PALMETTO GBA®

A CELERIAN GROUP COMPANY

A CMS Medicare Administrative Contractor

Direct Data Entry (DDE) User's Guide

Section 2: Checking Beneficiary Eligibility

October 2020

TABLE OF CONTENTS

TABLE OF FIGURES

ACRONYMS

Acronym	Description
A	
ACS	Automated Correspondence System
ADR	Additional Development Request
ADJ	Adjustment
APC	Ambulatory Payment Classification
ASC	Ambulatory Surgical Center
ANSI	American National Standards Institute
B	
C	
CAH	Critical Access Hospital
CARC	Claim Adjustment Reason Code
CLIA	Clinical Laboratory Improvement Amendments of 1988
CMG	Case-mix Group
CMHC	Community Mental Health Center
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
CO	Contractual Obligation
CORF	Comprehensive Outpatient Rehabilitation Facility
CPT	Current Procedural Terminology
CWF	Common Working File
D	
DCN	Document Control Number
DDE	Direct Data Entry
DME	Durable Medical Equipment
DRG	Diagnosis Related Grouping
DSH	Disproportionate Share Hospital
E	
EDI	Electronic Data Interchange
EGHP	Employer Group Health Plan
EMC	Electronic Media Claims
ERA	Electronic Remittance Advice
ESRD	End Stage Renal Disease
F	
FDA	Food and Drug Administration
FI	Fiscal Intermediary
FISS	Fiscal Intermediary Standard System
FQHC	Federally Qualified Health Centers
G	
H	
HCPC	Healthcare Common Procedure Code
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHPPS	Home Health Prospective Payment System
HIPPS	Health Insurance Prospective Payment System (the coding system for home health claims)
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HRR	Hospital Readmission Reduction
HSA	Health Service Area
HSP	Hospital Specific Payment
HSR	Hospital Specific Rate
I	
ICD	Internal Classification of Diseases
ICN	Internal Control Number
IDE	Investigational Device Exemption
IEQ	Initial Enrollment Questionnaire
IME	Indirect Medical Education

Acronym	Description
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
J	
K	
L	
LGHP	Large Group Health Plan
LOS	Length of Stay
LTR	Lifetime Reserve days
M	
MA	Medicare Advantage Plan
MAC	Medicare Administrative Contractor
MCE	Medicare Code Editor
MID	Beneficiary's Medicare Number (formerly Health Insurance Claim Number)
MR	Medical Review
MSA	Metropolitan Statistical Area
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
N	
NDC	National Drug Code
NIF	Not in File
NPI	National Provider Identifier
O	
OCE	Outpatient Code Editor
OMB	Office of Management and Budget
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
ORF	Outpatient Rehabilitation Facility
OSC	Occurrence Span Code
OTAF	Obligated To Accept in Full
OT	Occupational Therapy
P	
PC	Professional Component
PHS	Public Health Service
PPS	Prospective Payment System
PR	Patient Responsibility
PRO	Peer Review Organization
PS&R	Provider Statistical and Reimbursement Report
PT	Physical Therapy
Q	
R	
RA	Remittance Advice
RHC	Rural Health Clinic
RTP	Return To Provider
S	
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SLP	Speech Language Pathology
SMSA	Standard Metropolitan Statistical Area
T	
TC	Technical Component
TOB	Type of Bill
U	
UB	Uniform Billing
UPC	Universal Product Code
UPIN	Unique Physician Identification Number
URC	Utilization Review Committee
V	
W	
X	
X-Ref	Cross-reference
Y	
Y2K	Year 2000
Z	

DIRECT DATA ENTRY (DDE) USER'S GUIDE BREAKDOWN

Refer to the following sections of the DDE User Guide for detailed information about using the DDE screens.

Section	Section Title	Descriptive Language
1	Introduction & Connectivity	This section introduces you to the Direct Data Entry (DDE) system, and provides a list of the most common acronyms as well navigational tips to include function keys, shortcuts, and common claim status and locations. This section also provides screen illustrations with instructions for signing on, the main menu display, signing off, and changing passwords.

Section	Section Title	Descriptive Language
2	Checking Beneficiary Eligibility	This section explains how to access beneficiary eligibility information via the Common Working File (CWF) screens, Health Insurance Query Access (HIQA) and Health Insurance Query for HHAs (HIQH), to verify and ensure correct information is submitted on your Medicare claim. Screen examples and field descriptors are also provided.
3	Inquiries (Main Menu Option 01)	This section provides screen illustrations and information about the inquiry options available in DDE, such as viewing inquiry screens to check the validity of diagnosis codes, revenue codes, and HCPCS codes, checking beneficiary/patient eligibility, check the status of claims, view Additional Development Requests (ADRs) letters, Medicare check history, and home health payment totals.
4	Claims & Attachments (Main Menu Option 02)	This section includes instructions, screen illustrations, and field descriptions on how to enter UB-04 claim information, including home health requests for anticipated payment (RAPs), hospice notice of elections (NOEs), and roster bill data entry.
5	Claims Correction (Main Menu Option 03)	This section provides instructions, screen illustrations, and field descriptions on how to correct claims that are in the Return to Provider (RTP) file, adjust or cancel finalized claims.
6	Online Reports (Main Menu Option 04)	This section provides information on certain provider-specific reports that are available through the DDE system.

This publication was current at the time it was published. Medicare policy may change so links to the source documents have been provided within the document for your reference.

This publication was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Any changes or new information superseding the information in this guide are provided in the Medicare Part A and Home Health and Hospice (HHH) Bulletins/Advisories with publication dates after September 2020. Medicare Part A and HHH Bulletins/Advisories are available at www.PalmettoGBA.com/medicare.

SECTION 2 – CHECKING BENEFICIARY ELIGIBILITY

This section explains how to access beneficiary eligibility information via the Common Working File (CWF) screens using the Health Insurance Query Access (HIQA) and Health Insurance Query for Home Health (HIQH), to verify and ensure correct information is submitted on your Medicare claim.

2.A. Health Insurance Query Access

The Health Insurance Query Access (HIQA) gives Medicare providers direct access to the CMS's CWF Host database. Providers may query a beneficiary/patient's Master Record. The beneficiary/patient's record contains Medicare entitlement, hospice benefit information, Medicare Advantage (MA) Plan [also known as Medicare health maintenance organization (HMO)] information, and other payer information. Each beneficiary/patient record is located at one of nine CWF Host sites.

CWF edits claims for validity, entitlement, remaining benefits, and deductible status. A reply from CWF will be returned the following day. The majority of claims will be accepted by CWF for remittance. Others will reject, open for recycle at a later date, or suspend for investigative action.

The objectives of the CWF are to provide:

- Complete beneficiary/patient information to Medicare contractors such as Palmetto GBA
- Entitlement data
- Utilization data
- Claim history
- Information in a timely manner via an online process
- Accurate initial claims processing with—
  - Deductible access
  - Coinsurance access
  - Part A and Part B benefits paid comparison
  - Check editing prepayment (so contractor's approval equals CMS acceptance)
  - Duplicate payments prevention
  - Efficient implementation of future benefits and enhancements changes

2.A.1 Part A CWF Send Process

The Medicare contractor or satellite uses its best available information on beneficiary/patient eligibility and remaining benefits to fully adjudicate claims. Every claim has been grouped, priced, and evaluated for Medicare Secondary Payer (MSP) involvement and has its final reimbursement (including interest when applicable) before it is sent. High Speed ***bulk data transfer*** transmits the Medicare contractor paid claim to the host for approval. Prior to ***SEND***, the Medicare contractor converts adjudicated claims from in-house format to CWF format. This is known as the ***best shot*** approach for bill payment. Claims awaiting CWF transmission reside in status/location **S B9000.**

2.A.2. Part A Response Process

Palmetto GBA maintains a holding file containing claims awaiting an initial CWF response (**S B9099**). No manual transaction can be made against these claims. Claims cannot be finally adjudicated until a definitive response is received from CWF, unless a manual function instructs the system to process the claim without being transferred to CWF. Responses aid in processing and proper adjudication of Medicare claims. The responses Palmetto GBA receives from the CWF are:

- CWF Edit Error codes that tell us a CWF response is ready to be worked (a 5-digit code appears in the lower left corner of the UB04 claim screen).
- A CWF Disposition Code, a 2-digit category or status of claim, that indicates:
  - Claim is approved

  - Claim is rejected
  - Claims will be retrieved from history
- Alert codes, CWF requests for investigation of overlapping benefits and eligibility status.
- Approved claims, Medicare contractor produced provider check and remittance advice.
- Rejected claims that require further investigation. Medicare contractor reviews these claims, makes corrections, and resubmits them to CWF.
- Recycled claims, which recycle automatically, back to CWF. The FISS status/location definitions are:
  S B90_0 = 1st transmission
  S B90_1 = 2nd transmission
  S B90_2 = additional transmissions

2.A.3. CWF Host Sites

The Centers for Medicare & Medicaid Services maintains centralized files on each Medicare beneficiary/patient with minimal eligibility and utilization data. Contractors query this file to process claims. **CWF** disperses the beneficiary/patient files into **nine regional host sites**.

GL – Great Lakes	MA – Mid-Atlantic	SE – Southeast	GW – Great Western	
Illinois	Indiana	Alabama	Idaho	North Dakota
Michigan	Maryland	Mississippi	Iowa	Oregon
Minnesota	Ohio	North Carolina	Kansas	South Dakota
Wisconsin	Virginia	South Carolina	Missouri	Utah
	West Virginia	Tennessee	Montana	Washington
			Nebraska	Wyoming
PA – Pacific	**SO – South**	**KS – Keystone**	**NE – Northeast**	**SW – Southwest**
Alaska	Florida	Delaware	Connecticut	Arkansas
Arizona	Georgia	New Jersey	Maine	Colorado
California		New York	Massachusetts	Louisiana
Hawaii		Pennsylvania	New Hampshire	New Mexico
Nevada			Rhode Island	Oklahoma
			Vermont	Texas

2.A.4. HIQA Inquiry Screen

Once you have successfully logged onto the DDE system, from the blank screen, type HIQA to access the inquiry screen. The CWF beneficiary/patient inquiry area will display (Figure 1). To access a beneficiary/patient's CWF Master Record, enter information into this screen.

Once you type HIQA, ELGA, ELGH or HIQH and press enter, a special message will display before beneficiary eligibility information is made available. This message will notify you that beginning in the fall of 2019, the Centers for Medicare & Medicaid Services (CMS) plans to terminate access to ELGA, ELGH, HIQA and HIQH for those who already use the HIPAA Eligibility Transaction System (HETS). This will affect clearinghouses, third-party billers, providers and other users.

You will need to press the "ENTER" key to acknowledge the message before eligibility information displays. If you use automation methods to obtain beneficiary eligibility information via ELGA, ELGH, HIQA and HIQH, you may need to modify your program in order to accept the message.

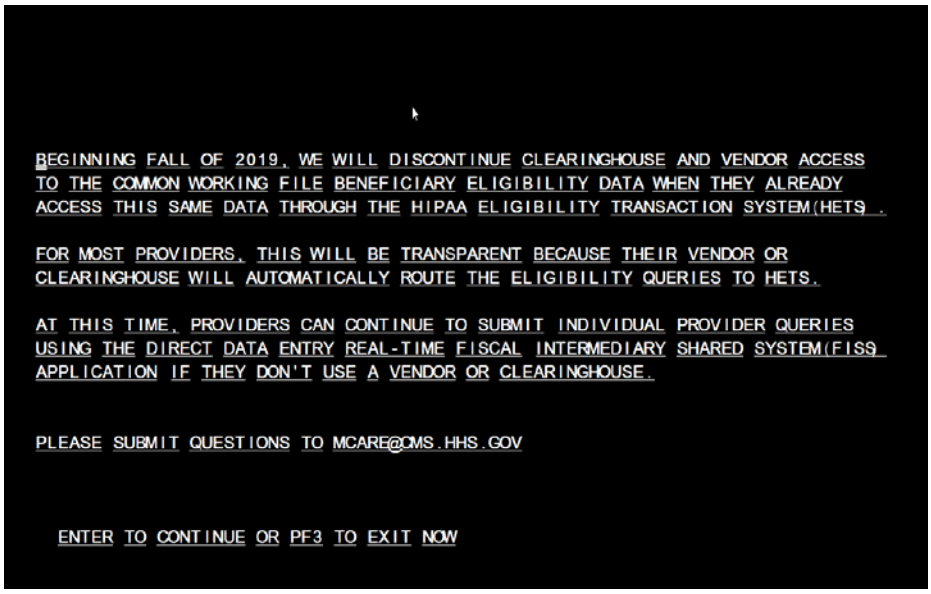


Figure 1 – CMS Notice

HIQA Inquiry Screen - Field definitions and completion requirements are provided in the table following Figure 1.

Figure 2 – CWF Beneficiary Inquiry Screen

Field Name	Description
RESPONSE CODE	Data in this field (a 'C' for Display on CRT) is automatically inserted by the system.
HIC/MBI NUMBER	Enter the beneficiary/patient's Medicare number as shown on the Medicare card in this field.
ELIG FROM DATE	This field identified the Eligibility THRU date inquired for the Beneficiary. This is an eight-position numeric field and values should be entered in MMDDCCYY format.
ELIG THRU DATE	This field identified the Eligibility THRU date inquired for the Beneficiary. This is an eight-position numeric field and values should be entered in MMDDCCYY format.
SURNAME	Enter the first six (6) letters of the beneficiary/patient's last name.
INITIAL	Enter the first initial of the beneficiary/patient's first name.

Field Name	Description
DATE OF BIRTH	Enter the beneficiary/patient's date of birth in MMDDCCYY format.
SEX CODE	Enter the beneficiary/patient's sex. Valid values are: F = Female M = Male
REQUESTOR ID	Identifies person submitting the inquiry or person requesting printed output. Enter '1' in this field.
PRINTER DEST	Leave this field blank (system default printer). This field is for the Printer device that the response will be directed to if a 'P' or 'E' is typed in the Response Code field.
INTER NO	Identifies the Medicare contractor processing the claim. Enter one of the following for a beneficiary/patient in Palmetto GBA's jurisdiction: ▪ 10111 = Part A Alabama ▪ 10211 = Part A Georgia ▪ 10311 = Part A Tennessee ▪ 11004 = Home health or hospice ▪ 11201 = Part A South Carolina ▪ 11301 = Part A Virginia ▪ 11401 = Part A West Virginia ▪ 11501 = Part A North Carolina
NPI NO	The 10-digit National Provider Identifier (NPI) number assigned to the provider rendering medical service to the beneficiary/patient.
HOST-ID	Host IDs are shown as two-letter abbreviations for the nine CWF host sites. You should access the appropriate host and enter one of the following designations: GL = Great Lakes GW = Great West KS = Keystone MA = Middle Atlantic PA = Pacific NE = Northeast SE = Southeast SO = South SW = Southwest
APP DATE	Date the beneficiary/patient was admitted to the hospital in MMDDYY format. This field is not required. However, entering a date will allow for the most recent information to be provided.
REASON CODE	Indicates the reason for the inquiry. Valid codes are: 1 = Status Inquiry 2 = Inquiry relating to an admission A '1' is automatically inserted in this field by the system. Change this only if applicable.

HIQA Page 1 - Field descriptions for Page 1 of the HIQA screen are provided in the table following Figure 3.

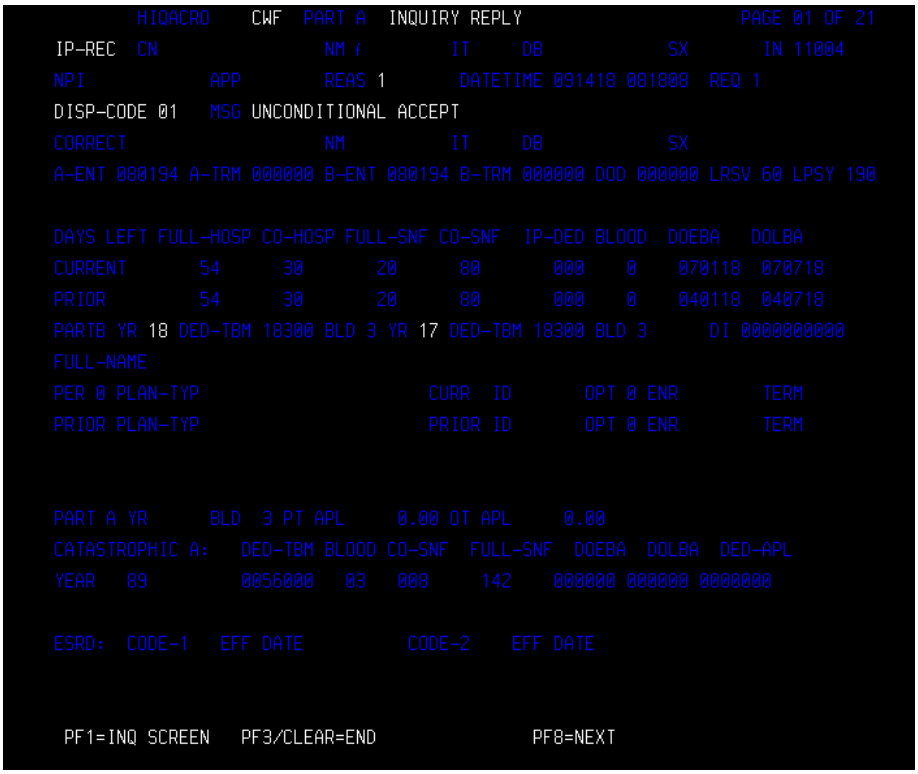


Figure 3 – CWF Part A Inquiry Reply Screen, Page 1

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
IN	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
NPI	**National Provider Identifier (NPI)** – The agency's NPI number used to access the record.
APP	**Applicable Date** – Used for spell determination.
REAS	**Reason Code** – Indicates the reason for the inquiry that was entered on the initial inquiry screen (see Figure 2).
DATETIME	**Date and Time Stamp** – date and time of the inquiry in Julian date format.
REQ	**Requestor ID** – auto populates

Field Name	Description
DISP-CODE	**Disposition Code** – Indicates a condition on a CABLE response. Valid values are: 01 = Part A Inquiry approved 02 = Part A Inquiry approved 03 = Part A Inquiry rejected 20 = Qualified approval but may require further investigation 25 = Qualified approval 50 = Not in file 51 = Not in file on CMS batch system 52 = Master record housed at another HOST site 53 = Not in file in CMS but sent to CMS's alpha-reinstate 55 = Does not match a master record ER = Consistency edit reject UR = Utilization edit CR = A/B crossover edit CI = CICS processing problem SV = Security violation
MSG	**Message** – The verbiage pertaining to the disposition code.
CORRECT	**Correct Claim Number** – Displays the beneficiary/patient's correct Medicare number. If the Medicare number entered in the inquiry screen (Figure 2) is different than the number in this field, this is the number you will use to submit claims.
NM	**Corrected Name** – This field displays the beneficiary/patient's correct name. The name in this field will be different only if the name entered in the inquiry screen (Figure 2) is not consistent with CMS's record.
IT	**Corrected Initial** – This field displays the beneficiary/patient's correct initial of the first name. The initial in this field will be different only if the initial entered in the inquiry screen (Figure 2) is not consistent with CMS's record.
DB	**Corrected Date of Birth** – This field displays the beneficiary/patient's correct date of birth. The date of birth in this field will be different only if the date of birth entered in the inquiry screen (Figure 2) is not consistent with CMS's record.
SX	**Corrected Sex Codes** – This field displays the beneficiary/patient's correct sex. The sex code in this field will be different only if the sex code entered in the inquiry screen (Figure 2) is not consistent with CMS's record.
A-ENT	**Part A Entitlement** – Date of entitlement to Part A benefits in a MMDDYY format.
A-TRM	**Part A Termination** – Indicates date of termination of Part A entitlement, when applicable, in a MMDDYY format. Otherwise, this field will display all zeros.
B-ENT	**Part B Entitlement** – Date of entitlement to Part B benefits in MMDDYY format.
B-TRM	**Part B Termination** – Indicates date of termination of Part B entitlement, when applicable, in MMDDYY format. Otherwise, this field will display all zeros.
DOD	**Date of Death** – If the beneficiary/patient is alive, the field will be all zeros.
LRSV	**Lifetime Reserve** – Shows the number of lifetime reserve days remaining.
LPSY	**Lifetime Psychiatric** – Shows the number of psychiatric days remaining.
DAYS LEFT FULL-HOSP	**Full Hospital Days Remaining** – Indicates the inpatient days remaining to be paid at full benefits.
CO-HOSP	**Coinsurance Hospital Days Remaining –** Indicates the impatient days remaining to be paid at coinsurance benefits.
FULL-SNF	**Full SNF Days Remaining** – Number of SNF days remaining to be paid at full benefits.
CO-SNF	**Coinsurance SNF Days Remaining** – Indicates the number of SNF days remaining to be paid at coinsurance benefits.
IP-DED	**Inpatient Deductible** – Amount of inpatient deductible remaining.
BLOOD	**Blood Deductible** – Number of pints blood deductible remaining.
DOEBA	**Date of Earliest Billing Action** – For this spell of illness.
DOLBA	**Date of Latest Billing Action** – For this spell of illness.
CURRENT	**Current Benefit Period** – applies to the remaining days, inpatient and blood deductible, DOEBA and DOLBA described above.

Field Name	Description
PRIOR	**Prior Benefit Period** – applies to the remaining days, inpatient and blood deductible, DOEBA and DOLBA described above.
PART B YR	**Most Recent Part B Year** – From the applicable date input field.
DED-TBM	**Deductible To Be Met –** Amount of the Part B cash deductible remaining to be met for the current year.
BLD	**Blood** – Part B blood deductible pints remaining to be met.
YR	**Year** – Next most recent Part B year.
DED-TBM	**Deductible to be Met**.
DI	**Data Indicators**. A. State Buy-In 0 = Does not apply 1 = State buy-in involved B. Alien Indicator 0 = Does not apply 1 = Alien nonpayment provision may apply C. Psychiatric Pre-entitlement 1 = Psychiatric pre-entitlement reduction applied D. Reason for entitlement 0 = Normal 1 = Disability 2 = End Stage Renal Disease (ESRD) 3 = Has or had ESRD, but has current DIB 4 = Old age, but has or had ESRD 8 = Has or had ESRD and is covered under premium Part A 9 = Covered under premium Part A
FULL NAME	Beneficiary/patient's full name.
PER	**Medicare Advantage (HMO) Period of Enrollment** – Code which indicates that the individual has had 1, 2, or 3 periods of enrollment in an HMO.
PLAN-TYP	**Medicare Advantage (HMO) Plan Type** – The type of plan the beneficiary/patient has.
CURR ID	**Medicare Advantage (HMO) Identification Code** – Valid values are: 1 Position = H 2 & 3 Position = State code 4 & 5 Position = HMO number within the state
OPT	**Medicare Advantage (HMO) Option Code** – Describes the beneficiary/patient's relationship with the HMO. Valid values are: 1 or 2 = HMO to process bills only for directly provided services and for service from providers with whom the HMO has effective arrangements. Palmetto GBA processes all other bills. C = HMO to process all bills.
ENR	**Medicare Advantage (HMO) Enrollment Date** – The date the beneficiary/patient enrolled in the MA plan.
TERM HMO	**Medicare Advantage (HMO) Termination Date** – The date the beneficiary/patient disenrolled from the MA plan.
PRIOR PLAN-TYP	**Prior Medicare Advantage (HMO) Plan type** – displays the prior type of plan the beneficiary/patient was enrolled in.
PRIOR ID	**Prior Medicare Advantage (HMO) Plan ID** – displays the prior plan ID.
OPT	**Prior Medicare Advantage (HMO) Option Enrollment Code** – displays the option code from a prior plan.
ENR	**Prior Medicare Advantage (HMO) Enrollment Date** – date the beneficiary/patient enrolled in prior plan.
TERM	**Prior Medicare Advantage (HMO) Termination Date** – date the beneficiary/patient disenrolled from a prior plan.
PART A YR	Current Part A impatient stay data.
BLD	**Blood** –Blood deductible pints remaining to be met.

Field Name	Description
PT APL	**Physical Therapy** – The Part B physical therapy amount remaining for the most recent Medicare Part B benefit year.
OT APL	**Occupational Therapy** – The Medicare Part B occupational therapy amount remaining for the most recent part B benefit year.
CATASTROPHIC A YEAR	This field identifies the catastrophic trailer year.
DED-TBM	**Deductible to be Met** – The amount of the deductible that still has to be met.
CO-SNF	**Coinsurance SNF Days Remaining** – The number of SNF coinsurance days remaining in the period.
FULL-SNF	**Full SNF Days Remaining** – the number of full SNF days remaining in the period.
DOEBA	**Date of Earliest Billing Action** – For this spell of illness.
DOLBA	**Date of Latest Billing Action** – For this spell of illness.
DED-APL	**Deductible Applied** – The amount of deductible applied for this period.
ESRD	**End Stage Renal Disease**
CODE-1	**ESRD Code 1** – The beneficiary/patient elected ESRD method 1, which means that the beneficiary/patient will receive all supplies and equipment for home-dialysis from an ESRD facility.
EFF DATE	**Effective Date** – The beneficiary/patient's ESRD effective date if he/she elected ESRD method 1.
CODE-2	**ESRD Code 2** – The beneficiary/patient elected ESRD method 2, which means that the beneficiary/patient will deal directly with one supplier for home dialysis supplies and equipment.
EFF DATE	**Effective Date** – The beneficiary/patient's ESRD effective date if he/she elected ESRD method 2.

HIQA Pages 2 - Field descriptions for Page 2 of the HIQA screen are provided in the table following Figure 4.

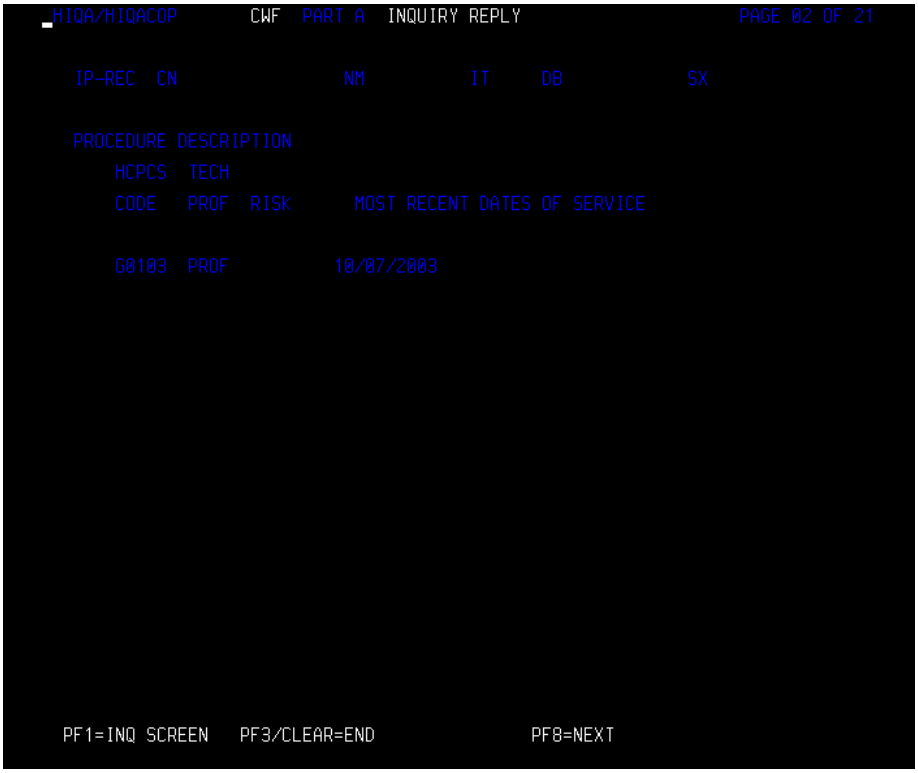


Figure 4 – CWF Part A Inquiry Reply Screen, Page 2

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
PROCEDURE DESCRIPTION	Technical and professional description of the HCPCS/procedure
HCPCS CODE	Healthcare Common Procedure Coding System (HCPCS) code of the procedure
TECH PROF	Technical or professional indicator
RISK	Not Used
MOST RECENT DATES OF SERVICE	Shows the three most recent dates of service for the HCPCS Technical and Professional codes.

HIQA Page 3 - Field descriptions for Page 3 of the HIQA screen are provided in the table following Figure 5.

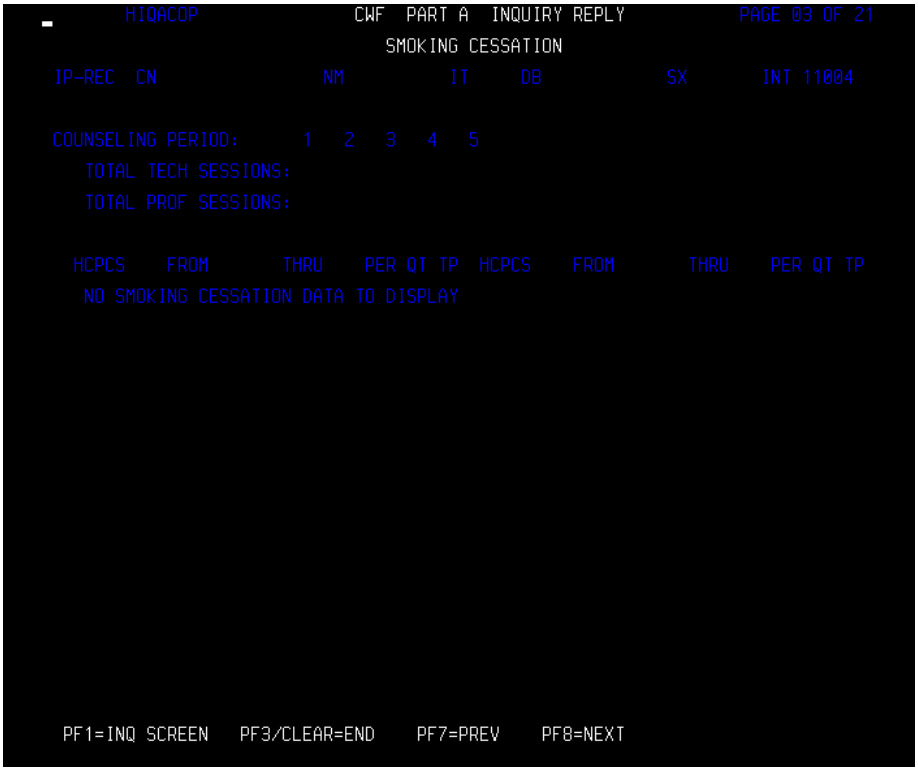


Figure 5 – CWF Part A Inquiry Reply Screen, Page 3

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
COUNSELING PERIOD	Identifies up to five years of counseling data. Valid values include: '1' = one year '2' = two years '3' = three years '4' = four years '5' = five years
TOTAL SESSIONS	Identifies the number of sessions billed for the beneficiary/patient.
HCPCS	HCPCS Code
FROM	From date of claim
THRU	Through date of claim
PER	Identifies up to five years of counseling data. Valid values include '1' = one year '2' = two years '3' = three years '4' = four years '5' = five years
QT	**Quantity** – The number of services billed for each date.

Field Name	Description
TP	Claim type

HIQA Page 4 - Field descriptions for Page 4 of the HIQA screen are provided in the table following Figure 6.

Figure 6 – CWF Part A Inquiry Reply Screen, Page 4

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
SPELL NUM	**Spell of Illness Number** – This number reflects the current home health spell of illness.
QUALIFYING IND	**Qualifying Stay Indicator** – This is a numeric field used to identify a qualifying A/B split hospitalization. Valid values are: 0 = No 1 = Yes
PART A VISITS REMAINING	The number of Part A visits remaining in the benefit period. Medicare Part A pays for the first 100 visits if a beneficiary/patient has a qualifying hospital stay, and if a beneficiary/patient is admitted to home health within 14 days of discharge. Medicare Part B pays for the remaining visits. In addition, Medicare Part B pays for all visits if there is no qualifying hospital stay (the patient must have Medicare Part B for Part B to reimburse for the services). If a beneficiary/patient has Medicare Part A only, then Part A will pay for all of their services.
EARLIEST BILLING	The date of the first bill submitted during the benefit period.
LATEST BILLING	The date of last bill submitted during the benefit period.
PARTB VISITS APPLIED	The number of visits reimbursed by Medicare Part B.

HIQA Page 5 - Field descriptions for Page 5 of the HIQA screen are provided in the table following Figure 7.

Figure 7 – CWF Part A Inquiry Reply Screen, Page 5

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
EPISODE START	The start date of a home health episode.
EPISODE END	The end date of a home health episode.
DOEBA	**Date of Earliest Billing Action** - the first service date of the HHPPS period.
DOLBA	**Date of Last Billing Action** - the last service date of the HHPPS period.

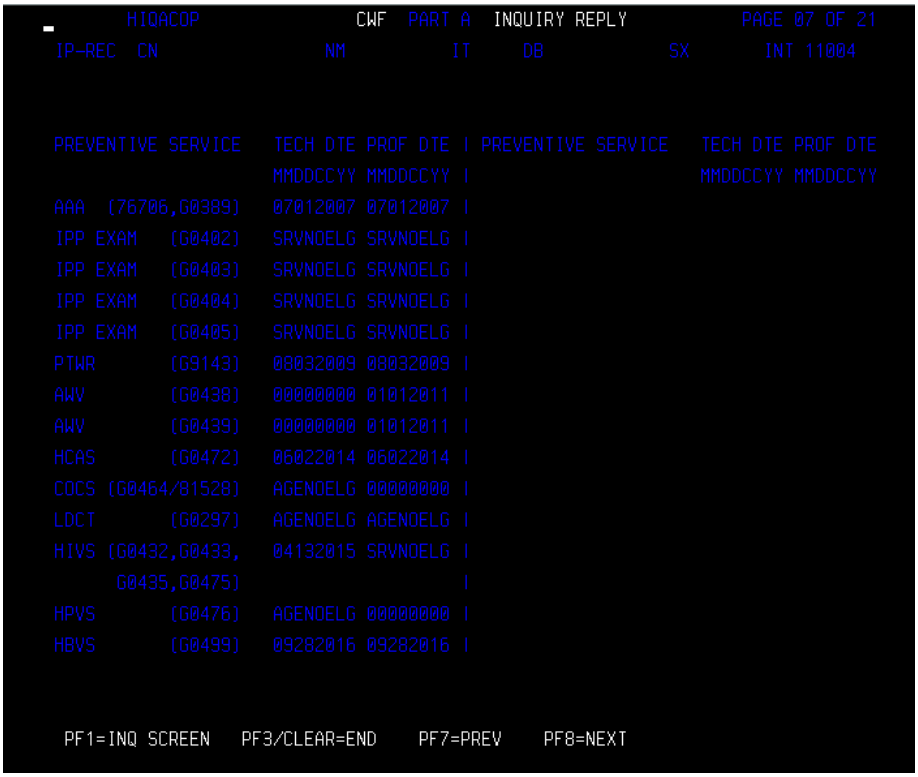
HIQA Pages 6 through 9 - Field descriptions for Page6 through 9 of the HIQA screens are provided in the table following Figure 8, Figure 9, Figure 10 and Figure 11.

```
HIQACOP              CWF  PART A  INQUIRY REPLY          PAGE 06 OF 21
IP-REC  CN              NM          IT     DB           SX       INT 11004


PREVENTIVE SERVICE   TECH DTE PROF DTE | PREVENTIVE SERVICE   TECH DTE PROF DTE
                     MMDDCCYY MMDDCCYY |                     MMDDCCYY MMDDCCYY
CARDIOVASC (80061)   01012005 01012005 | PCB EXAM   (G0101)   GDRNOELG GDRNOELG
CARDIOVASC (82465)   01012005 01012005 | PV 90732,90669,90670 VACCINTD VACCINTD
CARDIOVASC (83718)   01012005 01012005 | PROSTATE   (G0102)   01012000 01012000
CARDIOVASC (84478)   01012005 01012005 | PROSTATE   (G0103)   01012000 10012004
COLORECTAL (G0104)   01011998 01011998 | PAP TEST   (Q0091)   GDRNOELG GDRNOELG
COLORECTAL (G0105)   01011998 01011998 | DIABETES   (82947)   01012005 01012005
COLORECTAL (G0106)   01011998 01011998 | DIABETES   (82950)   01012005 01012005
COLORECTAL (G0120)   01011998 01011998 | DIABETES   (82951)   01012005 01012005
COLORECTAL (G0121)   07012001 07012001 | GLAU (G0117,G0118)   01012002 01012002
FOB TEST   (G0107)   01011998 01011998 | MAMM (G0202,G0203,   GDRNOELG GDRNOELG
FOB TEST   (G0328)   01012004 01012004 |       76092,77057,
FOB TEST   (82270)   01012007 01012007 |       77067)
IPP EXAM   (G0344)   SRVNOELG SRVNOELG | PAPT (P3000,G0123,   GDRNOELG GDRNOELG
IPP EXAM   (G0366)   SRVNOELG SRVNOELG |       G0143,G0144,
IPP EXAM   (G0367)   SRVNOELG 00000000 |       G0145,G0147,
IPP EXAM   (G0368)   00000000 SRVNOELG |       G0148)

 PF1=INQ SCREEN   PF3/CLEAR=END    PF7=PREV    PF8=NEXT
```

Figure 8 – CWF Part A Inquiry Reply Screen, Page 6



```
HIQACOP              CWF  PART A  INQUIRY REPLY          PAGE 07 OF 21
IP-REC  CN              NM          IT     DB           SX       INT 11004


PREVENTIVE SERVICE   TECH DTE PROF DTE | PREVENTIVE SERVICE   TECH DTE PROF DTE
                     MMDDCCYY MMDDCCYY |                     MMDDCCYY MMDDCCYY
AAA  (76706,G0389)   07012007 07012007 |
IPP EXAM   (G0402)   SRVNOELG SRVNOELG |
IPP EXAM   (G0403)   SRVNOELG SRVNOELG |
IPP EXAM   (G0404)   SRVNOELG SRVNOELG |
IPP EXAM   (G0405)   SRVNOELG SRVNOELG |
PTWR       (G9143)   08032009 08032009 |
AWV        (G0438)   00000000 01012011 |
AWV        (G0439)   00000000 01012011 |
HCAS       (G0472)   06022014 06022014 |
COCS (G0464/81528)   AGENOELG 00000000 |
LDCT       (G0297)   AGENOELG AGENOELG |
HIVS (G0432,G0433,   04132015 SRVNOELG |
      G0435,G0475)                     |
HPVS       (G0476)   AGENOELG 00000000 |
HBVS       (G0499)   09282016 09282016 |


 PF1=INQ SCREEN   PF3/CLEAR=END    PF7=PREV    PF8=NEXT
```

Figure 9 – CWF Part A Inquiry Reply Screen, Page 7

Figure 10 – CWF Part A Inquiry Reply Screen, Page 8

Figure 11 – CWF Part A Inquiry Reply Screen, Page 9

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.

Field Name	Description
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
Preventive Services	
CARDIOVASC	Cardiovascular
COLORECTAL	Colorectal
FOB TEST	Fecal Occult Blood Test
IPP EXAM	Initial Preventive Physical Examination
PCB EXAM	Pelvic and Clinical Breast Examination
PV	Pneumococcal Pneumonia Vaccine
PROSTATE	Prostate
PAP TEST	Pap Smear Test
DIABETES	Diabetes
GLAU	Glaucoma
MAMM	Mammography
PAPT	Pap Smear Test
AAA	Abdominal Aortic Aneurysm
PTWR	Pharmacogenomic Testing to Predict Warfarin Responsiveness
AWV	Annual Wellness Visit
HCAS	Hepatitis C Virus Screening
COCS	Colorectal Cancer Using Cologuard Screening - a multitarget stool DNA test
LDCT	Low Dose Computed Tomography screening for lung cancer
HIVS	Human Immunodeficiency Virus Screening
HPVS	Human Papillomavirus Screening
HBVS	Hepatitis B Virus Screening
BLANK	Healthcare Common Procedure Coding System (HCPCS) code for the preventive service
TECH DTE	Next eligible technical date for the preventive service listed
PROF DTE	Next eligible professional date for the preventive service listed

The TECH DTE and PROF DTE may show abbreviations in the MMDDYYYY field. Some common abbreviations that may occur include:

- AGENOELG – Beneficiary/patient not eligible due to age
- GDRNOELG – Beneficiary/patient not eligible due to gender
- NOPTBENT – Beneficiary/patient not entitled to Part B
- 00000000 – Service not applicable
- SRVNOELG – Beneficiary/patient not eligible for the service
- VACCINTD – Beneficiary/patient already vaccinated
- RECEIVED – Beneficiary/patient already received the service
- DODNOELG – Beneficiary/patient not eligible due to date of death

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
PROCEDURE DESCRIPTION	Technical and professional description of the HCPCS/procedure
HCPCS CODE	Healthcare Common Procedure Coding System (HCPCS) code of the procedure

Field Name	Description
TECH PROF	Technical or professional indicator
RISK	Not Used
MOST RECENT DATES OF SERVICE	Shows the three most recent dates of service for the HCPCS Technical and Professional codes.

HIQA Page 10 - Field descriptions for Page 10 of the HIQA screen are provided in the table following Figure 12.

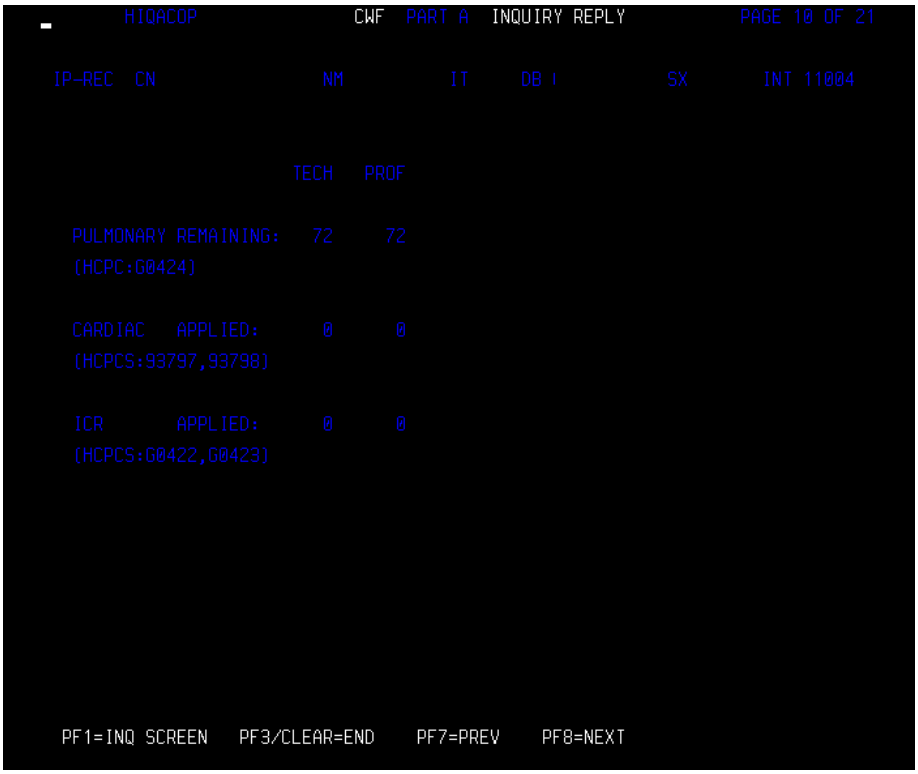


Figure 12 – CWF Part A Inquiry Reply Screen, Page 10

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
TECH	Technical
PROF	Professional
PULMONARY REMAINING	The total number of technical and professional Pulmonary Rehabilitation services remaining.
CARDIAC APPLIED	The total number of professional and technical Cardiac Rehabilitation services used.
ICR APPLIED	The total number of professional and technical Intensive Cardiac Rehabilitation services used.

HIQA Page 11 - Field descriptions for Page 11 of the HIQA screen are provided in the table following Figure 13.

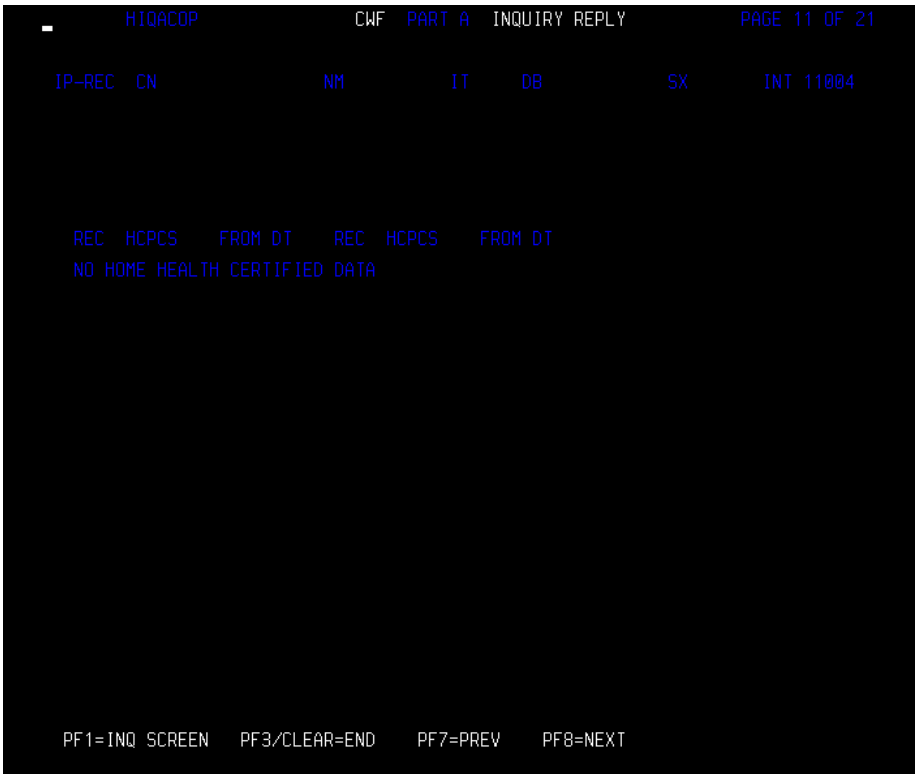


Figure 13 – CWF Part A Inquiry Reply Screen, Page 11

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
REC HCPCS	**Record HCPCS** – Identifies the HCPCS filed.
FROM DT	**From Date** – The home health certification from date.

HIQA Page 12 - Field descriptions for Page 12 of the HIQA screen are provided in the table following Figure 14.

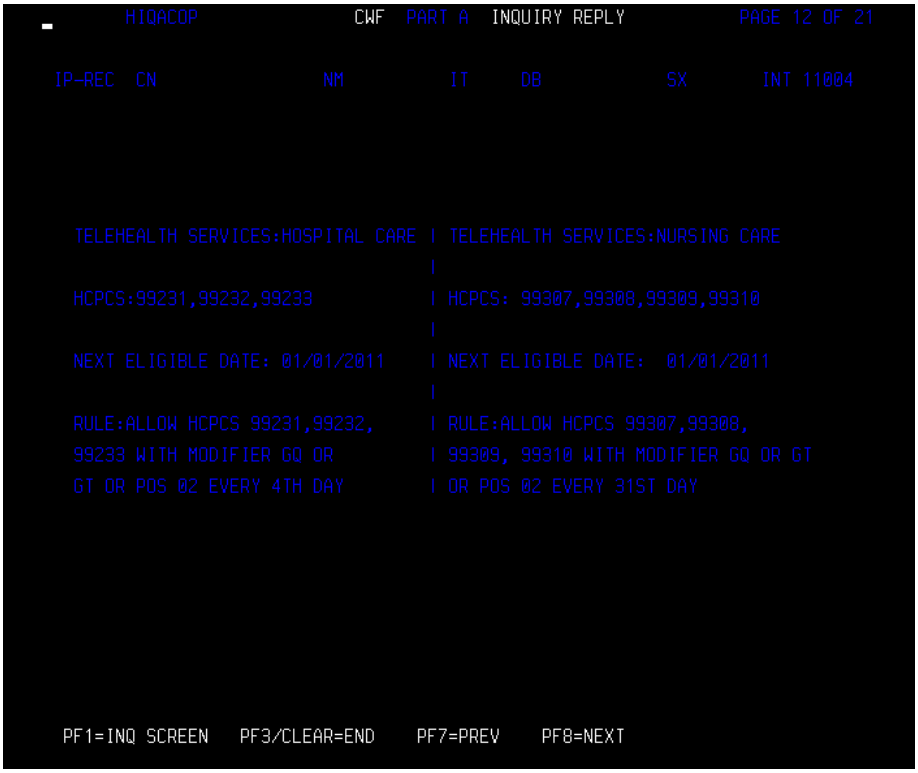


Figure 14 – CWF Part A Inquiry Reply Screen, Page 12

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
TELEHEALTH SERVICES: HOSPITAL CARE	Telehealth services rendered under hospital care.
TELEHEALTH SERVICES: NURSING CARE	Telehealth services rendered under nursing care.
HCPCS	The HCPCS codes billed.
NEXT ELIGIBILE DATE	The beneficiary/patient's next eligible date for services.
RULE	The Allowed HCPCS, with modifier and how often.

HIQA Page 13 - Field descriptions for Page 13 of the HIQA screen are provided in the table following Figure 15.

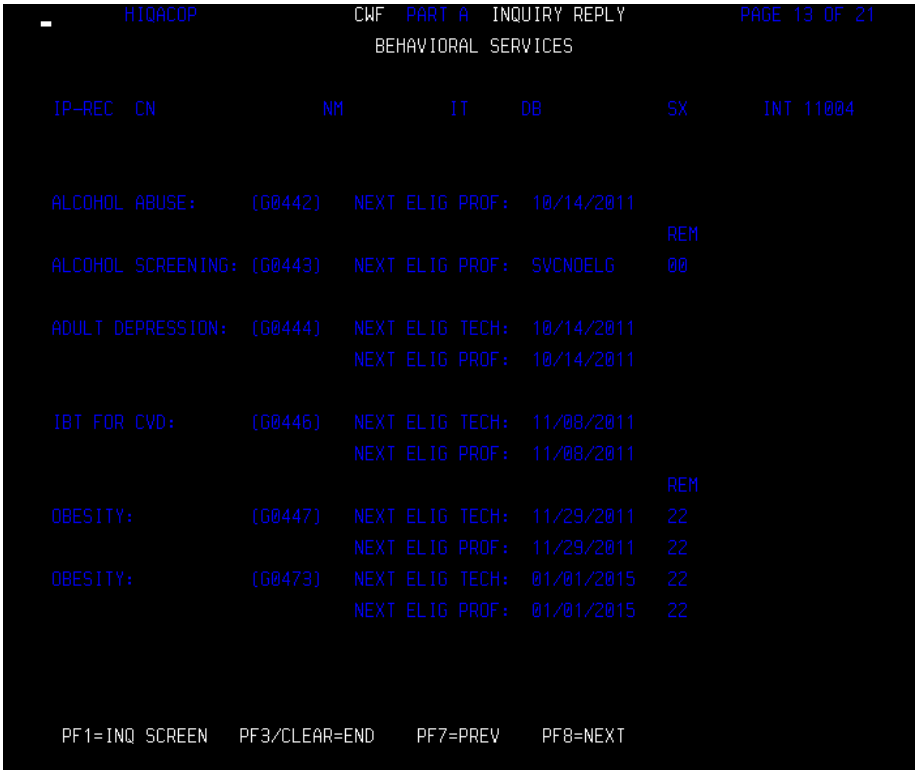


Figure 15 – CWF Part A Inquiry Reply Screen, Page 13

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
ALCOHOL ABUSE	This field identifies the HCPCS code billed for Alcohol abuse screening.
ALCOHOL SCREENING	This field identifies the HCPCS code billed for a face-to-face behavioral counseling for alcohol misuse.
ADULT DEPRESSION	This field identifies the HCPCS code billed for the annual depression screening.
IBT FOR CVD OBESITY	This field identifies the HCPCS code billed for **Intensive Behavioral Therapy (IBT) for Covered (CVD) Obesity**.
NEXT ELIG TECH	**Next Eligible Technical Date** – This field identifies the next date the patient is eligible for the technical component of the screening.
NEXT ELIG PROF	**Next Eligible Professional Date** – This field identifies the next date the patient is eligible for the professional component of the screening.

HIQA Page 14 - Field descriptions for Page 14 of the HIQA screen are provided in the table following Figure 16.

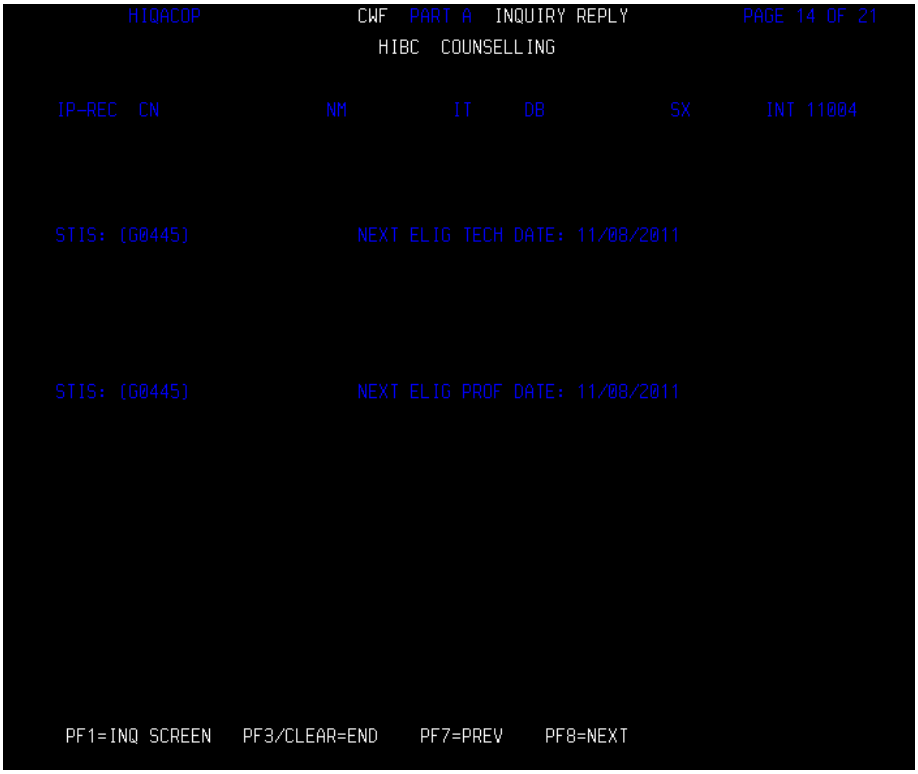


Figure 16 – CWF Part A Inquiry Reply Screen, Page 14

Field Name	Description
High Intensity Behavioral Counseling (HIBC) Counseling	
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
STIS	**Sexually Transmitted Infections** – This field identifies the codes billed for STI screening.
NEXT ELIG TECH DATE	**Next Eligible Technical Date** – This field identifies the next date the beneficiary/patient is eligible for the technical component of the screening.
NEXT ELIG PROF DATE	**Next Eligible Professional Date** – This field identifies the next date the beneficiary/patient is eligible for the professional component of the screening.

HIQA Page 15 - Field descriptions for Page 15 of the HIQA screen are provided in the table following Figure 17.

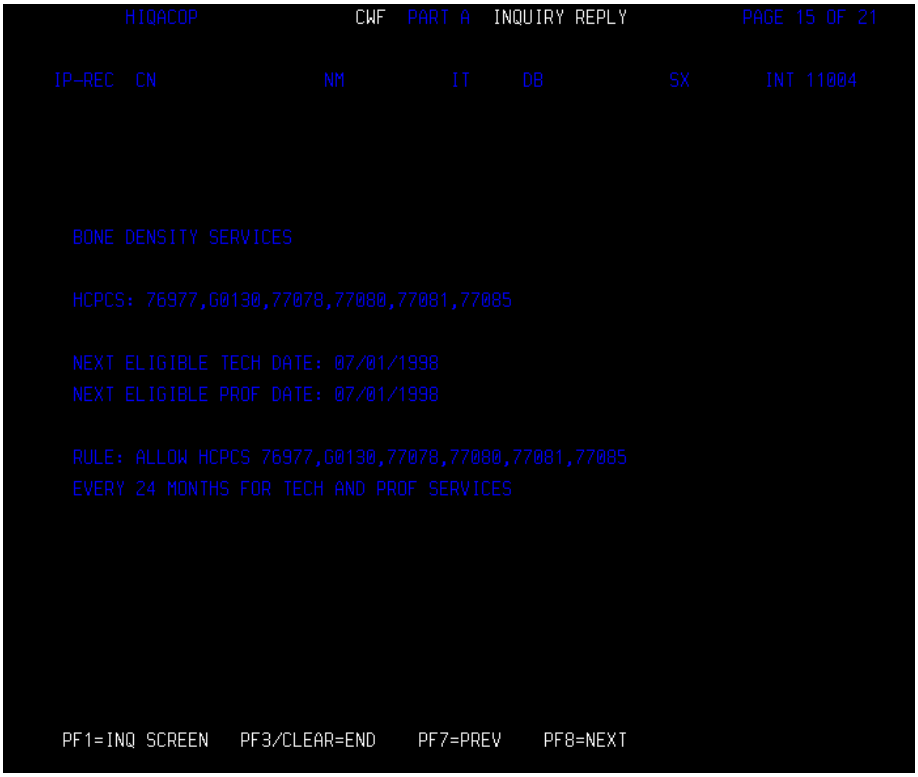


Figure 17 – CWF Part A Inquiry Reply Screen, Page 15

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
Bone Density Services	
HCPCS	This field identifies the HCPCS codes billed for the bone density services.
NEXT ELIGIBLE TECH DATE	This field reflects the next eligible date for the technical component of the bone density services.
NEXT ELIGIBLE PROF DATE	This field reflects the next eligible date for the professional component of the bone density services.
RULE	This field identifies the allowable HCPCS codes and how often for the bone density services.

HIQA Page 16 - Field descriptions for Page 16 of the HIQA screen are provided in the table following Figure 18.

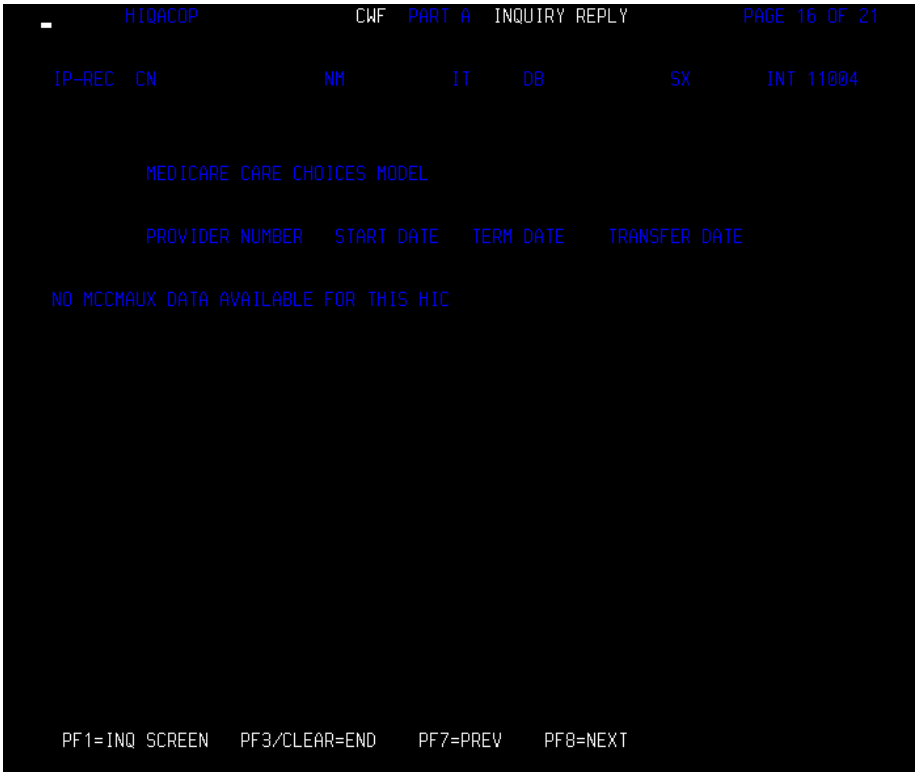


Figure 18 – CWF Part A Inquiry Reply Screen, Page 16

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
Medicare Care Choices Model Information	
PROVIDER NUMBER	This field identifies the provider number of the hospice that is providing care under the Medicare Care Choices Model (MCCM).
START DATE	This field identifies the start date of the beneficiary/patient MCCM enrollment.
TERM DATE	This field identifies the termination date of the beneficiary/patient MCCM enrollment.
TRANSFER DATE	This field identifies the date the beneficiary/patient transferred from one hospice to another during the MCCM enrollment.

HIQA Page 17 - Field descriptions for Page 17 of the HIQA screen are provided in the table following Figure 19.

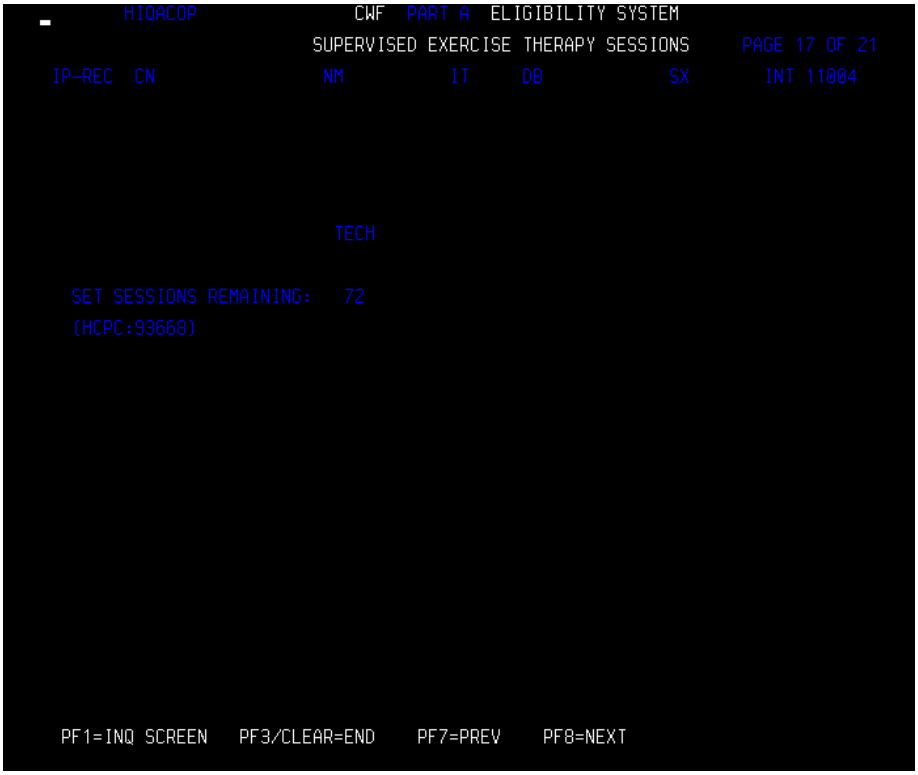


Figure 19 – CWF Part A Inquiry Reply Screen, Page 17

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
Supervised Exercise Therapy Sessions	
TECH	This is a heading only field. No data will be displayed in this field.
SET SESSIONS REMAINING	This field identifies the number Supervised Exercise Therapy (SET) sessions remaining. Up to 72 sessions are covered when medically necessary.
HCPC	This field displays the HCPC for SET sessions.

HIQA Page 18 - Field descriptions for Page 18 of the HIQA screen are provided in the table following Figure 20.

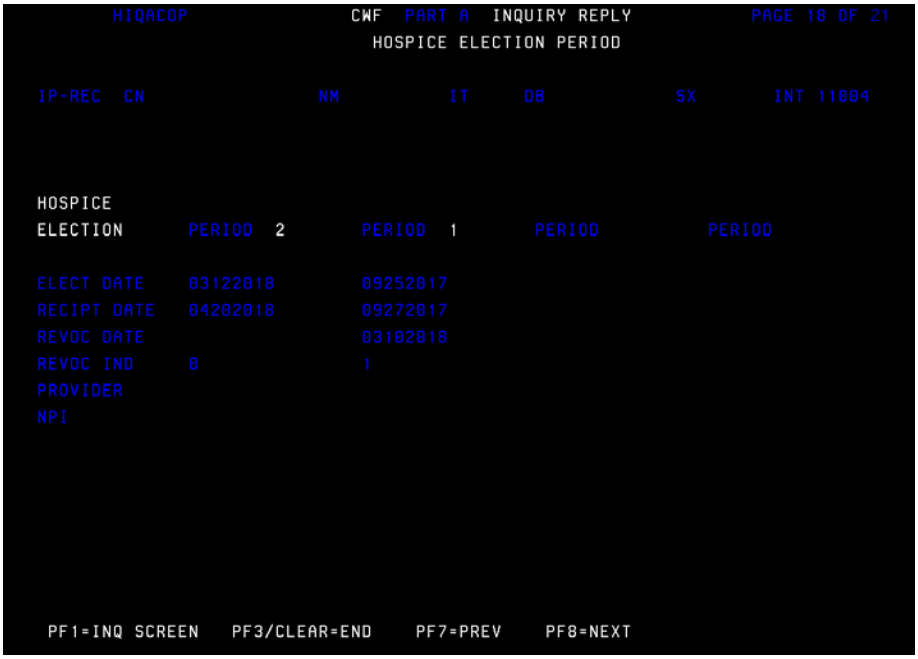


Figure 20 – CWF Part A Inquiry Reply Screen, Page 18

Field Name	Description
CN	**Claim Number** – The beneficiary/patient's Medicare number as it appears on the Medicare ID card.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
Hospice Election Period Data	
PERIOD	This field identifies the number of hospice elections the beneficiary/patient has.
ELECT DATE	The date the beneficiary/patient elected the Medicare hospice benefit as reported on the Notice of Election (NOE), Type of Bill (TOB) 8xA.
RECEIPT DATE	The date the NOE was received and accepted in the Medicare system.
REVOC DATE	The date the beneficiary/patient was discharged from or revoked the Medicare hospice benefit.
REVOC IND	**Revocation Indicator** – Indicates if a beneficiary/patient has revoked hospice benefits for the period. Valid values are: 0 = Beneficiary/patient has not revoked hospice benefits. 1 = Beneficiary/patient has revoked hospice benefits. 2 = Beneficiary/patient has revoked hospice benefits; record was manually updated by CWF at the request of the Medicare contractor.
PROVIDER	The provider from which the beneficiary/patient has elected for hospice benefits. This is the assigned Medicare provider number.
NPI	The 10-digit National Provider Identifier (NPI) number assigned to the provider rendering medical service to the beneficiary/patient.

HIQA Pages 19 and 20 - Field descriptions for Pages 19 and 20 of the HIQA screens are provided in the table following Figure 21 and Figure 22.

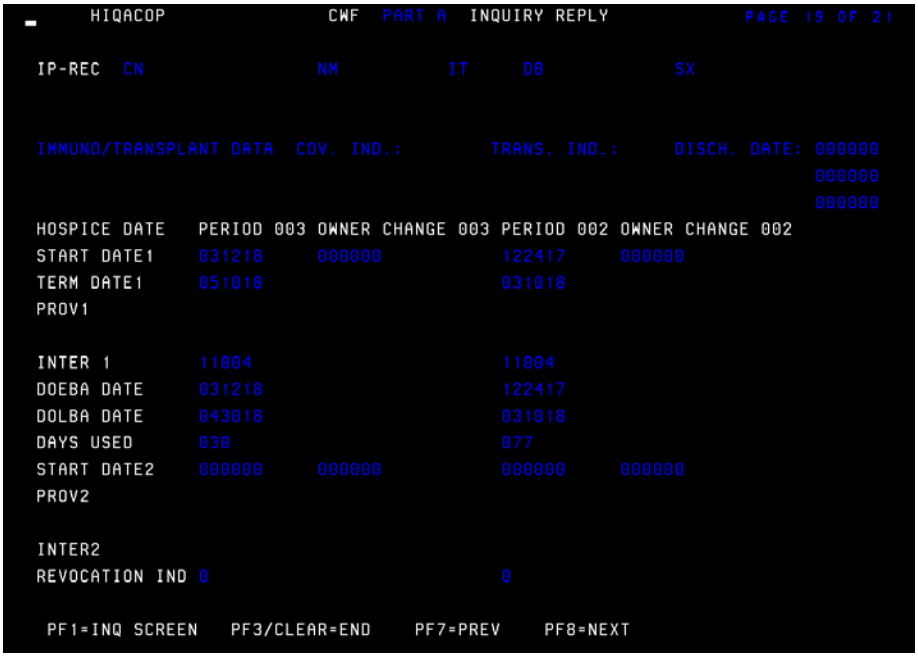


Figure 21 – CWF Part A Inquiry Reply Screen, Page 19

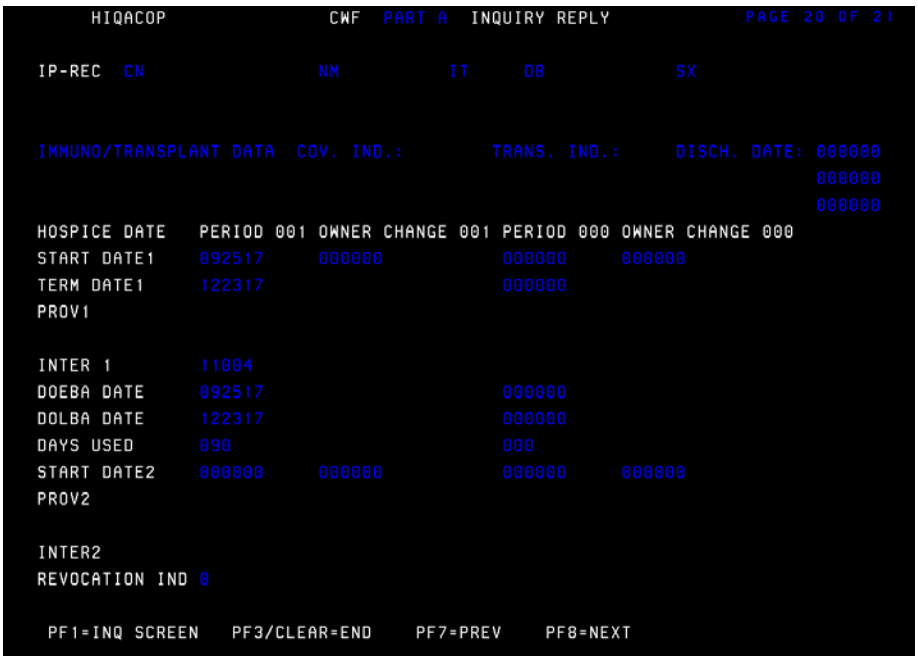


Figure 22 – CWF Part A Inquiry Reply Screen, Page 20

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.

Field Name	Description
TRANS IND	**Transplant Type Indicator** – Indicates the type of transplant surgery performed on the beneficiary/patient. Valid values are: 1 = Allograft bone marrow – transplant from another person 2 = Autograft bone marrow – transplant from beneficiary/patient H = Heart transplant K = Kidney transplant L = Liver transplant
DISCH DATE	**Discharge Date** – The date the beneficiary/patient was discharged from a hospital stay during which the indicated transplant occurred.
HOSPICE DATE	This is only a header. No data is displayed in this field.
PERIOD	Indicates the benefit period (e.g., 001, 002, 003, etc.) of the beneficiary/patient enrollment in the Medicare hospice benefit.
OWNER CHANGE	Indicates a change of ownership with the hospice. When no changes of ownership apply, the number will correspond with the 'Period' number.
START DATE1	The start date of a beneficiary/patient's period of hospice coverage.
TERM DATE 1	Indicates the termination/end of the hospice benefit period.
PROV1	**First Provider** – first provider the beneficiary/patient has elected for hospice benefits. This is the assigned Medicare provider number.
INTER1	**First Intermediary Number** – Indicator as to the Medicare contractor that is processing the Hospice claim.
DOEBA	Date of earliest billing action.
DOLBA	Date of last billing action.
DAYS USED	Lists the number of days used per benefit period.
START DATE2	Lists second start date if a beneficiary/patient elects to change hospices during a benefit period of if there is a hospice change of ownership.
PROV2	Indicates the Second provider to bill hospice claims when the beneficiary/patient chooses to change providers or if there is a hospice change of ownership during a benefit period.
INTER2	**Second Intermediary Number** – Indicator as to the Medicare contractor that is processing the hospice claim if the beneficiary/patient elects to change hospices or when there is a hospice change of ownership during a benefit period and claims are submitted to a different contractor.
REVOCATION IND	**Revocation Indicator** – Indicates if a beneficiary/patient has been discharged from or revoked hospice benefits for the period. Valid values are: 0 = Beneficiary/patient has not been discharged or revoked hospice benefits. 1 = Beneficiary/patient has been discharged or revoked hospice benefits. 2 = Beneficiary/patient has been discharged or revoked hospice benefits; record was manually updated by CWF at the request of the Medicare contractor.

HIQA Page 21 - Field descriptions for Page 21 of the HIQA screen are provided in the table following Figure 23

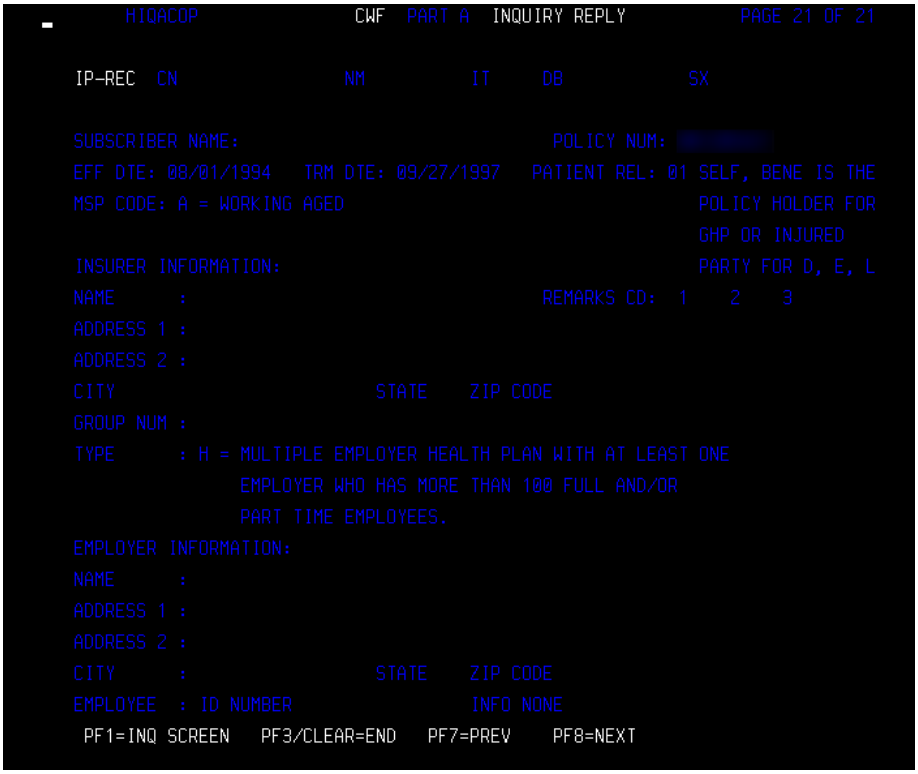


Figure 23 – CWF Part A Inquiry Reply Screen, Page 21

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
SUBSCRIBER NAME:	This field identifies the name of the policy holder of the primary plan.
POLICY NUM:	This field identifies the policy number of the primary plan.
EFF DATE	**Effective Date** – This field identifies the date the coverage of the primary plan began.
TRM DTE	**Termination Date** – This field identifies the date the coverage of the primary plan ended or was terminated.
PATIENT REL	**Patient Relationship** – This field identifies the relationship of the subscriber to the beneficiary/patient.
MSP CODE	**Medicare Secondary Payer Source Code** – This field identifies the MSP source code (e.g., disability, working aged, liability, etc.).
Insurer Information	
NAME	This field identifies the name of the primary insurer.
REMARKS CODE	This field identifies information needed by the contractor to assist in additional development. Up to three remarks codes may be displayed.
ADDRESS 1	This field provides the address of the primary insurer.
ADDRESS 2	This field provides the address of the primary insurer.
CITY STATE ZIP CODE	This field identifies the City, State, and ZIP code of the primary insurer.

Field Name	Description
GROUP NUM	**Insurer Group Number** – This field identifies the group number for the policyholder with the primary insurer.
TYPE	This field identifies the type of insurance (e.g., insurance or indemnity)
EMPLOYER INFORMATION	These fields are not utilized in DDE.

***NOTE**: HIQA Page 20 (Figure 22) reflects that it is Page 20 of 21. The total number of pages following Page 20 for an HIQA record varies depending upon whether or not there are valid MSP records. If a beneficiary/patient has more than one valid MSP record on the CWF, the pages that follow page 21 will provide the remaining insurance plans and information in the same layout as HIQA Page 21.

2.B. Health Insurance Query for HHA

The Health Insurance Query for HHAs (HIQH) allows different types of institutional providers to inquire about a beneficiary/patient and receive an immediate response about their Medicare eligibility based on available claims data. Since beneficiaries often move from home health to hospice care, both HHAs and hospices can employ HIQH as their single CWF inquiry transaction. HIQH, which includes the information made available in HIQA, gives Medicare providers direct access to the CMS's CWF Host database. Providers may query a beneficiary/patient's master record. The beneficiary/patient's record contains Medicare entitlement, hospice benefit information, health maintenance organization (HMO) information, and other payer information. Each beneficiary/patient record is located at one of nine CWF Host sites.

CWF edits claims for validity, entitlement, remaining benefits, and deductible status. A reply from CWF will be returned the following day. The majority of claims will be accepted by CWF for remittance. Others will reject, open for recycle at a later date, or suspend for investigative action.

The objectives of the CWF are to provide:

- Complete beneficiary/patient information to Medicare contractors as—
  - Entitlement data
  - Utilization data
  - Claim history
- Information in a timely manner via an online process
- Accurate initial claims processing with—
  - Deductible access
  - Coinsurance access
  - Part A and Part B benefits paid comparison
  - Check editing prepayment (so contractor's approval equals CMS acceptance)
  - Duplicate payments prevention
  - Efficient implementation of future benefits and enhancements changes

2.B.1. Part A CWF Send Process

The Medicare contractor or satellite uses its best available information on beneficiary/patient eligibility and remaining benefits to fully adjudicate claims. Every claim has been grouped, priced, and evaluated for Medicare Secondary Payer involvement and has its final reimbursement (including interest) before it is sent. High Speed ***bulk data transfer*** transmits the Medicare contractor paid claim to the host for approval. Prior to ***SEND***, the Medicare contractor converts adjudicated claims from in-house format to CWF format. This is known as the ***best shot*** approach for bill payment. Claims awaiting CWF transmission reside in status/location **S B9000.**

2.B.2. Part A Response Process

Palmetto GBA maintains a holding file containing claims awaiting an initial CWF response (**S B9099**). No manual transaction can be made against these claims. Claims cannot be finally adjudicated until a definitive response is received from CWF, unless a manual function instructs the system to process the claim without being transferred to CWF. Responses aid in processing and proper adjudication of Medicare claims. The responses Palmetto GBA receives from the CWF are:

- CWF Edit Error codes that tell us a CWF response is ready to be worked (a 5-digit code appears in the lower left corner of the UB04 screen).
- A CWF Disposition Code, a 2-digit category or status of claim, that indicates:
  - Claim is approved
  - Claim is rejected
  - Claims will be retrieved from history
- Alert codes, CWF requests for investigation of overlapping benefits and eligibility status.
- Approved claims, Medicare contractor produced provider check and remittance advice.
- Rejected claims that require further investigation. Medicare contractor reviews these claims, makes corrections, and resubmits them to CWF.
- Recycled claims, which recycle automatically, back to CWF. The FISS status/location definitions are:
  S B90_0 = 1st transmission
  S B90_1 = 2nd transmission
  S B90_2 = additional transmissions

2.B.3. CWF Host Sites

The Centers for Medicare & Medicaid Services maintains centralized files on each Medicare beneficiary/patient with minimal eligibility and utilization data. Contractors query this file to process claims. **CWF** disperses the beneficiary/patient files into **nine regional host sites**.

GL – Great Lakes	MA – Mid-Atlantic	SE – Southeast	GW – Great Western	
Illinois	Indiana	Alabama	Idaho	North Dakota
Michigan	Maryland	Mississippi	Iowa	Oregon
Minnesota	Ohio	North Carolina	Kansas	South Dakota
Wisconsin	Virginia	South Carolina	Missouri	Utah
	West Virginia	Tennessee	Montana	Washington
			Nebraska	Wyoming
PA – Pacific	**SO – South**	**KS – Keystone**	**NE – Northeast**	**SW – Southwest**
Alaska	Florida	Delaware	Connecticut	Arkansas
Arizona	Georgia	New Jersey	Maine	Colorado
California		New York	Massachusetts	Louisiana
Hawaii		Pennsylvania	New Hampshire	New Mexico
Nevada			Rhode Island	Oklahoma
			Vermont	Texas

2.B.4. HIQH Inquiry Screen

Once you have successfully logged onto the HIQH function, the CWF beneficiary/patient inquiry area will display (Figure 24). To access a beneficiary/patient's CWF Master Record, enter information into this screen.

HIQH Inquiry Screen – Field definitions and completion requirements are provided in the table following Figure 24.

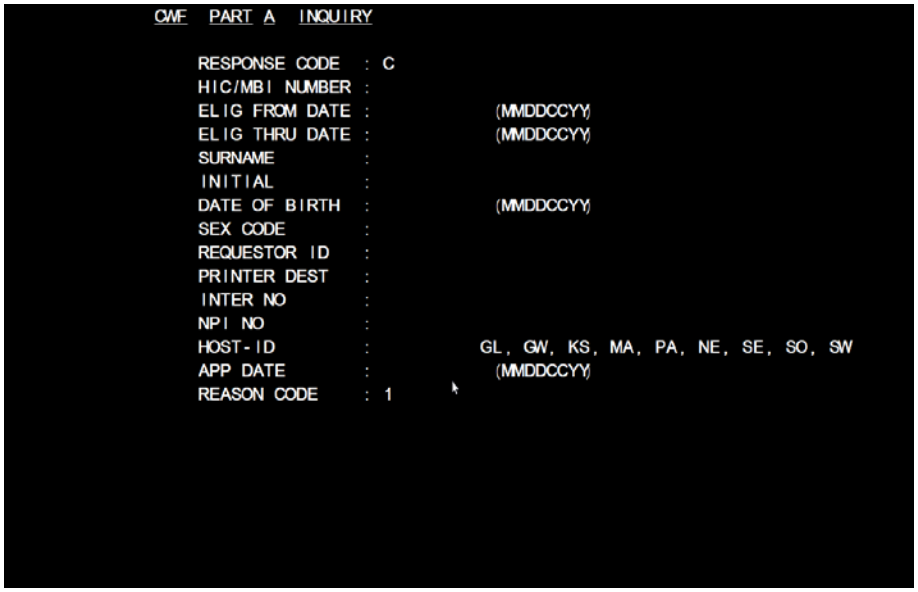


Figure 24 – CWF Part A Beneficiary Inquiry Screen

Field Name	Description
RESPONSE CODE	Data in this field (a 'C' for Display on CRT) is automatically inserted by the system.
ELIG FROM DATE	This field identified the Eligibility THRU date inquired for the Beneficiary. This is an eight-position numeric field and values should be entered in MMDDCCYY format.
ELIG THRU DATE	This field identified the Eligibility THRU date inquired for the Beneficiary. This is an eight-position numeric field and values should be entered in MMDDCCYY format.
HIC/MBI NUMBER	Enter the beneficiary/patient's Medicare number as shown on the Medicare card in this field.
SURNAME	Enter the first six (6) letters of the beneficiary/patient's last name.
INITIAL	Enter the first initial of the beneficiary/patient's first name.
DATE OF BIRTH	Enter the beneficiary/patient's date of birth in MMDDCCYY format.
SEX CODE	Enter the beneficiary/patient's sex. Valid values are: F = Female M = Male
REQUESTOR ID	Identifies person submitting the inquiry or person requesting printed output. Enter '1' in this field.
PRINTER DEST	Leave this field blank (system default printer). This field is for the Printer device that the response will be directed to if a 'P' or 'E' is typed in the Response Code field.
INTER NO	Identifies the Medicare contractor processing the claim. Enter one of the following for a beneficiary/patient in Palmetto GBA's jurisdiction: ▪ 11201 = Part A South Carolina ▪ 11501 = Part A North Carolina ▪ 11301 = Part A Virginia ▪ 11401 = Part A West Virginia ▪ 11004 = Home health or hospice ▪ 10111 = Part A Alabama ▪ 10211 = Part A Georgia ▪ 10311 = Part A Tennessee

Field Name	Description
NPI NO	The 10-digit National Provider Identifier (NPI) number assigned to the provider rendering medical service to the beneficiary/patient.
HOST-ID	Host IDs are shown as two-letter abbreviations for the nine CWF host sites. You should access the appropriate host and enter one of the following designations: GL = Great Lakes GW = Great West KS = Keystone MA = Middle Atlantic PA = Pacific NE = Northeast SE = Southeast SO = South SW = Southwest
APP DATE	Date the beneficiary/patient was admitted to the hospital in MMDDYY format. This field is not required. However, entering a date will allow for the most recent information to be provided.
REASON CODE	Indicates the reason for the inquiry. Valid codes are: 1 = Status Inquiry 2 = Inquiry relating to an admission A '1' is automatically inserted in this field by the system. Change this only if applicable.

HIQH Page 1 – Field definitions and completion requirements are provided in the table following Figure 25.

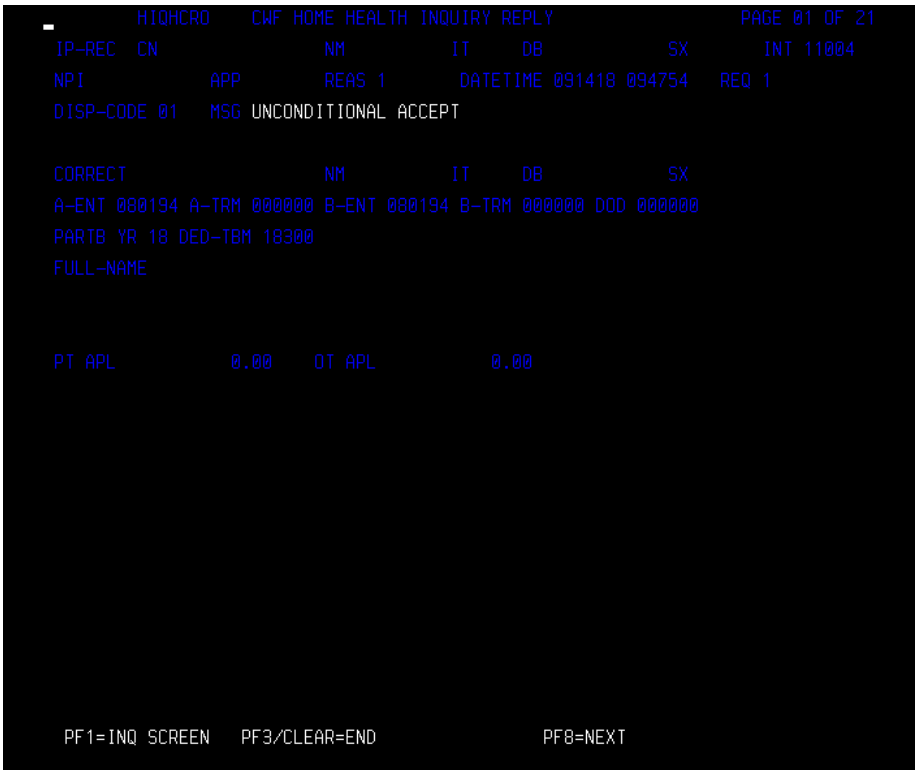


Figure 25 – CWF Part A Inquiry Reply Screen, Page 1

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
IN	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
NPI	**National Provider Identifier (NPI)** – The agency's NPI number used to access the record.

Field Name	Description
APP	**Applicable Date** – Used for spell determination.
REAS	**Reason Code** – Indicates the reason for the inquiry.
DATETIME	**Date and Time Stamp** – date and time of the inquiry in Julian date format.
REQ	**Requestor ID** – auto populates
DISP-CODE	**Disposition Code** - Indicates a condition on a CABLE response. Valid values are: 01 = Part A Inquiry approved 02 = Part A Inquiry approved 03 = Part A Inquiry rejected 20 = Qualified approval but may require further investigation 25 = Qualified approval 50 = Not in file 51 = Not in file on CMS batch system 52 = Master record housed at another HOST site 53 = Not in file in CMS but sent to CMS's alpha-reinstate 55 = Does not match a master record ER = Consistency edit reject UR = Utilization edit CR = A/B crossover edit CI = CICS processing problem SV = Security violation
MSG	**Message** – The verbiage pertaining to the disposition code.
CORRECT	**Correct Claim Number** – Displays the beneficiary/patient's correct Medicare number. If the Medicare number entered in the inquiry screen (Figure 24) is different than the number in this field, this is the number you will use to submit claims.
NM	**Corrected Name** – This field displays the beneficiary/patient's correct name. The name in this field will be different only if the name entered in the inquiry screen (Figure 24) is not consistent with CMS's record.
IT	**Corrected Initial** – This field displays the beneficiary/patient's correct initial of the first name. The initial in this field will be different only if the initial entered in the inquiry screen (Figure 24) is not consistent with CMS's record.
DB	**Corrected Date of Birth** – This field displays the beneficiary/patient's correct date of birth. The date of birth in this field will be different only if the date of birth entered in the inquiry screen (Figure 24) is not consistent with CMS's record.
SX	**Corrected Sex Codes** – This field displays the beneficiary/patient's correct sex. The sex code in this field will be different only if the sex code entered in the inquiry screen (Figure 24) is not consistent with CMS's record.
A-ENT	**Part A Entitlement** – Date of entitlement to Part A benefits in a MMDDYY format.
A-TRM	**Part A Termination** – Indicates date of termination of Part A entitlement, when applicable, in a MMDDYY format. Otherwise, this field will display all zeros.
B-ENT	**Part B Entitlement** – Date of entitlement to Part B benefits in MMDDYY format.
B-TRM	**Part B Termination** – Indicates date of termination of Part B entitlement, when applicable, in MMDDYY format. Otherwise, this field will display all zeros.
DOD	**Date of Death** – If the beneficiary/patient is alive, the field will be all zeros.
PART B YR	**Most Recent Part B Year** – From the applicable date input field.
DED-TBM	**Deductible To Be Met –** Amount of the Part B cash deductible remaining to be met for the current year.
FULL NAME	Beneficiary's/patient's full name.
PT APL	**Physical Therapy-** The amount applied to the physical therapy services provided in an outpatient setting.
OT APL	**Occupational Therapy** – The amount applied to the occupational therapy services provided in an outpatient setting.

HIQH Page 2 – Field definitions and completion requirements are provided in the table following Figure 26.

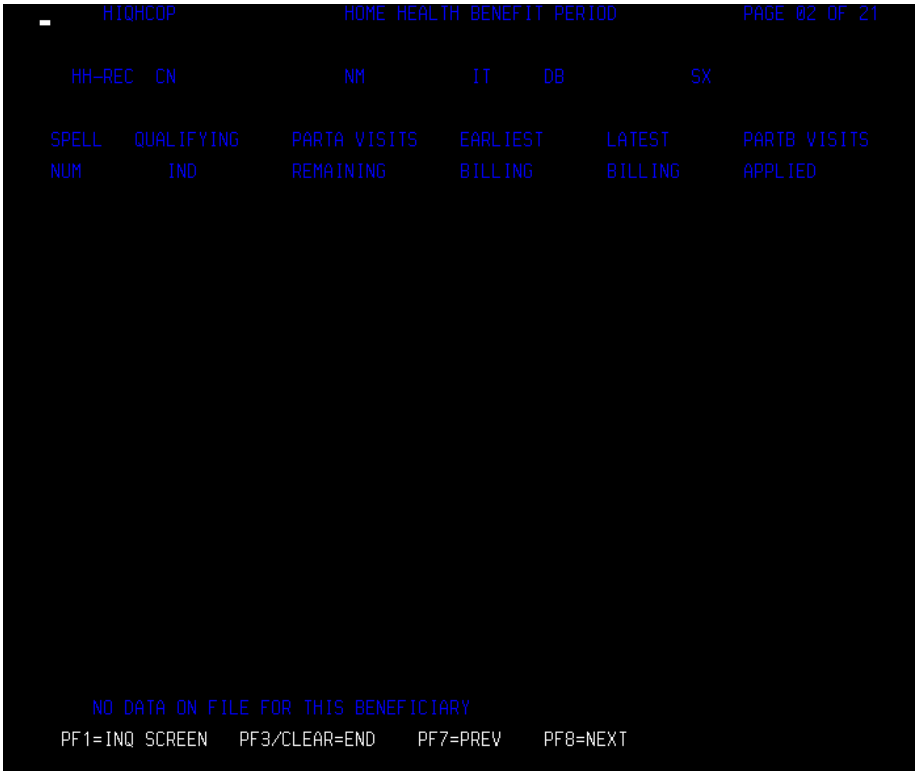


Figure 26 – CWF Part A Inquiry Reply Screen, Page 2

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
SPELL NUM	**Spell of Illness Number** – This number reflects the current home health spell of illness.
QUALIFYING IND	**Qualifying Stay Indicator** – This is a numeric field used to identify a qualifying A/B split hospitalization. Valid values are: 0 = No 1 = Yes
PART A VISITS REMAINING	The number of Part A visits remaining in the episode of care. Medicare Part A pays for the first 100 visits if a beneficiary/patient has a qualifying hospital stay, and if a beneficiary/patient is admitted to home health within 14 days of discharge. Medicare Part B pays for the remaining visits. In addition, Medicare Part B pays for all visits if there is no qualifying hospital stay (the beneficiary/patient must have Medicare Part B for Part B to reimburse for the services). If a beneficiary/patient has Medicare Part A only, then Part A will pay for all of their services.
EARLIEST BILLING	The earliest date submitted for the spell of illness.
LATEST BILLING	The latest date submitted for the spell of illness.
PARTB VISITS APPLIED	The number of visits in the episode of care that were reimbursed by Medicare Part B.

HIQH Page 3 – Field definitions and completion requirements are provided in the table following Figure 27.

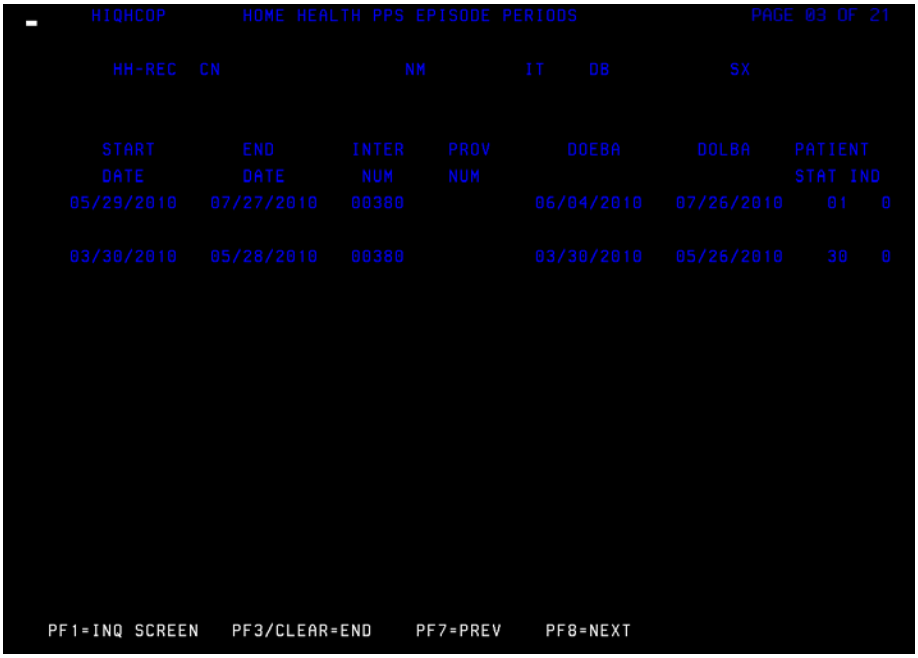


Figure 27 – CWF Part A Inquiry Reply Screen, Page 3

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
START DATE	**Start Date** – Shows the start date of the home health episode.
END DATE	**End Date** – Indicates end date of the home health episode.
INTER NUM	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
PROV NUM	**Provider Number**- The provider number of the home health agency that submitted the claim.
DOEBA	**Date of Earliest Billing Action** - the first service date of the HHPPS period.
DOLBA	**Date of Last Billing Action** - the last service date of the HHPPS period.
PATIENT STAT	**Patient Status Code** – the patient status code submitted in field 22 of the claim.
PATIENT IND	**Patient Indicator** – Valid values are: 0 = Episode in good status – Final Claim received on time 1 = RAP auto cancelled 2 = RAP not cancelled – Final Claim denied by Medical Review– Entire episode cancelled

HIQH Page 4 – Field definitions and completion requirements are provided in the table following Figure 28.

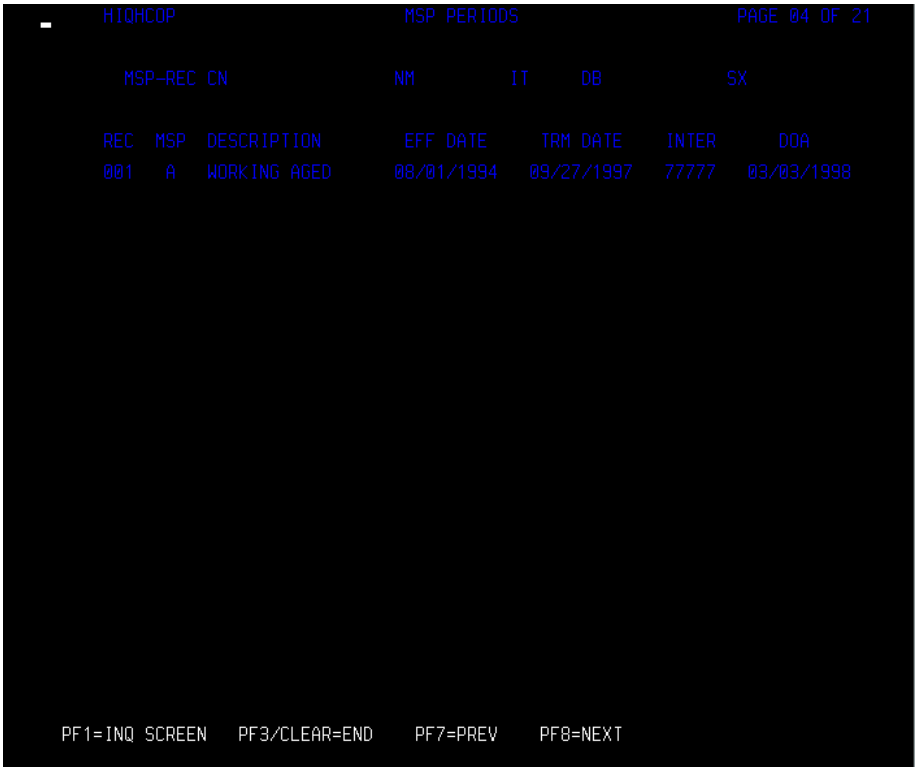


Figure 28 – CWF Part A Inquiry Reply Screen, Page 4

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
REC	**Record Number –** Identifies the MSP segment number.
MSP	**Medicare Secondary Payer** – Identifies the type of MSP record on file. Valid values are: A = Working Aged B = ESRD D = No-Fault E = Workers' Compensation F = PHS Other Federal Agency G = Disability H = Black Lung I = Veterans (VA) L = Liability W = Workers' Compensation set aside
DESCRIPTION	Type of primary insurance plan (Working Aged, Disabled, Workers Comp, etc.).
EFF DATE	**Effective Date** – The effective date of the primary plan.
TRM DATE	**Termination Date** – The termination date of the primary plan (if applicable).
INTER	The Medicare contractor number associated with the source of the MSP information.
DOA	**Date of Accretion** – the date the MSP record was established in CWF.

HIQH Page 5 – Field definitions and completion requirements are provided in the table following Figure 29.

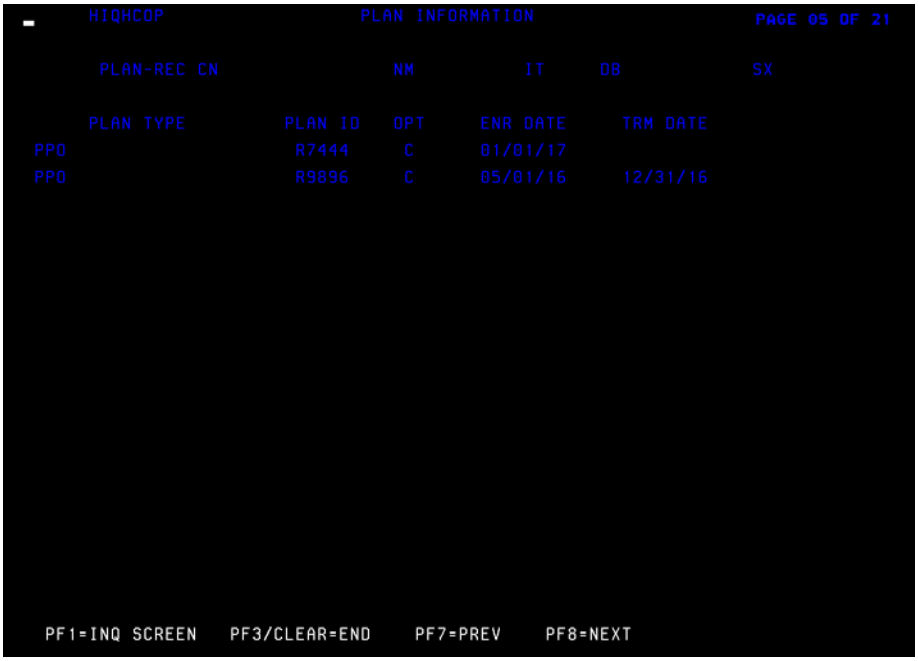


Figure 29 – CWF Part A Inquiry Reply Screen, Page 5

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
PLAN TYPE	Medicare Advantage (MA) Plan (HMO) **Type** such as PPO.
PLAN ID	Medicare Advantage (MA) Plan (HMO) **Identification Code** – Valid values are: Position 1 = H 2 & 3 = State Code 4 & 5 = HMO Number within the state
OPT	MA Plan (HMO) **Option Code –**Describes the type of plan the beneficiary/patient selected (risk or cost based). Valid values are: 1 or 2 = MA Plan to process bills only for directly provided services and for service from provider with whom the MA plan has effective arrangements. Palmetto GBA processes all other bills. C = MA Plan to process all bills.
ENR DATE	**Medicare Advantage (HMO) Enrollment Date** – The date of the beneficiary/patient enrolled in the MA Plan.
TRM DATE	**Medicare Advantage (HMO) Termination Date** – The date the beneficiary/patient disenrolled from the MA Plan.

HIQH Pages 6 through 9 - Field definitions and completion requirements are provided in the table following Figure 30, Figure 31, Figure 32 and Figure 33.

```
        HIQHCRO    CWF HOME HEALTH INQUIRY REPLY                PAGE 06 OF 21
 IP-REC  CN               NM          IT     DB           SX       INT 11004


 PREVENTIVE SERVICE   TECH DTE PROF DTE | PREVENTIVE SERVICE   TECH DTE PROF DTE
                      MMDDCCYY MMDDCCYY |                     MMDDCCYY MMDDCCYY
 CARDIOVASC (80061)   01012005 01012005 | PCB EXAM   (G0101)  GDRNOELG GDRNOELG
 CARDIOVASC (82465)   01012005 01012005 | PV 90732,90669,90670 VACCINTD VACCINTD
 CARDIOVASC (83718)   01012005 01012005 | PROSTATE   (G0102)  01012000 01012000
 CARDIOVASC (84478)   01012005 01012005 | PROSTATE   (G0103)  01012000 10012004
 COLORECTAL (G0104)   01011998 01011998 | PAP TEST   (Q0091)  GDRNOELG GDRNOELG
 COLORECTAL (G0105)   01011998 01011998 | DIABETES   (82947)  01012005 01012005
 COLORECTAL (G0106)   01011998 01011998 | DIABETES   (82950)  01012005 01012005
 COLORECTAL (G0120)   01011998 01011998 | DIABETES   (82951)  01012005 01012005
 COLORECTAL (G0121)   07012001 07012001 | GLAU (G0117,G0118)  01012002 01012002
 FOB TEST   (G0107)   01011998 01011998 | MAMM (G0202,G0203,  GDRNOELG GDRNOELG
 FOB TEST   (G0328)   01012004 01012004 |       76092,77057,
 FOB TEST   (82270)   01012007 01012007 |       77067)
 IPP EXAM   (G0344)   SRVNOELG SRVNOELG | PAPT (P3000,G0123,  GDRNOELG GDRNOELG
 IPP EXAM   (G0366)   SRVNOELG SRVNOELG |       G0143,G0144,
 IPP EXAM   (G0367)   SRVNOELG 00000000 |       G0145,G0147,
 IPP EXAM   (G0368)   00000000 SRVNOELG |       G0148)

  PF1=INQ SCREEN   PF3/CLEAR=END    PF7=PREV    PF8=NEXT
```

Figure 30 – CWF Part A Inquiry Reply Screen, Page 6

```
        HIQHCRO    CWF HOME HEALTH INQUIRY REPLY                PAGE 07 OF 21
 IP-REC  CN               NM          IT     DB           SX       INT 11004


 PREVENTIVE SERVICE   TECH DTE PROF DTE | PREVENTIVE SERVICE   TECH DTE PROF DTE
                      MMDDCCYY MMDDCCYY |                     MMDDCCYY MMDDCCYY
 AAA  (76706,G0389)   07012007 07012007 |
 IPP EXAM   (G0402)   SRVNOELG SRVNOELG |
 IPP EXAM   (G0403)   SRVNOELG SRVNOELG |
 IPP EXAM   (G0404)   SRVNOELG SRVNOELG |
 IPP EXAM   (G0405)   SRVNOELG SRVNOELG |
 PTWR       (G9143)   08032009 08032009 |
 AWV        (G0438)   00000000 01012011 |
 AWV        (G0439)   00000000 01012011 |
 HCAS       (G0472)   06022014 06022014 |
 CDCS (G0464/81528)   AGENOELG 00000000 |
 LDCT       (G0297)   AGENOELG AGENOELG |
 HIVS (G0432,G0433,   04132015 SRVNOELG |
       G0435,G0475)                     |
 HPVS       (G0476)   AGENOELG 00000000 |
 HBVS       (G0499)   09282016 09282016 |


  PF1=INQ SCREEN   PF3/CLEAR=END    PF7=PREV    PF8=NEXT
```

Figure 31 – CWF Part A Inquiry Reply Screen, Page 7

Figure 32 – CWF Part A Inquiry Reply Screen, Page 8

Figure 33 – CWF Part A Inquiry Reply Screen, Page 9

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).

Field Name	Description
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
Preventive Services	
CARDIOVASC	Cardiovascular
COLORECTAL	Colorectal
FOB TEST	Fecal Occult Blood Test
IPP EXAM	Initial Preventive Physical Examination
PCB EXAM	Pelvic and Clinical Breast Examination
PV	Pneumococcal Pneumonia Vaccine
PROSTATE	Prostate
PAP TEST	Pap Smear Test
DIABETES	Diabetes
GLAU	Glaucoma
MAMM	Mammography
PAPT	Pap Smear Test
AAA	Abdominal Aortic Aneurysm
IPP EXAM	Initial Preventive Physical Examination
PTWR	Pharmacogenomic Testing to Predict Warfarin Responsiveness
AWV	Annual Wellness Visit
HCAS	Hepatitis C Virus Screening
COCS	Colorectal Cancer Using Cologuard Screening - a multitarget stool DNA test
LDCT	Low Dose Computed Tomography screening for lung cancer
HIVS	Human Immunodeficiency Virus Screening
HPVS	Human Papillomavirus Screening
HBVS	Hepatitis B Virus Screening
BLANK	Healthcare Common Procedure Coding System (HCPCS) code for the preventive service
TECH DTE	Next eligible technical date for the preventive service listed
PROF DTE	Next eligible professional date for the preventive service listed

The TECH DTE and PROF DTE may show abbreviations in the MMDDYYYY field. Some common abbreviations that may occur include:

- AGENOELG – Beneficiary/patient not eligible due to age
- GDRNOELG – Beneficiary/patient not eligible due to gender
- NOPTBENT – Beneficiary/patient not entitled to Part B
- 00000000 – Service not applicable
- SRVNOELG – Beneficiary/patient not eligible for the service
- VACCINTD – Beneficiary/patient already vaccinated
- RECEIVED – Beneficiary/patient already received the service
- DODNOELG – Beneficiary/patient not eligible due to date of death

HIQH Page 10 – Field definitions and completion requirements are provided in the table following Figure 34.

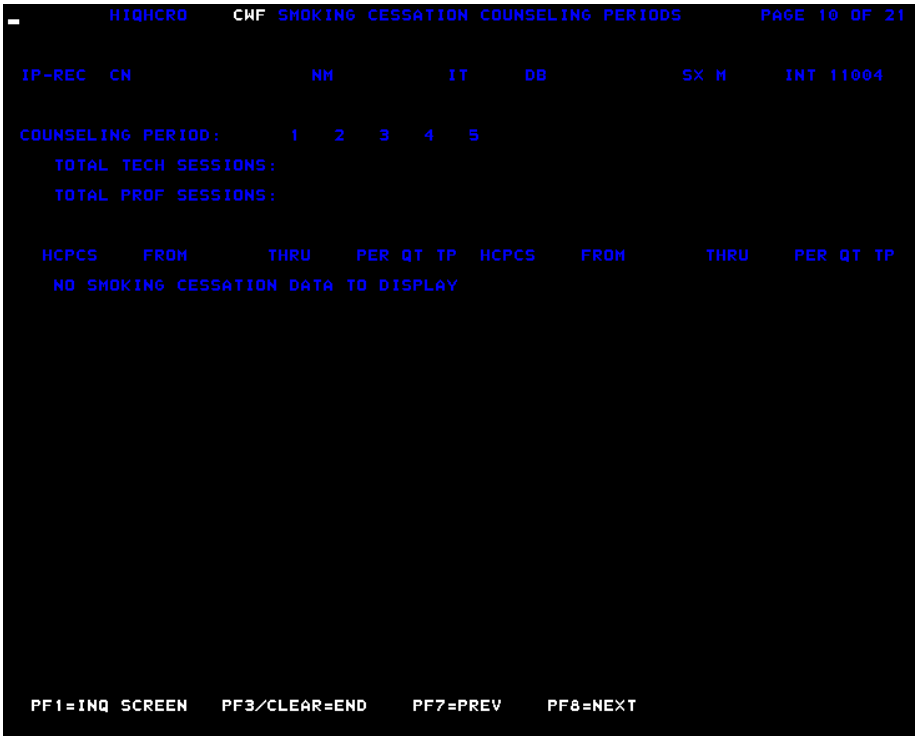


Figure 34 – CWF Part A Inquiry Reply Screen, Page 10

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
COUNSELING PERIOD	Identifies up to five years of counseling data. Valid values include '1' = one year '2' = two years '3' = three years '4' = four years '5' = five years
TOTAL SESSIONS	Identifies the number of sessions billed for the beneficiary/patient.
HCPCS	HCPCS Code
FROM	From date of claim
THRU	Through date of claim
PER	Identifies up to five years of counseling data. Valid values include: '1' = one year '2' = two years '3' = three years '4' = four years '5' = five years
QT	**Quantity** – The number of services billed for each date.
TP	Claim type

HIQH Page 11 – Field definitions and completion requirements are provided in the table following Figure 35.

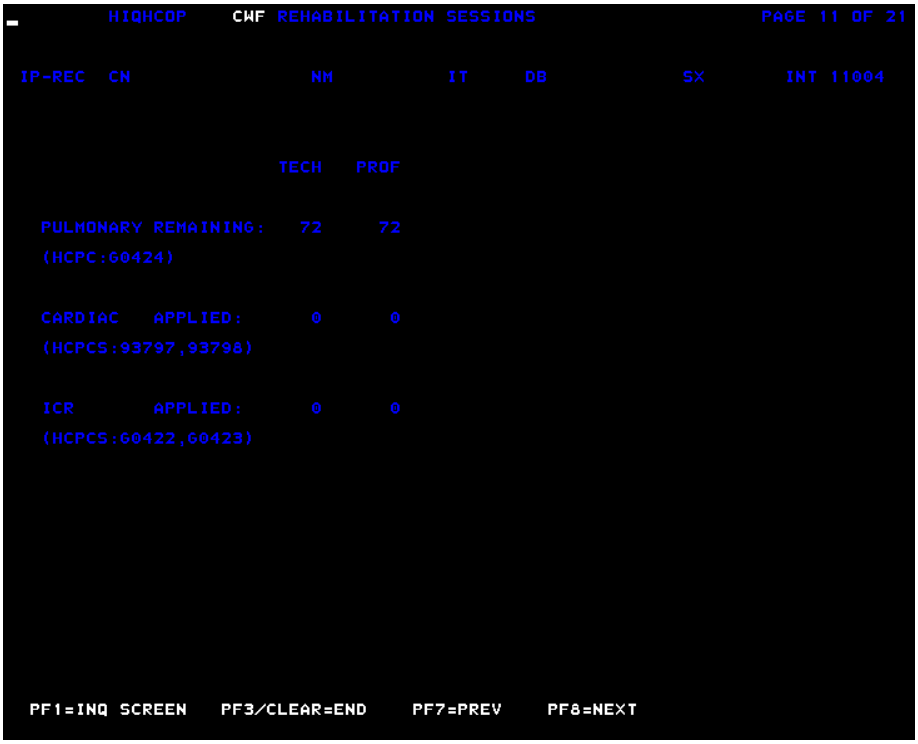


Figure 35 – CWF Part A Inquiry Reply Screen, Page 11

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
TECH	Technical
PROF	Professional
PULMONARY REMAINING	The total number of technical and professional Pulmonary Rehabilitation services remaining.
CARDIAC APPLIED	The total number of professional and technical Cardiac Rehabilitation services used.
ICR APPLIED	The total number of professional and technical Intensive Cardiac Rehabilitation services used.

HIQH Page 12 – Field definitions and completion requirements are provided in the table following Figure 36.

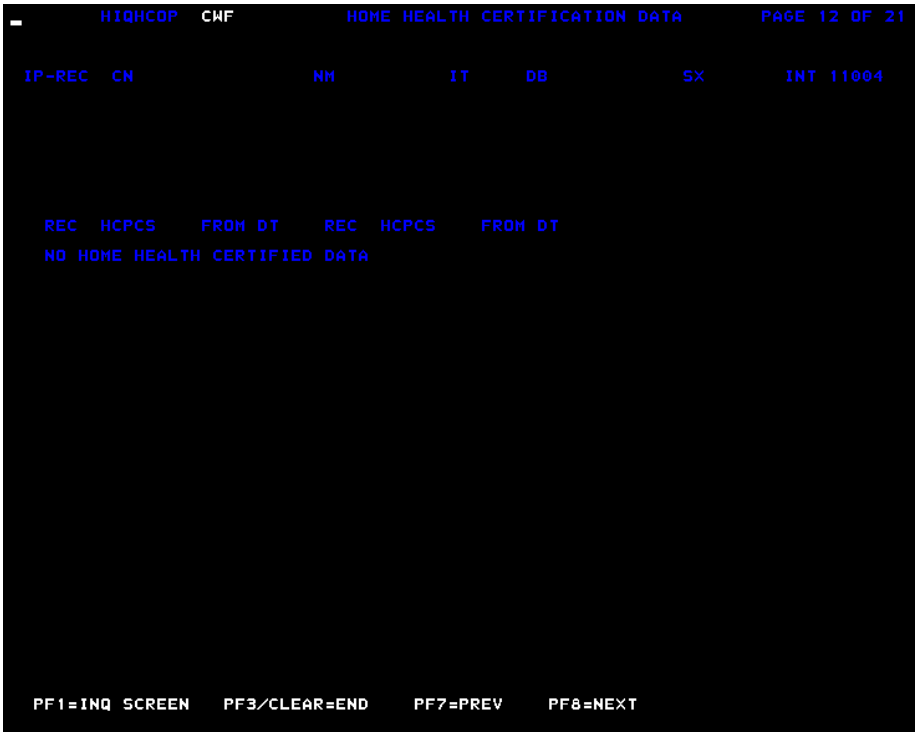


Figure 36 – CWF Part A Inquiry Reply Screen, Page 12

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
REC HCPCS	**Record HCPCS** – Identifies the HCPCS filed.
FROM DT	**From Date** – The home health certification from date.

HIQH Page 13 – Field definitions and completion requirements are provided in the table following Figure 37.

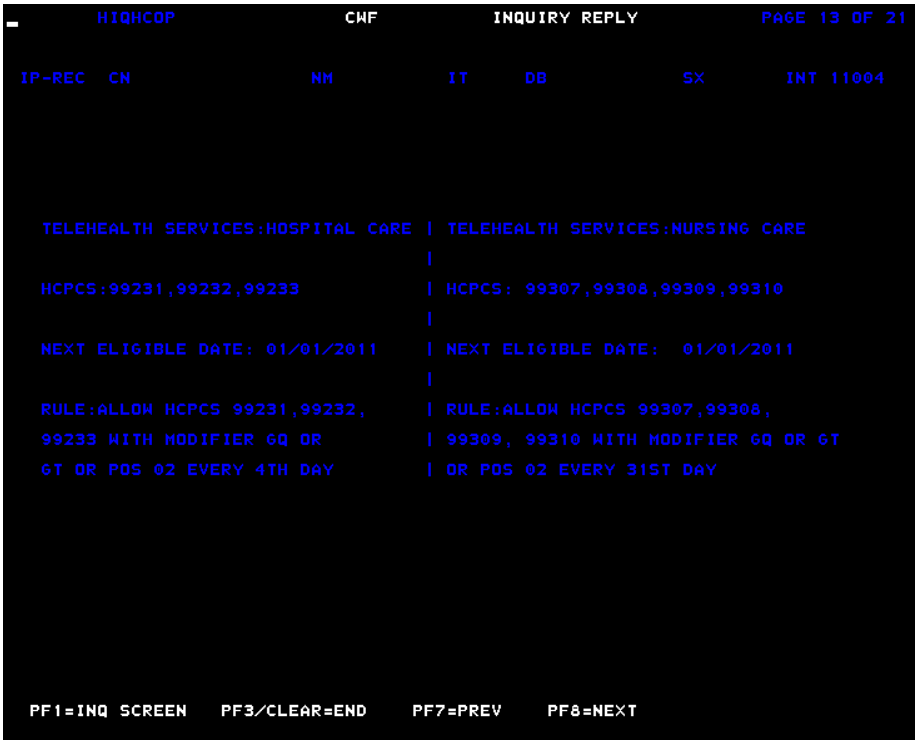


Figure 37 – CWF Part A Inquiry Reply Screen, Page 13

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
TELEHEALTH SERVICES: HOSPITAL CARE	Telehealth services rendered under hospital care.
TELEHEALTH SERVICES: NURSING CARE	Telehealth services rendered under nursing care.
HCPCS	The HCPCS codes billed.
NEXT ELIGIBILE DATE	The beneficiary/patient's next eligible date for services.
RULE	The Allowed HCPCS, with modifier and how often.

HIQH Page 14 – Field definitions and completion requirements are provided in the table following Figure 38.

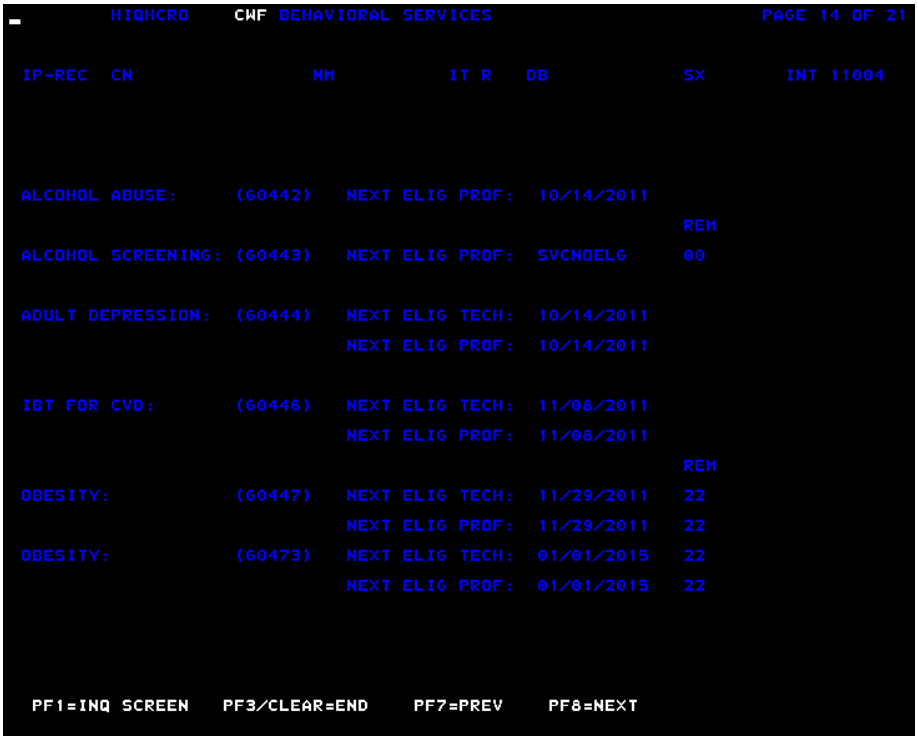


Figure 38 – CWF Part A Inquiry Reply Screen, Page 14

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
ALCOHOL ABUSE	This field identifies the HCPCS code billed for Alcohol abuse screening.
ALCOHOL SCREENING	This field identifies the HCPCS code billed for a face-to-face behavioral counseling for alcohol misuse.
ADULT DEPRESSION	This field identifies the HCPCS code billed for the annual depression screening.
IBT FOR CVD OBESITY	This field identifies the HCPCS code billed for **Intensive Behavioral Therapy (IBT) for Covered (CVD) Obesity**.
NEXT ELIG TECH	**Next Eligible Technical Date** – This field identifies the next date the beneficiary/patient is eligible for the technical component of the screening.
NEXT ELIG PROF	**Next Eligible Professional Date** – This field identifies the next date the beneficiary/patient is eligible for the professional component of the screening.

HIQH Page 15 – Field definitions and completion requirements are provided in the table following Figure 39.

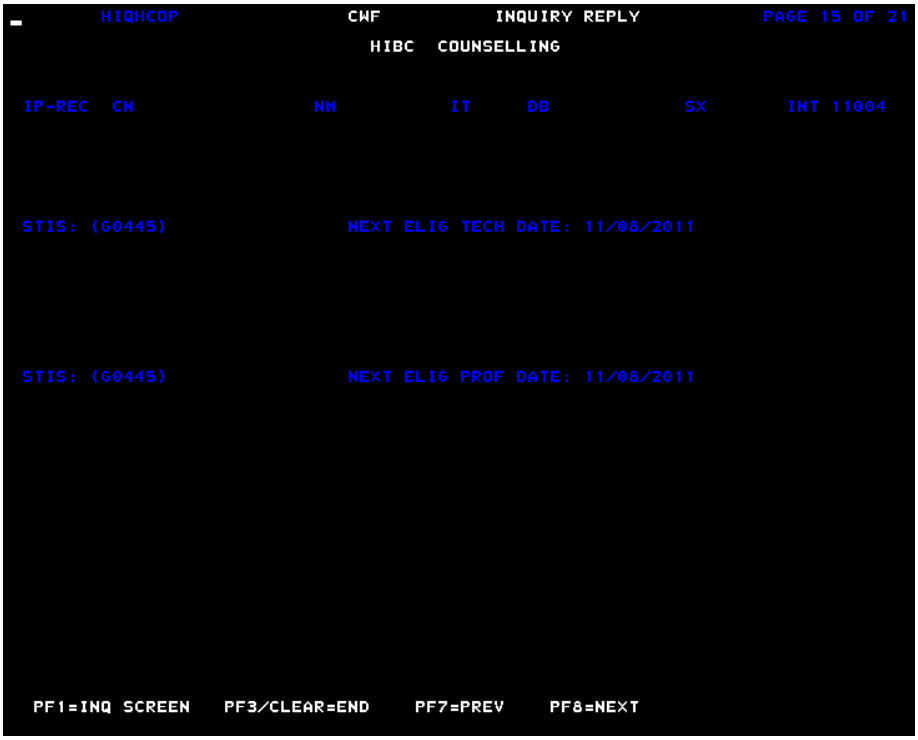


Figure 39 – CWF Part A Inquiry Reply Screen, Page 15

Field Name	Description
High Intensity Behavioral Counseling (HIBC) Counselling	
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
STIS	**Sexually Transmitted Infections** – This field identifies the codes billed for STI screening.
NEXT ELIG TECH DATE	**Next Eligible Technical Date** – This field identifies the next date the beneficiary/patient is eligible for the technical component of the screening.
NEXT ELIG PROF DATE	**Next Eligible Professional Date** – This field identifies the next date the beneficiary/patient is eligible for the professional component of the screening.

HIQH Page 16 – Field definitions and completion requirements are provided in the table following Figure 40.

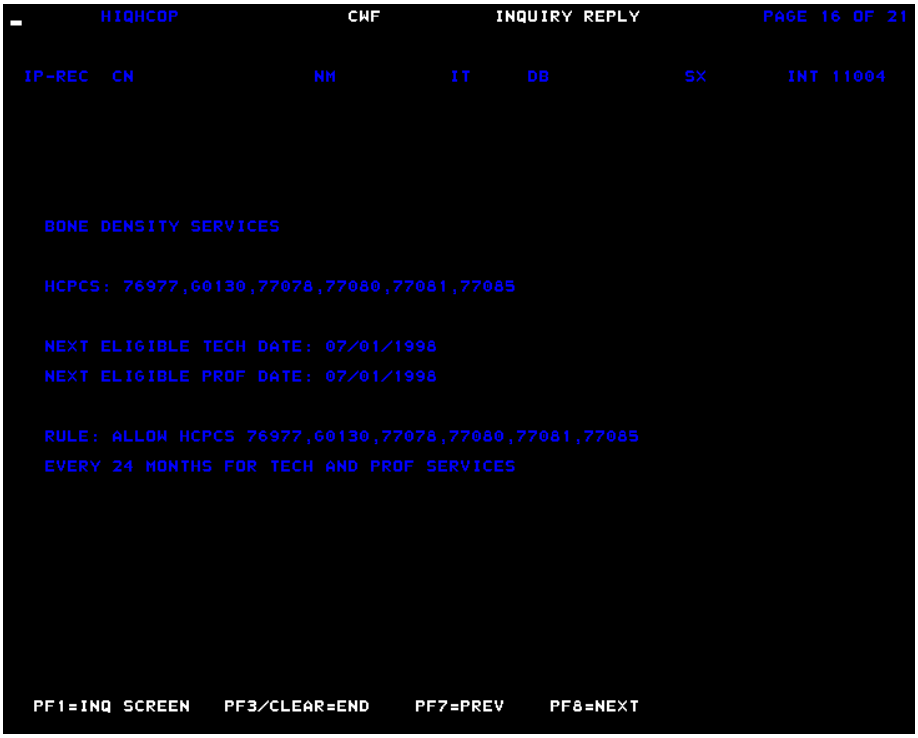


Figure 40 – CWF Part A Inquiry Reply Screen, Page 16

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
Bone Density Services	
HCPCS	This field identifies the HCPCS codes billed for the bone density services.
NEXT ELIGIBLE TECH DATE	This field reflects the next eligible date for the technical component of the bone density services.
NEXT ELIGIBLE PROF DATE	This field reflects the next eligible date for the professional component of the bone density services.
RULE	This field identifies the allowable HCPCS codes and how often for the bone density services.

HIQH Page 17 – Field definitions and completion requirements are provided in the table following Figure 41.

Figure 41 – CWF Part A Inquiry Reply Screen, Page 17

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
Medicare Care Choices Model Information	
PROVIDER NUMBER	This field identifies the provider number of the hospice that is providing care under the Medicare Care Choices Model (MCCM).
START DATE	This field identifies the start date of the beneficiary/patient MCCM enrollment.
TERM DATE	This field identifies the termination date of the beneficiary/patient MCCM enrollment.
TRANSFER DATE	This field identifies the date the beneficiary/patient transferred from one hospice to another during the MCCM enrollment.

HIQH Page 18 – Field definitions and completion requirements are provided in the table following Figure 42.

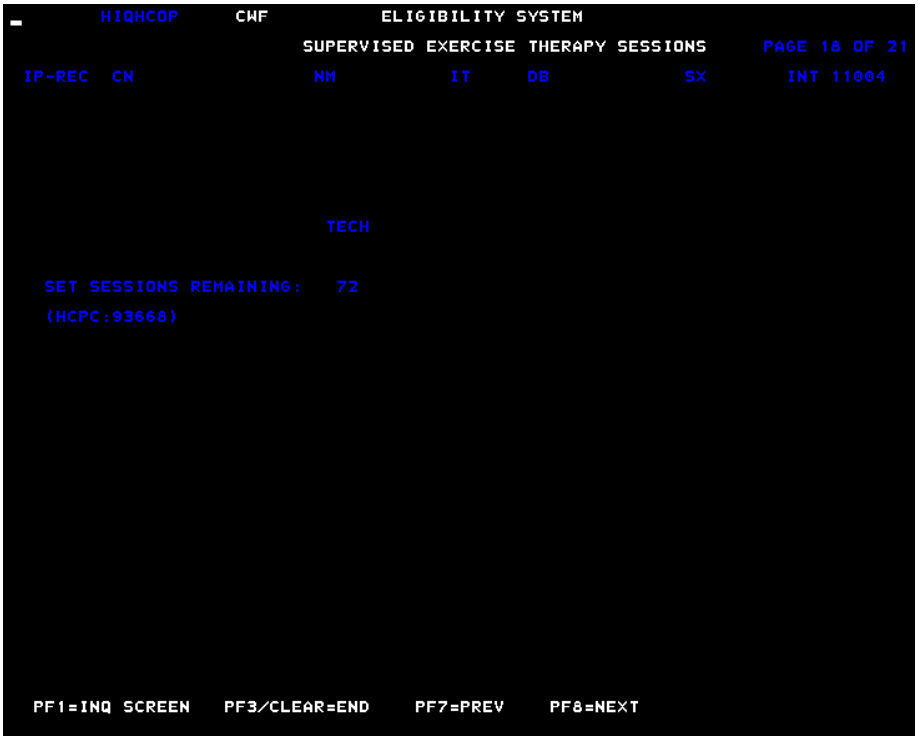


Figure 42 – CWF Part A Inquiry Reply Screen, Page 18

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
Supervised Exercise Therapy Sessions	
TECH	This is a heading only field. No data will be displayed in this field.
SET SESSIONS REMAINING	This field identifies the number Supervised Exercise Therapy (SET) sessions remaining. Up to 72 sessions are covered when medically necessary.
HCPC	This field displays the HCPC for SET sessions.

HIQH Page 19 – Field definitions and completion requirements are provided in the table following Figure 43.

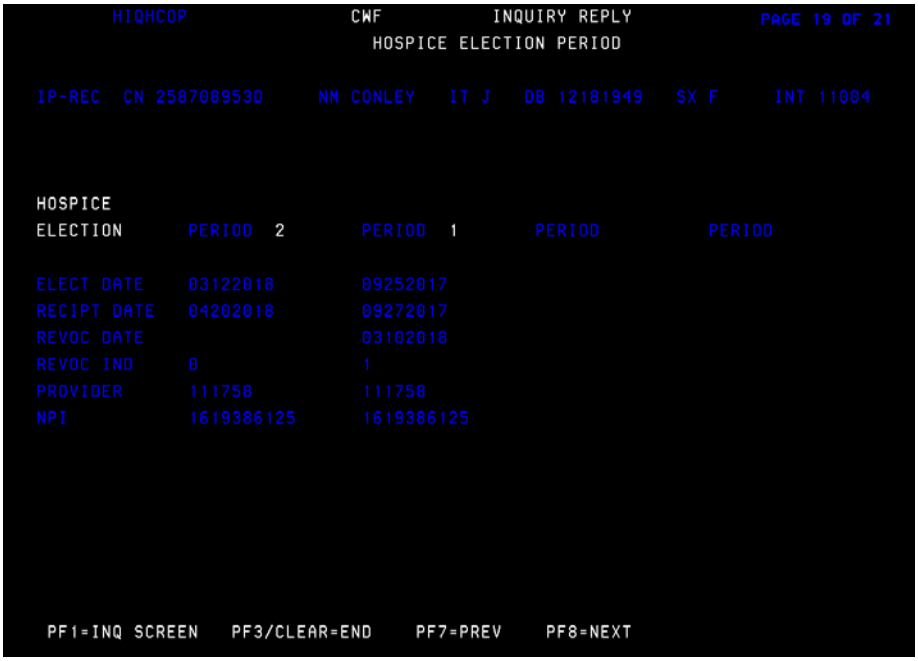


Figure 43 – CWF Part A Inquiry Reply Screen, Page 19

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
Hospice Election Period Data	
PERIOD	This field identifies the number of hospice elections the beneficiary/patient has.
ELECT DATE	The date the beneficiary/patient elected the Medicare hospice benefit as reported on the Notice of Election (NOE), Type of Bill (TOB) 8xA.
RECEIPT DATE	The date the NOE was received and accepted in the Medicare system.
REVOC IND	**Revocation Indicator** – Indicates if a beneficiary/patient has revoked hospice benefits for the period. Valid values are: 0 = Beneficiary/patient has not revoked hospice benefits. 1 = Beneficiary/patient has revoked hospice benefits. 2 = Beneficiary/patient has revoked hospice benefits; record was manually updated by CWF at the request of the Medicare contractor.
PROVIDER	The provider from which the beneficiary/patient has elected for hospice benefits. This is the assigned Medicare provider number.
NPI	The 10-digit National Provider Identifier (NPI) number assigned to the provider rendering medical service to the beneficiary/patient.

HIQH Pages 20 and 21 – Field definitions for pages 20 and 21 are provided in the table following Figure 44 and Figure 45.

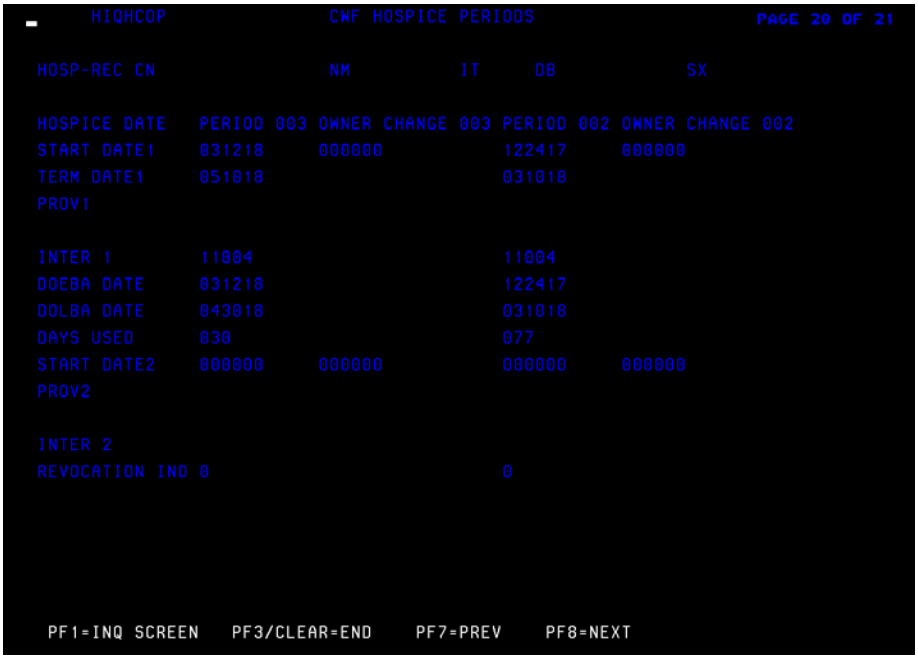


Figure 44 – CWF Part A Inquiry Reply Screen, Page 20

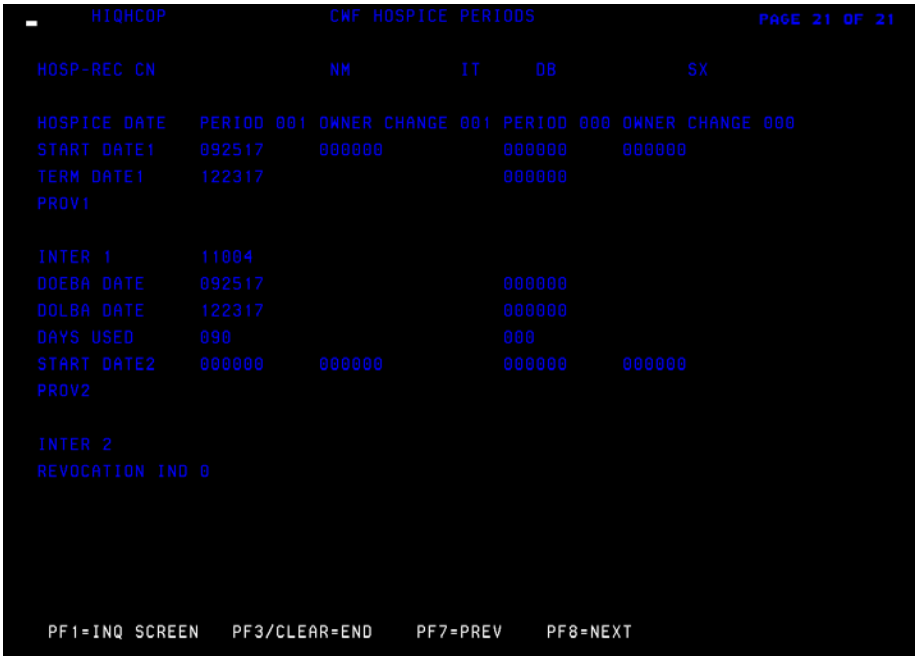


Figure 45 – CWF Part A Inquiry Reply Screen, Page 21

Field Name	Description
CN	**Claim Number** – Shows the beneficiary/patient's Medicare number.
NM	**Name** – Shortened form of the beneficiary/patient's surname (last name).
IT	**Initial** – First letter of beneficiary/patient's first name.
DB	**Date of Birth** – Beneficiary/patient's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary/patient's sex code.
HOSPICE DATE	This is only a header. No data is displayed in this field.

Field Name	Description
PERIOD	Indicates the benefit period (e.g., 001, 002, 003, etc.) of the beneficiary/patient enrollment in the Medicare hospice benefit.
OWNER CHANGE	Indicates a change of ownership with the hospice. When no changes of ownership apply, the number will correspond with the 'Period' number.
START DATE1	The start date of a beneficiary/patient's the hospice benefit period.
TERM DATE 1	Indicates the termination/end of the hospice benefit period.
PROV1	**First Provider** – first provider the beneficiary/patient has elected for hospice benefits. This is the assigned Medicare provider number.
INTER1	**First Intermediary Number** – Indicator as to the Medicare contractor that is processing the Hospice claim.
DOEBA	Date of earliest billing action.
DOLBA	Date of last billing action.
DAYS USED	Lists the number of days used per benefit period.
START DATE2	Lists second start date if a beneficiary/patient elects to change hospices or if there is a hospice change of ownership during a benefit period.
PROV2	Indicates the Second provider number to bill hospice claims when a beneficiary/patient chooses to change providers during a benefit period or when there is a hospice change of ownership.
INTER2	**Second Intermediary Number** – Indicator as to the Medicare contractor that is processing the hospice claim if the beneficiary/patient elects to change hospices or when there is a hospice change of ownership during a benefit period and claims are submitted to a different contractor.
REVOCATION IND	**Revocation Indicator** – Indicates if a beneficiary/patient has been discharged from revoked hospice benefits for the period. Valid values are: 0 = Beneficiary/patient has not been discharged or revoked hospice benefits. 1 = Beneficiary/patient has been discharged or revoked hospice benefits. 2 = Beneficiary/patient has been discharged or revoked hospice benefits; record was manually updated by CWF at the request of the Medicare contractor.