

APPENDIX E

ADDITIONAL DATA ELEMENTS

Activities Permitted Code

Adjudication or Payment Date

Adjusted Repriced Claim Reference Number

Adjustment Amount

Adjustment Quantity

Adjustment Reason Code

Amount Qualifier Code

Assigned Number

Attachment Control Number

Attachment Description

Attachment Report Type Code

Attachment Transmission Code

Attending Physician Middle Name

Attending Physician Name Suffix

Attending Physician Secondary Identifier

Auto Accident State or Province Code

Billing Provider Contact Name

Billing Provider Credit Card Identifier

Billing Provider Identifier

Bundled or Unbundled Line Number

Certification Condition Indicator

Certification Type Code

Claim Adjustment Group Code

Claim DRG Amount

Claim DRG Outlier Amount

Claim Disproportionate Share Amount

Claim ESRD Payment Amount

Claim Filing Indicator Code

Claim HCPCS Payable Amount

Claim Indirect Teaching Amount

Claim MSP Pass-through Amount

Claim PPS Capital Amount

Claim PPS Capital Outlier Amount

Claim Total Denied Charge Amount

Claim or Encounter Identifier

Code Category

Contact Function Code

Contract Amount

Contract Code

Contract Percentage

Contract Type Code

Contract Version Identifier

Coordination of Benefits Total Submitted Charge Amount

Cost Report Day Count

Country Code

Covered Days or Visits Count

Creditor Debit Card Authorization Number

Creditor Debit Card Holder First Name

Creditor Debit Card Holder Last or Organizational Name

Creditor Debit Card Holder Middle Name

Creditor Debit Card Holder Name Suffix

Creditor Debit Card Number

Creditor Debit Card Maximum Amount

Currency Code

Date Time Period Format Qualifier

Date Time Qualifier

Delay Reason Code

Delivery Pattern Time Code

Diagnosis Date

Diagnosis Related Group DRG Code

Discipline Type Code

Document Control Identifier

Duration of Visits Number of Units

Duration of Visits Units

Entity Identifier Code

Entity Type Qualifier

Estimated Claim Due Amount

Exception Code

Explanation of Benefits Indicator

Fixed Format Information

Frequency Count

Frequency Period

Functional Limitation Code

Hierarchical Child Code

Hierarchical ID Number

Hierarchical Level Code

Hierarchical Parent ID Number

Hierarchical Structure Code

Home Health Certification Period

Identification Code Qualifier

Information Receiver Identification Number

Investigational Device Exemption Identifier

Laboratory or Facility Address Line

Laboratory or Facility City Name

Laboratory or Facility Name

Laboratory or Facility Postal Zone or ZIP Code

Laboratory or Facility Primary Identifier

Laboratory or Facility Secondary Identifier

Laboratory or Facility State or Province Code

Last Admission Period

Last Visit Date

Lifetime Psychiatric Days Count

Lifetime Reserve Days Count

Medicare Assignment Code

Medicare Coverage Indicator

Medicare Paid at 100 Amount

Medicare Paid at 80 Amount

Mental Status Code

Non-Covered Charge Amount

Nonpayable Professional Component Amount

Note Reference Code

Number of Visits

Old Capital Amount

Operating Physician Middle Name

Operating Physician Name Suffix

Operating Physician Secondary Identifier

Originator Application Transaction Identifier

Other Insured Birth Date

Other Insured Gender Code

Other Insured Name Suffix

Other Payer Address Line

Other Payer Attending Provider Identifier

Other Payer City Name

Other Payer Operating Provider Identifier

Other Payer Other Provider Identifier

Other Payer Patient Primary Identifier

Other Payer Patient Secondary Identifier

Other Payer Postal Zone or ZIP Code

Other Payer Primary Identifier

Other Payer Referring Provider Identifier

Other Payer Service Facility Provider Identifier

Other Payer State Code

Other Provider Identifier

Other Provider Middle Name

Other Provider Name Suffix

Other Provider Secondary Identifier

PPS-Capital DSHDRG Amount

PPS-Capital Exception Amount

PPS-Capital FSPDRG Amount

PPS-Capital HSPDRG Amount

PPS-Capital IME Amount

PPS-Operating Federal Specific DRG Amount

PPS-Operating Hospital Specific DRG Amount

Paid From Part A Medicare Trust Fund Amount

Paid From Part B Medicare Trust Fund Amount

Patient Discharge Facility Type Code

Patient Name Suffix

Patient Primary Identifier

Patient Responsibility Amount

Patient Secondary Identifier

Patient Weight

Pay-To Provider Additional Identifier

Pay-To Provider Address Line

Pay-To Provider City Name

Pay-To Provider Identifier

Pay-To Provider Last or Organizational Name

Pay-To Provider Postal Zone or ZIP Code

Pay-To Provider State Code

Payer Additional Identifier

Payer Address Line

Payer City Name

Payer Identifier

Payer Postal Zone or ZIP Code

Payer State Code

Peer Review Authorization Number

Physician Contact Date

Physician Order Date

Policy Compliance Code

Pregnancy Indicator

Pricing Methodology

Procedure Code Description

Product or Service ID Qualifier

Prognosis Code

Property Casualty Claim Number

Provider Code

Provider Taxonomy Code

Provider or Supplier Signature Indicator

Receiver Primary Identifier

Referring Provider First Name

Referring Provider Identifier

Referring Provider Last Name

Referring Provider Middle Name

Referring Provider Name Suffix

Referring Provider Secondary Identifier

Reimbursement Rate

Reject Reason Code

Related Causes Code

Remark Code

Repriced Allowed Amount

Repriced Approved Amount

Repriced Approved DRG Code

Repriced Approved HCPCS Code

Repriced Approved Revenue Code

Repriced Approved Service Unit Count

Repriced Claim Reference Number

Repriced Saving Amount

Repricing Organization Identifier

Repricing Per Diem or Flat Rate Amount

Responsible Party Address Line

Responsible Party City Name

Responsible Party First Name

Responsible Party Last or Organization Name

Responsible Party Middle Name

Responsible Party Postal Zone or ZIP Code

Responsible Party State Code

Responsible Party Suffix Name

Service Adjudication or Payment Date

Service From Date

Service Line Paid Amount

Service Line Rate

Ship Delivery or Calendar Pattern Code

Skilled Nursing Facility Indicator

Special Program Indicator

Submitter Contact Name

Submitter First Name

Submitter Identifier

Submitter Last or Organization Name

Submitter Middle Name

Subscriber Birth Date

Subscriber Gender Code

Subscriber Name Suffix

Subscriber Supplemental Identifier

Surgery Date

Surgical Procedure Code

Terms Discount Percentage

Total Claim Charge Amount

Total Medicare Paid Amount

Total Visits Projected This Certification Count

Transaction Segment Count

Transaction Set Control Number

Transaction Set Creation Date

Transaction Set Creation Time

Transaction Set Identifier Code

Transaction Set Purpose Code

Transmission Type Code

Treatment Code

Unit or Basis for Measurement Code

Value Added Network Trace Number

Visits

Visits Prior to Recertification Date Count