are not subject to

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COL	FIELD	LENGTH	NOTES
			coinsurance 3 - Charges are not subject to deductible or coinsurance 4 - No charge or units associated with this 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)
302	DIAGNOSIS CODES (132) **(dgn_cd1-dgn_cd10)**	10*5	ICD-9-CM codes of any coexisting conditions shown in medical record as affecting services provided. Up to 10 codes may be listed, each with 5 digits.
352	YEAR OF FILE **(year)**	4	Year of the file
356	RECORD TYPE **(saf_ind)**	1	S - SAF record
357	SEGMENT LINK NUMBER (21) **(link_num)**	10	A system generated number used to keep records/segments belonging to a specific claim together. Use in conjunction with the daily date in column 43 to identify a specific claim.
367	TOTAL SEGMENT COUNT (22) **(tot_seg)**	2	Total number of segments for each claim.(corresponds to total number of original var-length recs for each claim. Max =10)
369	SEGMENT NUMBER (23) **(seg_num)**	2	Number of each segment. (corresponds to original var-length record for this claim. Values: 1 to 10)

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COL	FIELD	LENGTH	NOTES
371	RECORD COUNT (**rec_count**)	3	Counter for each claim.
374	Filler	1	

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