

# *Research Data Distribution Center*

## *LDS Inpatient SNF Claim Record*

### *Data Dictionary*

*Variable Name*

*Label*

*CLAIM\_NO*

*CLAIM NUMBER*

The unique number used to identify a unique claim.

*DESY\_SORT\_KEY*

*DESY SORT KEY*

This field contains the key to link data for each beneficiary across all claim files.

*REC\_LVL*

*NCH Near-Line Record Version Code*

The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored:

DB2 ALIAS: NCH\_REC\_VRSN\_CD

SAS ALIAS: REC\_LVL

STANDARD ALIAS: NCH\_NEAR\_LINE\_REC\_VRSN\_CD

TITLE ALIAS: NCH\_VERSION

CODES:

A = Record format as of January 1991

B = Record format as of April 1991

C = Record format as of May 1991

D = Record format as of January 1992

E = Record format as of March 1992

F = Record format as of May 1992

G = Record format as of October 1993

H = Record format as of September 1998

I = Record format as of July 2000

COMMENT:

Prior to Version H this field was named:

CLM\_NEAR\_LINE\_REC\_VRSN\_CD

SOURCE:

NCH

*RIC\_CD*

*NCN Near Line Record Identification Code*

A code defining the type of claim record being processed. COMMON ALIAS: RIC

DBS ALAIS: NEAR\_LINE\_RIC\_CD

SAS ALIAS: RIC\_CD

*Variable Name*

*Label*

STANDARD ALIAS: NCH\_NEAR\_LINE\_RIC\_CD  
TITLE ALIAS: RIC  
CODES:  
REFER TO: NCH\_NEAR\_LINE\_RIC\_TB  
IN THE CODES APPENDIX  
COMMENT:  
Prior to Version H this field was named:  
RIC\_CD.  
SOURCE:  
NCH

*CLM\_TYPE*

*NCH Claim Type Code*

The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was populated with data through-out history (back to service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97).  
Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.

DB2 ALIAS: NCH\_CLM\_TYPE\_CD  
SAS ALIAS: CLM\_TYPE  
STANDARD ALIAS: NCH\_CLM\_TYPE\_CD  
SYSTEM ALIAS: LTTYPE  
TITLE ALIAS: CLAIM\_TYPE

DERIVATION:  
FFS CLAIM TYPE CODES DERIVED FROM:  
NCH CLM\_NEAR\_LINE\_RIC\_CD  
NCH PMT\_EDIT\_RIC\_CD  
NCH CLM\_TRANS\_CD  
NCH PRVDR\_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:  
(Pre-HDC processing -- AVAILABLE IN NCH)  
CLM\_MCO\_PD\_SW  
CLM\_RLT\_COND\_CD  
MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD  
MCO\_PRD\_EFCTV\_DT  
MCO\_PRD\_TRMNTN\_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

*Variable Name*

*Label*

(HDC processing -- AVAILABLE IN NMUD)

FI\_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD)

FI\_NUM

CLM\_FAC\_TYPE\_CD

CLM\_SRVC\_CLSFCTN\_TYPE\_CD

CLM\_FREQ\_CD

NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED

FROM: (AVAILABLE IN NMUD)

CARR\_NUM

CLM\_DEMO\_ID\_NUM

OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD)

FI\_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD)

FI\_NUM

CLM\_FAC\_TYPE\_CD

CLM\_SRVC\_CLSFCTN\_TYPE\_CD

CLM\_FREQ\_CD

DERIVATION RULES:

SET CLM\_TYPE\_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V','W' OR 'U'
2. PMT\_EDIT\_RIC\_CD EQUAL 'F'
3. CLM\_TRANS\_CD EQUAL '5'

SET CLM\_TYPE\_CD TO 20 (SNF NON-SWING BED CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR\_NUM IS NOT 'U', 'W', 'Y' OR 'Z'

SET CLM\_TYPE\_CD TO 30 (SNF SWING BED CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'

*Variable Name*

*Label*

3. CLM\_TRANS\_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR\_NUM EQUAL 'U', 'W', 'Y' OR 'Z'

SET CLM\_TYPE\_CD TO 40 (OUTPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'
2. PMT\_EDIT\_RIC\_CD EQUAL 'D'
3. CLM\_TRANS\_CD EQUAL '6'

SET CLM\_TYPE\_CD TO 41 (OUTPATIENT 'FULL'  
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE  
THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'
2. PMT\_EDIT\_RIC\_CD EQUAL 'D'
3. CLM\_TRANS\_CD EQUAL '6'
4. FI\_NUM = 80881

SET CLM\_TYPE\_CD TO 42 (OUTPATIENT 'ABBREVIATED'  
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)

1. FI\_NUM = 80881
2. CLM\_FAC\_TYPE\_CD = '1' OR '8';  
CLM\_SRVC\_CLSFCTN\_TYPE\_CD = '2', '3' OR '4'  
& CLM\_FREQ\_CD = 'Z', 'Y' OR 'X'

SET CLM\_TYPE\_CD TO 50 (HOSPICE CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'I'
3. CLM\_TRANS\_CD EQUAL 'H'

SET CLM\_TYPE\_CD TO 60 (INPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -  
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_MCO\_PD\_SW = '1'
2. CLM\_RLT\_COND\_CD = '04'
3. MCO\_CNTRCT\_NUM

MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN  
THE MCO\_PRD\_EFCTV\_DT &  
MCO\_PRD\_TRMNTN\_DT ENROLLMENT PERIODS

SET\_CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER

*Variable Name*

*Label*

CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'
4. FI\_NUM = 80881

SET CLM\_TYPE\_CD TO 62 (INPATIENT 'ABBREVIATED' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. FI\_NUM = 80881 AND
2. CLM\_FAC\_TYPE\_CD = '1'; CLM\_SRVC\_CLSFCTN\_TYPE\_CD = '1'; CLM\_FREQ\_CD = 'Z'

SET CLM\_TYPE\_CD TO 71 (RIC O non-DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 72 (RIC O DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'
2. HCPCS\_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SET CLM\_TYPE\_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM-- EFFECTIVE WITH HDC PROCESSING) WHERE THE CONDITIONS ARE MET:

1. CARR\_NUM = 80882 AND
2. CLM\_DEMO\_ID\_NUM = 38

SET CLM\_TYPE\_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 82 (RIC M DMEPOS DMERC CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'
2. HCPCS\_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

CODES:

REFER TO: NCH\_CLM\_TYPE\_TB  
IN THE CODES APPENDIX

SOURCE:  
NCH

*Variable Name*

*Label*

*STATE\_CD*

*Beneficiary Residence SSA Standard State Code*

The SSA standard state code of a beneficiary's residence. DA3  
ALIAS: SSA\_STANDARD\_STATE\_CODE

DB2 ALIAS: BENE\_SSA\_STATE\_CD

SAS ALIAS: STATE\_CD

STANDARD ALIAS: BENE\_RSDNC\_SSA\_STD\_STATE\_CD

TITLE ALIAS: BENE\_STATE\_CD

EDIT-RULES:

OPTIONAL: MAY BE BLANK

CODES:

REFER TO: GEO\_SSA\_STATE\_TB

IN THE CODES APPENDIX

COMMENT:

1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement.
2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish.
3. Also used for special studies.

SOURCE:

SSA/EDB

*THRU\_DT*

*Claim Through Date*

The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').

For the Limited Data Set Standard View of the Inpatient/SNF files, the claim through date is coded as the quarter of the calendar year when the claim through date occurred.

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM\_THRU\_DT

SAS ALIAS: THRU\_DT

STANDARD ALIAS: CLM\_THRU\_DT

TITLE ALIAS: THRU\_DATE

*Variable Name*

*Label*

EDIT-RULES FOR LIMITED DATA SET DATA:  
YYYYQ000 WHERE Q IS ONE OF THE  
FOLLOWING VALUES.  
1 = FIRST QUARTER OF THE CALENDAR YEAR  
2 = SECOND QUARTER OF THE CALENDAR YEAR  
3 = THIRD QUARTER OF THE CALENDAR YEAR  
4 = FOURTH QUARTER OF THE CALENDAR YEAR

SOURCE:  
CWF

*QUERY\_CD*

*Claim Query Code*

Code indicating the type of claim record being processed with  
respect to payment (debit/credit indicator;  
interim/final indicator).

DB2 ALIAS: CLM\_QUERY\_CD  
SAS ALIAS: QUERY\_CD  
STANDARD ALIAS: CLM\_QUERY\_CD  
TITLE ALIAS: QUERY\_CD

CODES:  
0 = Credit adjustment  
1 = Interim bill  
2 = Home Health Agency (HHA) benefits  
exhausted (obsolete 7/98)  
3 = Final bill  
4 = Discharge notice (obsolete 7/98)  
5 = Debit adjustment

SOURCE:  
CWF

*PROVIDER*

*Provider Number*

The identification number of the institutional provider certified  
by Medicare to provide services to the  
beneficiary.

DB2 ALIAS: PRVDR\_NUM  
SAS ALIAS: PROVIDER  
STANDARD ALIAS: PRVDR\_NUM  
TITLE ALIAS: PROVIDER\_NUMBER

CODES:  
REFER TO: PRVDR\_NUM\_TB  
IN THE CODES APPENDIX  
SOURCE:  
OSCAR

*Variable Name*

*Label*

*SGMT\_CNT*

*Claim Total Segment Count*

Effective with Version I, the count used to identify the total number of segments associated with a given claim. Each claim could have up to 10 segments.

2 DIGITS UNSIGNED

DB2 ALIAS: TOT\_SGMT\_CNT

SAS ALIAS: SGMT\_CNT

STANDARD ALIAS:

CLM\_TOT\_SGMT\_CNT TITLE ALIAS:

SEGMENT\_COUNT SOURCE:

CWF

*SGMT\_NUM*

*Claim Segment Number*

Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991).

For institutional claims prior to 7/00, this number will be either 1 or 2. For noninstitutional claims, the number will always be 1.

2 DIGITS UNSIGNED

DB2 ALIAS: CLM\_SGMT\_NUM

SAS ALIAS: SGMT\_NUM

STANDARD ALIAS:

CLM\_SGMT\_NUM TITLE ALIAS:

SEGMENT\_NUMBER SOURCE:

CWF

*PE\_RIC*

*NCH Payment and Edit Record Identification Code*

The code used for payment and editing purposes that indicates the type of institutional claim record.

DB2 ALIAS: PMT\_EDIT\_RIC\_CD

SAS ALIAS: PE\_RIC

STANDARD ALIAS: NCH\_PMT\_EDIT\_RIC\_CD

TITLE ALIAS: NCH\_PAYMENT\_EDIT\_REC

CODES:

C = Inpatient hospital, SNF

D = Outpatient

E = Religious Nonmedical Health Care Institutions (eff. 8/00 Christian Science, prior to 7/00)

F = Home Health Agency

(HHA) G = Discharge notice

(obsoleted 7/98)

I = Hospice

COMMENT:

Prior to Version H this field was named:

PMT\_EDIT\_RIC\_CD.

SOURCE:

NCH QA Process

*Variable Name*

*Label*

*TRANS\_CD*

*Claim Transaction Code*

The code derived by CWF to indicate the type of claim submitted by an institutional provider.

DB2 ALIAS: CLM\_TRANS\_CD  
SAS ALIAS: TRANS\_CD  
STANDARD ALIAS: CLM\_TRANS\_CD  
SYSTEM ALIAS: LTCLTRAN  
TITLE ALIAS: TRANSACTION\_CODE

CODES:  
REFER TO: CLM\_TRANS\_TB  
IN THE CODES APPENDIX

SOURCE:  
CWF

*FAC\_TYPE*

*Claim Facility Type Code*

The first digit of the type of bill (TOB1) submitted on an institutional claim used to identify the type of facility that provided care to the beneficiary.

COMMON ALIAS: TOB1  
DB2 ALIAS: CLM\_FAC\_TYPE\_CD  
SAS ALIAS: FAC\_TYPE  
STANDARD ALIAS: CLM\_FAC\_TYPE\_CD  
TITLE ALIAS: TOB1

CODES:  
REFER TO: CLM\_FAC\_TYPE\_TB  
IN THE CODES APPENDIX

SOURCE:  
CWF

*TYPESRVC*

*Claim Service Classification Type Code*

The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification of the type of service provided to the beneficiary.

COMMON ALIAS: TOB2  
DB2 ALIAS: SRVC\_CLSFCTN\_CD  
SAS ALIAS: TYPESRVC  
STANDARD ALIAS: CLM\_SRVC\_CLSFCTN\_TYPE\_CD  
TITLE ALIAS: TOB2

CODES:  
REFER TO: CLM\_SRVC\_CLSFCTN\_TYPE\_TB  
IN THE CODES APPENDIX

SOURCE:  
CWF

***Variable Name***

***Label***

***FREQ\_CD***

***Claim Frequency Code***

The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care.

COMMON ALIAS: TOB3  
DB2 ALIAS: CLM\_FREQ\_CD  
SAS ALIAS: FREQ\_CD  
STANDARD ALIAS: CLM\_FREQ\_CD  
SYSTEM ALIAS: LTFREQ  
TITLE ALIAS: FREQUENCY\_CD

CODES:  
REFER TO: CLM\_FREQ\_TB  
IN THE CODES APPENDIX

SOURCE:  
CWF

***CNTY\_CD***

***Beneficiary Residence SSA Standard County Code***

The SSA standard county code of a beneficiary's residence. DA3  
ALIAS: SSA\_STANDARD\_COUNTY\_CODE  
DB2 ALIAS: BENE\_SSA\_CNTY\_CD  
SAS ALIAS: CNTY\_CD  
STANDARD ALIAS: BENE\_RSDNC\_SSA\_STD\_CNTY\_CD  
TITLE ALIAS: BENE\_COUNTY\_CD

EDIT-RULES:  
OPTIONAL: MAY BE BLANK

SOURCE:  
SSA/EDB

***FI\_NUM***

***FI Number***

The identification number assigned by CMS to a fiscal intermediary authorized to process institutional claim records.

DB2 ALIAS: FI\_NUM  
SAS ALIAS: FI\_NUM  
STANDARD ALIAS: FI\_NUM  
SYSTEM ALIAS: LTFI  
TITLE ALIAS: INTERMEDIARY

CODES:  
REFER TO: FI\_NUM\_TB  
IN THE CODES APPENDIX

COMMENT:  
Prior to Version H this field was named:  
FICARR\_IDENT\_NUM.

SOURCE:  
CWF

*Variable Name*

*Label*

*SEX*

*Beneficiary Sex Identification Code*

The sex of a beneficiary. COMMON ALIAS:  
SEX\_CD DA3 ALIAS: SEX\_CODE  
DB2 ALIAS: BENE\_SEX\_IDENT\_CD  
SAS ALIAS: SEX  
STANDARD ALIAS: BENE\_SEX\_IDENT\_CD  
SYSTEM ALIAS: LTSEX  
TITLE ALIAS: SEX\_CD

EDIT-RULES:  
REQUIRED FIELD

CODES:  
1 = Male  
2 = Female  
0 = Unknown

SOURCE:  
SSA,RRB,EDB

*RACE*

*Beneficiary Race Code*

The race of a beneficiary.  
DA3 ALIAS: RACE\_CODE  
DB2 ALIAS: BENE\_RACE\_CD  
SAS ALIAS: RACE  
STANDARD ALIAS: BENE\_RACE\_CD  
SYSTEM ALIAS: LTRACE  
TITLE ALIAS: RACE\_CD

CODES:  
0 = Unknown  
1 = White  
2 = Black  
3 = Other  
4 = Asian  
5 = Hispanic  
6 = North American Native

SOURCE:  
SSA

*Variable Name*

*Label*

*BENE\_DOB*

*Beneficiary Birth Date*

The beneficiary's date of birth.  
For the Limited Data Set Standard View of  
the Inpatient/SNF files, the beneficiary's  
date of birth is coded as a range.

8 DIGITS UNSIGNED

DB2 ALIAS: BENE\_BIRTH\_DT  
SAS ALIAS: BENE\_DOB  
STANDARD ALIAS: BENE\_BIRTH\_DT  
TITLE ALIAS: BENE\_BIRTH\_DATE

EDIT-RULES FOR LIMITED DATA SET DATA:

000000R

WHERE R HAS ONE OF THE FOLLOWING VALUES.

0 = Unknown  
1 = <65  
2 = 65 Thru 69  
3 = 70 Thru 74  
4 = 75 Thru 79  
5 = 80 Thru 84  
6 = >84

SOURCE:

CWF

*MS\_CD*

*CWF Beneficiary Medicare Status Code*

The CWF -derived reason for a beneficiary's entitlement to  
Medicare benefits, as of the reference date (CLM\_THRU\_DT).

COBOL ALIAS: MSC  
COMMON ALIAS: MSC  
DB2 ALIAS: BENE\_MDCR\_STUS\_CD  
SAS ALIAS: MS\_CD  
STANDARD ALIAS: CWF\_BENE\_MDCR\_STUS\_CD  
SYSTEM ALIAS: LTMSC

*Variable Name*

*Label*

TITLE ALIAS: MSC

DERIVATION:

CWF derives MSC from the following:

1. Date of Birth
2. Claim Through Date
3. Original/Current Reasons for entitlement
4. ESRD Indicator
5. Beneficiary Claim Number

Items 1,3,4,5 come from the CWF Beneficiary Master Record; item 2 comes from the FI/Carrier claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

CODES:

- 10 = Aged without ESRD
- 11 = Aged with ESRD
- 20 = Disabled without ESRD
- 21 = Disabled with ESRD
- 31 = ESRD only

COMMENT:

Prior to Version H this field was named:

BENE\_MDCR\_STUS\_CD. The name has been changed to distinguish this CWF-derived field from the EDB-derived MSC (BENE\_MDCR\_STUS\_CD).

SOURCE:

CWF

*PDGNS\_CD*

*Claim Principal Diagnosis Code*

The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.

NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer.

- DB2 ALIAS: PRNCPAL\_DGNS\_CD
- SAS ALIAS: PDGNS\_CD
- STANDARD ALIAS: CLM\_PRNCPAL\_DGNS\_CD
- TITLE ALIAS: PRINCIPAL\_DIAGNOSIS

EDIT-RULES:

ICD-9-CM

SOURCE:

CWF

*Variable Name*

*Label*

*NOPAY\_CD*

*Claim Medicare Non Payment Reason Code*

The reason that no Medicare payment is made for services on an institutional claim.

NOTE: Effective with Version I, this field was put on all institutional claim types.

Prior to Version I, this field was present only on inpatient/SNF claims.

DB2 ALIAS: MDCR\_NPMT\_RSN\_CD

SAS ALIAS: NOPAY\_CD

STANDARD ALIAS: CLM\_MDCR\_NPMT\_RSN\_CD

SYSTEM ALIAS: LTNPMT

TITLE ALIAS: NON\_PAYMENT\_REASON

EDIT-RULES:

OPTIONAL

CODES:

REFER TO: CLM\_MDCR\_NPMT\_RSN\_TB

IN THE CODES APPENDIX

SOURCE:

CWF

*TRTMT\_CD*

*Claim Excepted/Nonexcepted Medical Treatment Code*

Effective with Version I, the code used to identify whether or not the medical care or treatment received by a beneficiary, who has elected care from a

Religious Nonmedical Health Care Institution (RNHCI), is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is re-quired under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted.

DB2 ALIAS: EXCPTD\_NEXCPTD\_CD

SAS ALIAS: TRTMT\_CD

STANDARD ALIAS: CLM\_EXCPTD\_NEXCPTD\_TRTMT\_CD

TITLE ALIAS: EXCPTD\_NEXCPTD\_CD

CODES:

0 = No Entry

1 = Excepted

2 = Nonexcepted

SOURCE:

CWF

*Variable Name*

*Label*

*PMT\_AMT*

*Claim Payment Amount*

Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. \*\*NOTE: In some situations, a negative claim payment amount may be pre-sent; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)

Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). It does NOT include the pass thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement.

Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center code = '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount.

Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total payment. The Medicare payment amount takes into account the wage index adjustment and the beneficiary deductible and coinsurance amounts. NOTE: There is no CWF edit check to validate that the revenue center Medicare payment amount equals the claim level Medicare payment amount.

*Variable Name*

*Label*

Under Home Health PPS, beneficiaries will be classified into an appropriate case mix category known as the Home Health Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG).

For the RAP, the PRICER will determine the payment amount appropriate to the HIPPS code by computing 60% (for first episode) or 50% (for subsequent episodes) of the case mix episode payment. The payment is then wage index adjusted.

For the final claim, PRICER calculates 100% of the amount due, because the final claim is processed as an adjustment to the RAP, reversing the RAP payment in full. Although final claim will show 100% payment amount, the provider will actually receive the 40% or 50% payment.

Exceptions: For claims involving demos and BBA encounter data, the amount reported in this field may not just represent the actual provider payment.

For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

For BBA encounter data (non-demo) -- 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the BBA plan.

9.2 DIGITS SIGNED

COMMON ALIAS: REIMBURSEMENT

DB2 ALIAS: CLM\_PMT\_AMT

SAS ALIAS: PMT\_AMT

STANDARD ALIAS: CLM\_PMT\_AMT

TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:

*Variable Name*

*Label*

+9(9).99

COMMENT:

Prior to Version H the size of this field was S9(7)V99. Also the noninstitutional claim records carried this field as a line item. Effective with Version H, this element is a claim level field across all claim types (and the line item field has been renamed.)

SOURCE:

CWF

LIMITATIONS:

Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM\_DISP\_CD of '02', the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over or under the actual Medicare payment amount.

*PRPAYAMT*

*NCH Primary Payer Claim Paid Amount*

The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on an institutional, carrier, or DMERC claim.

9.2 DIGITS SIGNED

DB2 ALIAS: PRMRY\_PYR\_PD\_AMT

SAS ALIAS: PRPAYAMT

STANDARD ALIAS: NCH\_PRMRY\_PYR\_CLM\_PD\_AMT

TITLE ALIAS: PRIMARY\_PAYER\_AMOUNT

EDIT-RULES:

+9(9).99

COMMENT:

Prior to Version H this field was named: BENE\_PRMRY\_PYR\_CLM\_PMT\_AMT and the field size was S9(7)V99.

SOURCE:

NCH

*PRPAY\_CD*

*NCH Primary Payer Code*

The code, on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's

*Variable Name*

*Label*

health insurance bills.

DB2 ALIAS: NCH\_PRMRY\_PYR\_CD

SAS ALIAS: PRPAY\_CD

STANDARD ALIAS: NCH\_PRMRY\_PYR\_CD

TITLE ALIAS: PRIMARY\_PAYER\_CD

DERIVATION:

DERIVED FROM:

CLM\_VAL\_CD

CLM\_VAL\_AMT

DERIVATION RULES

SET NCH\_PRMRY\_PYR\_CD TO 'A' WHERE THE  
CLM\_VAL\_CD = '12'

SET NCH\_PRMRY\_PYR\_CD TO 'B' WHERE THE  
CLM\_VAL\_CD = '13'

SET NCH\_PRMRY\_PYR\_CD TO 'C' WHERE THE  
CLM\_VAL\_CD = '16' and CLM\_VAL\_AMT is zeroes

SET NCH\_PRMRY\_PYR\_CD TO 'D' WHERE THE  
CLM\_VAL\_CD = '14'

SET NCH\_PRMRY\_PYR\_CD TO 'E' WHERE THE  
CLM\_VAL\_CD = '15'

SET NCH\_PRMRY\_PYR\_CD TO 'F' WHERE  
THE CLM\_VAL\_CD = '16' (CLM\_VAL\_AMT not  
equal to zeroes)

SET NCH\_PRMRY\_PYR\_CD TO 'G' WHERE THE  
CLM\_VAL\_CD = '43'

SET NCH\_PRMRY\_PYR\_CD TO 'H' WHERE THE  
CLM\_VAL\_CD = '41'

SET NCH\_PRMRY\_PYR\_CD TO 'I' WHERE THE  
CLM\_VAL\_CD = '42'

SET NCH\_PRMRY\_PYR\_CD TO 'L' (or prior to 4/97  
set code to 'J') WHERE THE CLM\_VAL\_CD = '47'

CODES:

REFER TO: BENE\_PRMRY\_PYR\_TB

IN THE CODES APPENDIX

COMMENT:

Prior to Version H this field was named:

BENE\_PRMRY\_PYR\_CD.

SOURCE:

NCH

*Variable Name*

*Label*

*CANCELCD*

*FI Requested Claim Cancel Reason Code*

The reason that an intermediary requested cancelling a previously submitted institutional claim.

DB2 ALIAS: RQST\_CNCL\_RSN\_CD

SAS ALIAS: CANCELCD

STANDARD ALIAS: FI\_RQST\_CLM\_CNCL\_RSN\_CD

TITLE ALIAS: CANCEL\_CD

CODES:

REFER TO: FI\_RQST\_CLM\_CNCL\_RSN\_TB

IN THE CODES APPENDIX

COMMENT:

Prior to Version H this field was named:

INTRMDRY\_RQST\_CLM\_CNCL\_RSN\_CD.

SOURCE:

CWF

*ACTIONCD*

*FI Claim Action Code*

The type of action requested by the intermediary to be taken on an institutional claim.

DB2 ALIAS: FI\_CLM\_ACTN\_CD

SAS ALIAS: ACTIONCD

STANDARD ALIAS: FI\_CLM\_ACTN\_CD

TITLE ALIAS: ACTION\_CD

CODES:

REFER TO: FI\_CLM\_ACTN\_TB

IN THE CODES APPENDIX

COMMENT:

Prior to Version H this field was named:

INTRMDRY\_CLM\_ACTN\_CD.

SOURCE:

CWF

*PRSTATE*

*NCH Provider State Code*

Effective with Version H, the two position SSA state code where provider facility is located.

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS: NCH\_PRVDR\_STATE\_CD

SAS ALIAS: PRSTATE

STANDARD ALIAS: NCH\_PRVDR\_STATE\_CD

*Variable Name*

*Label*

TITLE ALIAS: PROVIDER\_STATE\_CD

DERIVATION:

DERIVED FROM:

NCH PRVDR\_NUM

DERIVATION RULES:

SET NCH\_PRVDR\_STATE\_CD TO  
PRVDR\_NUM POS1-2.

FOR PRVDR\_NUM POS1-2 EQUAL '55

SET NCH\_PRVDR\_STATE\_CD TO '05'.

FOR PRVDR\_NUM POS1-2 EQUAL '67

SET NCH\_PRVDR\_STATE\_CD TO '45'.

FOR PRVDR\_NUM POS1-2 EQUAL '68

SET NCH\_PRVDR\_STATE\_CD TO '10'.

CODES:

REFER TO: GEO\_SSA\_STATE\_TB

IN THE CODES APPENDIX

SOURCE:

NCH

*AT\_UPIN*

*Claim Attending Physician UPIN Number*

On an institutional claim, the unique physician identification number (UPIN) of the physician who would normally be expected certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the beneficiary's medical care and treatment (attending physician).

This field is ENCRYPTED for the Limited Data Set Standard View of the Inpatient/SNF files.

COMMON ALIAS: ATTENDING\_PHYSICIAN\_UPIN

DB2 ALIAS: ATNDG\_UPIN

SAS ALIAS: AT\_UPIN

STANDARD ALIAS: CLM\_ATNDG\_PHYSN\_UPIN\_NUM

TITLE ALIAS: ATTENDING\_PHYSICIAN

COMMENT:

Prior to Version H this field was named:

CLM\_PRMRY\_CARE\_PHYSN\_IDENT\_NUM and contained

10 positions (6-position UPIN and 4-position physician surname).

SOURCE:

CWF

*OP\_UPIN*

*Claim Operating Physician UPIN Number*

*Variable Name*

*Label*

On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal element is used by the provider to identify the operating physician who performed the surgical procedure.

This field is ENCRYPTED for the Limited Data Set Standard View of the Inpatient/SNF files.

DB2 ALIAS: OPRTG\_UPIN  
SAS ALIAS: OP\_UPIN  
STANDARD ALIAS: CLM\_OPRTG\_PHYSN\_UPIN\_NUM  
TITLE ALIAS: OPRTG\_UPIN

COMMENT:  
Prior to Version H this field was named: CLM\_PRNCPAL\_PRCDR\_PHYSN\_NUM and contained 10 positions (6-position UPIN and 4-position physician surname).

NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces.

SOURCE:  
CWF

*OT\_UPIN*

*Claim Other Physician UPIN Number*

On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the claim.

This field is ENCRYPTED for the Limited Data Set Standard View of the Inpatient/SNF files.

DB2 ALIAS: OTHR\_UPIN  
SAS ALIAS: OT\_UPIN  
STANDARD ALIAS: CLM\_OTHR\_PHYSN\_UPIN\_NUM  
TITLE ALIAS: OTH\_PHYSN\_UPIN

COMMENT:  
Prior to Version H this field was named: CLM\_OTHR\_PHYSN\_IDENT\_NUM and contained 10 positions (6-position UPIN and 4-position other physician surname).

NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces.

SOURCE:  
CWF

*Variable Name*

*Label*

*MCOPDSW*

*Claim MCO Paid Switch*

A switch indicating whether or not a Managed Care Organization (MCO) has paid the provider for an institutional claim.

COBOL ALIAS: MCO\_PD\_IND  
DB2 ALIAS: CLM\_MCO\_PD\_SW  
SAS ALIAS: MCOPDSW  
STANDARD ALIAS: CLM\_MCO\_PD\_SW  
TITLE ALIAS: MCO\_PAID\_SW

CODES:  
1 = MCO has paid the provider for a claim  
Blank or 0 = MCO has not paid the provider  
COMMENT:  
Prior to Version H this field was named: CLM\_GHO\_PD\_SW.

SOURCE:  
CWF

*STUS\_CD*

*Patient Discharge Status Code*

The code used to identify the status of the patient as of the CLM\_THRU\_DT.  
COMMON ALIAS: DISCHARGE\_DESTINATION/PATIENT\_STATUS  
DB2 ALIAS: PTNT\_DSCHRG\_STUS  
SAS ALIAS: STUS\_CD  
STANDARD ALIAS: PTNT\_DSCHRG\_STUS\_CD  
SYSTEM ALIAS: LTCLMST  
TITLE ALIAS: PTNT\_DSCHRG\_STUS\_CD

CODES:  
REFER TO: PTNT\_DSCHRG\_STUS\_TB  
IN THE CODES APPENDIX

COMMENT:  
Prior to Version H this field was named: CLM\_STUS\_CD.

SOURCE:  
CWF

*DGNS\_E*

*Claim Diagnosis E Code*

Effective with Version H, the ICD-9-CM code used to identify the external cause of injury, poisoning, or other adverse affect. Redundantly

*Variable Name*

*Label*

this field is also stored as the last occurrence of the diagnosis trailer.

NOTE: During the Version H conversion, the data in the last occurrence of the diagnosis trailer was used to populate history.

DB2 ALIAS: CLM\_DGNS\_E\_CD  
SAS ALIAS: DGNS\_E  
STANDARD ALIAS: CLM\_DGNS\_E\_CD  
TITLE ALIAS: DGNS\_E\_CD

SOURCE:  
CWF

*PPS\_IND*

*Claim PPS Indicator Code*

Effective with Version H, the code indicating whether or not the (1) claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee (MQGE).

NOTE: Beginning with NCH weekly process date 10/3/97 through 5/29/98, this field was populated with only the PPS indicator. Beginning with NCH weekly process date 6/5/98, this field was additionally populated with the deemed MQGE indicator. Claims processed prior to 10/3/97 will contain spaces.

COBOL ALIAS: PPS\_IND  
DB2 ALIAS: CLM\_PPS\_IND\_CD  
SAS ALIAS: PPS\_IND  
STANDARD ALIAS: CLM\_PPS\_IND\_CD  
TITLE ALIAS: PPS\_IND

CODES:  
REFER TO: CLM\_PPS\_IND\_TB  
IN THE CODES APPENDIX

SOURCE:  
CWF

*TOT\_CHRG*

*Claim Total Charge Amount*

Effective with Version G, the total charges for all services included on the institutional claim.

This field is redundant with revenue center code 0001/total charges.

9.2 DIGITS SIGNED

DB2 ALIAS: CLM\_TOT\_CHRG\_AMT

*Variable Name*

*Label*

SAS ALIAS: TOT\_CHRG  
STANDARD ALIAS: CLM\_TOT\_CHRG\_AMT  
TITLE ALIAS: CLAIM\_TOTAL\_CHARGES  
  
EDIT-RULES:  
+9(9).99  
  
COMMENT:  
Prior to Version H the size of this field was  
S9(7)V99.  
  
SOURCE:  
CWF

*IPDGNCNT*

*Inpatient/SNF Claim Diagnosis Code Count*

The count of the number of diagnosis codes (both principal and other) reported on an inpatient/SNF claim. The purpose of this count is to indicate how many claim diagnosis trailers are present.  
  
2 DIGITS UNSIGNED  
  
DB2 ALIAS: IP\_CLM\_DGNS\_CD\_CNT  
SAS ALIAS: IPDGNCNT  
STANDARD ALIAS: IP\_CLM\_DGNS\_CD\_CNT  
  
EDIT-RULES:  
RANGE: 0 TO 10  
  
COMMENT:  
Prior to Version H this field was named:  
CLM\_OTHR\_DGNS\_CD\_CNT and the principal was  
not included in the count.  
  
SOURCE:  
CWF

*IPPRCNT*

*Inpatient/SNF Claim Procedure Code Count*

The count of the number of procedure codes (both principal and other) reported on an inpatient/SNF claim. The purpose of this count is to indicate how many claim procedure trailers are present.  
  
2 DIGITS UNSIGNED  
  
DB2 ALIAS: IP\_PRCDR\_CD\_CNT  
SAS ALIAS: IPPRCNT  
STANDARD ALIAS: IP\_CLM\_PRCDR\_CD\_CNT  
  
EDIT-RULES:  
RANGE: 0 TO 6  
  
COMMENT:

***Variable Name***

***Label***

Prior to Version H this field was named:  
CLM\_PRCDR\_CD\_CNT.

SOURCE:  
CWF

***IPLCONCNT***

***Inpatient/SNF Claim Related Condition Code Count***

The count of the number of condition codes reported on an inpatient/SNF claim. The purpose of this count is to indicate how many condition code trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: IP\_RLT\_COND\_CD\_CNT  
SAS ALIAS: IPLCONCNT  
STANDARD ALIAS: IP\_CLM\_RLT\_COND\_CD\_CNT

EDIT-RULES:  
RANGE: 0 TO 30

COMMENT:  
Prior to Version H this field was named:  
CLM\_RLT\_COND\_CD\_CNT.

SOURCE:  
CWF

***IPOCRCNT***

***Inpatient/SNF Claim Related Occurrence Code Count***

The count of the number of occurrence codes reported on an inpatient/SNF claim. The purpose of this count is to indicate how many occurrence code trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: IP\_OCRNC\_CD\_CNT  
SAS ALIAS: IPOCRCNT  
STANDARD ALIAS: IP\_CLM\_RLT\_OCRNC\_CD\_CNT

EDIT-RULES:  
RANGE: 0 TO 30

COMMENT:  
Prior to Version H this field was named:  
CLM\_RLT\_OCRNC\_CD\_CNT.

SOURCE:  
CWF

***IPVALCNT***

***Inpatient/SNF Claim Value Code Count***

The count of the number of value codes reported on an inpatient/SNF claim. The purpose of the count is to indicate how many value code trailers are present.

*Variable Name*

*Label*

2 DIGITS UNSIGNED  
DB2 ALIAS: IP\_VAL\_CD\_CNT  
SAS ALIAS: IPVALCNT  
STANDARD ALIAS: IP\_CLM\_VAL\_CD\_CNT  
EDIT-RULES:  
RANGE: 0 TO 36  
COMMENT:  
Prior to Version H this field was named:  
CLM\_VAL\_CD\_CNT.  
SOURCE:  
CWF

*IPREVCNT*

*Inpatient/SNF Revenue Center Code Count*

The count of the number of revenue codes reported on an inpatient/SNF claim. The purpose of the count is to indicate how many revenue center trailers are present.

2 DIGITS UNSIGNED  
DB2 ALIAS: IP\_REV\_CNTR\_CD\_CNT  
SAS ALIAS: IPREVCNT  
STANDARD ALIAS: IP\_REV\_CNTR\_CD\_I\_CNT  
EDIT-RULES:  
RANGE: 0 TO 45  
COMMENT:  
Prior to Version H this field was named:  
CLM\_REV\_CNTR\_CD\_CNT.  
If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).  
SOURCE:  
CWF

*ADMSN\_DT*

*Claim Admission Date*

On an institutional claim, the date the beneficiary was admitted to the hospital, skilled nursing facility, or christian science sanitorium.

*Variable Name*

*Label*

For the Limited Data Set Standard View of the Inpatient/SNF files, the admission date for the claim is coded as the quarter of the calendar year when the admission occurred.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM\_ADMSN\_DT

SAS ALIAS: ADMSN\_DT

STANDARD ALIAS: CLM\_ADMSN\_DT

TITLE ALIAS: ADMISSION\_DT

EDIT-RULES FOR LIMITED DATA SET DATA:  
YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES.

1 = FIRST QUARTER OF THE CALENDAR YEAR

2 = SECOND QUARTER OF THE CALENDAR YEAR

3 = THIRD QUARTER OF THE CALENDAR YEAR

4 = FOURTH QUARTER OF THE CALENDAR YEAR

SOURCE:

CWF

*SRC\_ADMS*

*Claim Source Inpatient Admission Code*

The code indicating the means by which the beneficiary was admitted to the inpatient health care facility or SNF if the type of (1) emergency, (2) urgent, or (3) elective.

DB2 ALIAS: SRC\_IP\_ADMSN\_CD

SAS ALIAS: SRC\_ADMS

STANDARD ALIAS: CLM\_SRC\_IP\_ADMSN\_CD

TITLE ALIAS: IP\_ADMISSION\_SOURCE

CODES:

REFER TO: CLM\_SRC\_IP\_ADMSN\_TB

IN THE CODES APPENDIX

SOURCE:

CWF

*AD\_DGNS*

*Claim Admitting Diagnosis Code*

An ICD-9-CM code on the institutional inpatient/ SNF claim indicating the beneficiary's initial diagnosis at admission.

DB2 ALIAS: CLM\_ADMTG\_DGNS\_CD

SAS ALIAS: AD\_DGNS

STANDARD ALIAS: CLM\_ADMTG\_DGNS\_CD

TITLE ALIAS: ADMITTING\_DIAGNOSIS

SOURCE:

CWF

*Variable Name*

*Label*

*PTNTSTUS*

*NCH Patient Status Indicator Code*

Effective with Version H, the code on an inpatient/SNF and Hospice claim, indicating whether the beneficiary was discharged, or still a patient (used for internal CWFMQA editing purposes.)

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS: NCH\_PTNT\_STUS\_IND

SAS ALIAS: PTNTSTUS

STANDARD ALIAS: NCH\_PTNT\_STUS\_IND\_CD

TITLE ALIAS: NCH\_PATIENT\_STUS

DERIVATION:

DERIVED FROM:

NCH\_PTNT\_DSCHRG\_STUS\_CD

DERIVATION RULES:

SET NCH\_PTNT\_STUS\_IND\_CD TO 'A' WHERE THE PTNT\_DSCHRG\_STUS\_CD NOT EQUAL TO '20' - '30' OR '40' - '42'.

SET NCH\_PTNT\_STUS\_IND\_CD TO 'B' WHERE THE PTNT\_DSCHRG\_STUS\_CD EQUAL TO '20' - '29' OR '40' - '42'.

SET NCH\_PTNT\_STUS\_IND\_CD TO 'C' WHERE THE PTNT\_DSCHRG\_STUS\_CD EQUAL TO '30'

CODES:

A = Discharged

B = Died

C = Still patient

SOURCE:

NCH QA Process

*PER\_DIEM*

*Claim Pass Thru Per Diem Amount*

f the established reimbursable costs for the current year divided by the estimated Medicare days for the current year (all PPS claims), as calculated by the FI and reimbursement staff. Items reimbursed as a pass through include capital-related costs; direct medical education costs; kidney acquisition costs for hospitals approved as RTCs; and bad debts (per Provider Reimbursement Manual,

*Variable Name*

*Label*

Part 1, Section 2405.2). \*\*Note: Pass throughs are not included in the Claim Payment Amount.

9.2 DIGITS SIGNED

DB2 ALIAS: PASS\_THRU\_PER\_DIEM

SAS ALIAS: PER\_DIEM

STANDARD ALIAS: CLM\_PASS\_THRU\_PER\_DIEM\_AMT

TITLE ALIAS: PER\_DIEM

EDIT-RULES:

+9(9).99

COMMENT:

Prior to Version H the field size was:

S9(5)V99.

SOURCE:

CWF

*COIN\_AMT*

*NCH Beneficiary Part A Coinsurance Liability Amount*

The amount of money for which the intermediary has determined that the beneficiary is liable for Part A coinsurance on the

9.2 DIGITS SIGNED

DB2 ALIAS: PTA\_COINSRNC\_AMT

SAS ALIAS: COIN\_AMT

STANDARD ALIAS: NCH\_BENE\_PTA\_COINSRNC\_AMT

TITLE ALIAS: BENE\_PTA\_COINSURANCE

EDIT-RULES:

+9(9).99

DERIVATION:

DERIVED FROM:

CLM\_VAL\_CD

CLM\_VAL\_AMT

DERIVATION RULES:

Based on the presence of value code equal to

8, 9, 10 or 11 move the corresponding value

amount to the NCH\_BENE\_IP\_PTA\_COINSRC\_AMT.

COMMENT:

Prior to Version H this field was named:

BENE\_PTA\_COINSRNC\_LBLTY\_AMT and the field

size was S9(5)V99.

SOURCE:

NCH

***Variable Name***

***BLDDEDAM***

***Label***

***NCH Beneficiary Blood Deductible Liability Amount***

The amount of money for which the intermediary determined the beneficiary is liable for the blood deductible.

9.2 DIGITS SIGNED

DB2 ALIAS: BLOOD\_DDCTBL\_AMT

SAS ALIAS: BLDDEDAM

STANDARD ALIAS: NCH\_BENE\_BLOOD\_DDCTBL\_AMT

TITLE ALIAS: BLOOD\_DEDUCTIBLE

EDIT-RULES:

+9(9).99

DERIVATION:

DERIVED FROM:

CLM\_VAL\_CD

CLM\_VAL\_AMT

DERIVATION RULES:

Based on the presence of value code equal to '06' move the corresponding value amount to NCH\_BENE\_BLOOD\_DDCTBL\_AMT.

COMMENT:

Prior to Version H, this field was named:

BENE\_BLOOD\_DDCTBL\_LBLTY\_AMT and the field size was S9(5)V99. Also, for OP claims, this field was stored in a blood trailer. Version H eliminated the OP blood trailer.

SOURCE:

NCH QA PROCESS

***BLDTCHRG***

***NCH Blood Total Charge Amount***

Effective with Version H, the total charge for blood usage (for internal CWFMQA editing purposes).

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

9.2 DIGITS SIGNED

DB2 ALIAS: BLOOD\_TOT\_CHRG\_AMT

SAS ALIAS: BLDTCHRG

STANDARD ALIAS: NCH\_BLOOD\_TOT\_CHRG\_AMT

TITLE ALIAS: BLOOD\_CHARGES

EDIT-RULES:

+9(9).99

*Variable Name*

*Label*

DERIVATION:  
DERIVED FROM:  
REV\_CNTR\_CD  
REV\_CNTR\_TOT\_CHRG\_AMT

DERIVATION RULES:  
Based on the presence of revenue center codes  
0380 thru 0389 move the related total charge  
amount to the NCH\_BLOOD\_TOT\_CHRG\_AMT.

SOURCE:  
NCH QA Process

*BLDNCHRG*

*NCH Blood Non-Covered Charge Amount*

Effective with Version H, the total noncovered charges for  
blood usage (for internal CWFMQA editing purposes).

NOTE: During the Version H conversion this field  
was populated with data throughout history (back  
to service year 1991).

9.2 DIGITS SIGNED

DB2 ALIAS: BLOOD\_NCVR\_AMT  
DB2 ALIAS: BLOOD\_NCVR\_AMT  
SAS ALIAS: BLDNCHRG  
STANDARD ALIAS: NCH\_BLOOD\_NCOV\_CHRG\_AMT  
TITLE ALIAS: BLOOD\_NCV\_CHARGES

EDIT-RULES:  
+9(9).99

DERIVATION:  
DERIVED FROM:  
REV\_CNTR\_CD  
REV\_CNTR\_NCOV\_CHRG\_AMT

DERIVATION RULES:  
Based on the presence of revenue center codes  
equal to 0380 thru 0389 move the related noncovered  
charges to NCH\_BLOOD\_NCOV\_CHRG\_AMT.

SOURCE:  
NCH QA Process

*PCCHGAMT*

*NCH Professional Component Charge Amount*

Effective with Version H, for inpatient and out- patient claims,  
the amount of physician and other professional charges covered  
under Medicare Part B

(used for internal CWFMQA editing purposes and other  
internal processes (e.g. if computing interim payment

*Variable Name*

*Label*

these charges are deducted)).

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

9.2 DIGITS SIGNED

DB2 ALIAS: PROFNL\_CMPNT\_AMT

SAS ALIAS: PCCHGAMT

STANDARD ALIAS: NCH\_PROFNL\_CMPNT\_CHRG\_AMT

TITLE ALIAS: PROFNL\_CMPNT\_CHARGES

EDIT-RULES:

+9(9).99

DERIVATION:

1. IF INPATIENT - DERIVED FROM:

CLM\_VAL\_CD

CIm\_VAL\_AMT

DERIVATION RULES:

Based on the presence of value code 04 or 05 move the related value amount to the NCH\_PROFNL\_CMPNT\_CHRG\_AMT.

2. IF OUTPATIENT - DERIVED

FROM: REV\_CNTR\_CD

REV\_CNTR\_TOT\_CHRG\_AMT

DERIVATION RULES (Effective 10/98):

Based on the presence of revenue center codes 096X, 097X & 098X move the related total charge amount to NCH\_PROFNL\_CMPNT\_CHRG\_AMT.

NOTE1: During the Version H conversion, this field was populated with data throughout history BUT the derivation rule applied to the outpatient claim was incomplete (i.e., revenue codes 0972, 0973, 0974 and 0979 were omitted from the calculation).

SOURCE:

NCH QA Process

*TDEDAMT*

*NCH Inpatient Total Deduction Amount*

Effective with Version H, the total Part A deductions reported on the Inpatient claim (used for internal CWFMQA editing purposes).

NOTE: During the Version H conversion this field was populated with data throughout history (back

*Variable Name*

*Label*

to 1991), but the derivation rule applied was incomplete for claims processed prior to 10/93. Disregard any data present in this field on claims with NCH weekly process date earlier than 10/93.

9.2 DIGITS SIGNED

DB2 ALIAS: IP\_TOT\_DDCTN\_AMT  
SAS ALIAS: TDEDAMT  
STANDARD ALIAS: NCH\_BENE\_IP\_DDCTBL\_AMT  
TITLE ALIAS: IP\_TOT\_DEDUCTIONS

EDIT-RULES:

+9(9).99

DERIVATION:

DERIVED FROM:

CLM\_VAL\_CD

CLM\_VAL\_AMT

DERIVATION RULES (Effective 10/93):

Accumulate the value amounts associated with value codes equal to 06, 08 thru 11 and A1, B1 or C1 and move to NCH\_BENE\_IP\_DDCTBL\_AMT.

NOTE: Value codes 08-11 did not exist in the NCH prior to 2/93; values codes A1, B1, C1 did not exist prior to 10/93.

SOURCE:

NCH QA Process

*PPS\_CPTL*

*Claim Total PPS Capital Amount*

The total amount that is payable for capital PPS for the claim. This is the sum of the capital hospital specific portion, federal specific portion, outlier portion, disproportionate share portion, indirect medical education portion, exception payments, and hold harmless payments.

9.2 DIGITS SIGNED

DB2 ALIAS: TOT\_PPS\_CPTL\_AMT  
SAS ALIAS: PPS\_CPTL  
STANDARD ALIAS: CLM\_TOT\_PPS\_CPTL\_AMT  
TITLE ALIAS: PPS\_CAPITAL

EDIT-RULES:

+9(9).99

COMMENT:

Prior to Version H the size of this field was: S9(7)V99.

SOURCE:

CWF

*Variable Name*

*Label*

*CPTL\_HSP*

*Claim PPS Capital HSP Amount*

Effective 3/2/92, the hospital specific portion of the PPS payment for capital.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS\_CPTL\_HSP\_AMT

SAS ALIAS: CPTL\_HSP

STANDARD ALIAS: CLM\_PPS\_CPTL\_HSP\_AMT

TITLE ALIAS: PPS\_CAPITAL\_HSP

EDIT-RULES:

+9(9).99

COMMENT:

Prior to Version H the size of this field was:

S9(7)V99.

SOURCE:

CWF

*CPTL\_FSP*

*Claim PPS Capital FSP Amount*

Effective 3/2/92, the amount of the federal specific portion of the PPS payment for capital.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS\_CPTL\_FSP\_AMT

SAS ALIAS: CPTL\_FSP

STANDARD ALIAS: CLM\_PPS\_CPTL\_FSP\_AMT

TITLE ALIAS: PPS\_CAPITAL\_FSP

EDIT-RULES:

+9(9).99

COMMENT:

Prior to Version H the size of this field was:

S9(7)V99.

SOURCE:

CWF

*CPTLOUTL*

*Claim PPS Capital Outlier Amount*

Effective 3/2/92, the amount of the outlier portion of the PPS payment for capital.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS\_OUTLIER\_AMT

SAS ALIAS: CPTLOUTL

*Variable Name*

*Label*

STANDARD ALIAS: CLM\_PPS\_CPTL\_OUTLIER\_AMT

TITLE ALIAS: PPS\_CPTL\_OUTLIER

EDIT-RULES:

+9(9).99

COMMENT:

Prior to Version H the size of this field was:

S9(7)V99.

SOURCE:

CWF

*DISP\_SHR*

*Claim PPS Capital Disproportionate Share Amount*

Effective 3/2/92, the amount of disproportionate share (rate reflecting indigent population served) portion of the PPS payment

9.2 DIGITS SIGNED

DB2 ALIAS: PPS\_DSPRPRTNT\_AMT

SAS ALIAS: DISP\_SHR

STANDARD ALIAS: CLM\_PPS\_CPTL\_DSPRPRTNT\_SHR\_AMT

TITLE ALIAS: PPS\_DISP\_SHR

EDIT-RULES:

+9(9).99

COMMENT:

Prior to Version H the size of the field was:

S9(7)V99.

SOURCE:

CWF

*IME\_AMT*

*Claim PPS Capital IME Amount*

Effective 3/2/92, the amount of the indirect medical education (IME) (reimbursable amount for teaching hospitals only; an added amount passed by Congress

to augment normal PPS payments for teaching hospitals to compensate them for higher patient costs resulting from medical education programs for interns and residents) portion of the PPS payment for capital.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS\_CPTL\_IME\_AMT

SAS ALIAS: IME\_AMT

STANDARD ALIAS: CLM\_PPS\_CPTL\_IME\_AMT

TITLE ALIAS: PPS\_CPTL\_IME

EDIT-RULES:

*Variable Name*

*Label*

+9(9).99

COMMENT:

Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE:

CWF

*CPTL\_EXP*

*Claim PPS Capital Exception Amount*

Effective 3/2/92, the capital PPS amount of exception payments provided for hospitals with inordinately high levels of capital obligations. Exception payments expire at the end of the 10-year transition period.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS\_EXCPTN\_AMT

SAS ALIAS: CPTL\_EXP

STANDARD ALIAS: CLM\_PPS\_CPTL\_EXCPTN\_AMT

TITLE ALIAS: PPS\_CPTL\_EXCP

EDIT-RULES:

+9(9).99

COMMENT:

Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE:

CWF

*HLDHRMLS*

*Claim PPS Old Capital Hold Harmless Amount*

Effective 3/2/92, this amount is the hold harmless amount payable for old capital as computed by PRICER for providers with a payment code equal to 'A'. The hold harmless amount-old capital is 100 percent of the reasonable costs of old capital for sole community sole community hospitals, or 85 percent of the reasonable costs associated with old capital for all other hospitals, plus a payment for new capital.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS\_CPTL\_HRMLS\_AMT

SAS ALIAS: HLDHRMLS

STANDARD ALIAS: CLM\_PPS\_OLD\_CPTL\_HLD\_HRMLS\_AMT

TITLE ALIAS: PPS\_CPTL\_HOLD\_HRMLS

EDIT-RULES:

+9(9).99

*Variable Name*

*Label*

COMMENT:  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE:  
CWF

*DSCHFRCT*

*Claim PPS Capital Discharge Fraction Percent*

Effective 3/2/92, the percent resulting from dividing the days by the average length of stay for capital PPS transfer cases (PRICER codes 03, 05, 06) not to exceed 1.

1.4 DIGITS SIGNED

DB2 ALIAS: PPS\_DSCHRG\_PCT  
SAS ALIAS: DSCHFRCT  
STANDARD ALIAS: CLM\_PPS\_CPTL\_DSCHRG\_FRCTN\_PCT  
TITLE ALIAS: PPS\_CAPITL\_DSCHRG\_FRACTION\_PCT

EDIT-RULES:  
+9.9(4)

SOURCE:  
CWF

*DRGWTAMT*

*Claim PPS Capital DRG Weight Number*

Effective 3/2/92, the number used to determine a transfer adjusted case mix index for capital PPS. The number is determined by multiplying the DRG weight times the discharge fraction.

3.4 DIGITS SIGNED

DB2 ALIAS: PPS\_DRG\_WT\_NUM  
SAS ALIAS: DRGWTAMT  
STANDARD ALIAS: CLM\_PPS\_CPTL\_DRG\_WT\_NUM  
TITLE ALIAS: PPS\_CAPITAL\_DRG\_WEIGHT\_NUM

EDIT-RULES:  
+999.9(4)

SOURCE:  
CWF

*UTIL\_DAY*

*Claim Utilization Day Count*

On an institutional claim, the number of covered days of care that are chargeable to Medicare facility utilization that includes full days, coinsurance days, and lifetime reserve days.

3 DIGITS SIGNED

*Variable Name*

*Label*

DB2 ALIAS: CLM\_UTLZTN\_DAY\_CNT  
SAS ALIAS: UTIL\_DAY  
STANDARD ALIAS: CLM\_UTLZTN\_DAY\_CNT  
TITLE ALIAS: UTILIZATION\_DAYS  
  
EDIT -  
RULES: +999  
  
SOURCE:  
CWF

*COIN\_DAY*

*Beneficiary Total Coinsurance Days Count*

The count of the total number of coinsurance days involved with the beneficiary's stay in a facility.  
3 DIGITS SIGNED  
  
DB2 ALIAS: COINSRNC\_DAY\_CNT  
SAS ALIAS: COIN\_DAY  
STANDARD ALIAS: BENE\_TOT\_COINSRNC\_DAY\_CNT  
TITLE ALIAS: COINSRNC\_DAYS  
  
EDIT -  
RULES: +999  
  
SOURCE:  
CWF

*LRD\_USE*

*Beneficiary LRD Used Count*

The number of lifetime reserve days that the beneficiary has elected to use during the period covered by the institutional claim. Under Medicare, each beneficiary has a one-time reserve of sixty additional days of inpatient hospital coverage that can be used after 90 days of inpatient care have been provided in a single benefit period. This count is used to subtract from the total number of lifetime reserve days that a beneficiary has available.  
3 DIGITS SIGNED  
  
DB2 ALIAS: BENE\_LRD\_USE\_CNT  
SAS ALIAS: LRD\_USE  
STANDARD ALIAS: BENE\_LRD\_USE\_CNT  
TITLE ALIAS: LRD\_USED  
  
EDIT -  
RULES: +999  
  
SOURCE:  
CWF

***Variable Name***

***Label***

*NUTILDAY*

*Claim Non Utilization Days Count*

On an institutional claim, the number of days of care that are not chargeable to Medicare facility utilization.

5 DIGITS SIGNED

DB2 ALIAS: NUTLZTN\_DAY\_CNT

SAS ALIAS: NUTILDAY

STANDARD ALIAS: CLM\_NUTLZTN\_DAY\_CNT

TITLE ALIAS: NUTLZTN\_DAYS

EDIT- RULES:

+9(5)

SOURCE:

CWF

*BLDFRNSH*

*NCH Blood Pints Furnished Quantity*

Number of whole pints of blood furnished to the beneficiary.

3 DIGITS SIGNED

DB2 ALIAS: NCH\_BLOOD\_PT\_FRNSH

SAS ALIAS: BLDFRNSH

STANDARD ALIAS: NCH\_BLOOD\_PT\_FRNSH\_QTY

TITLE ALIAS: BLOOD\_PINTS\_FURNISHED

EDIT - RULES:

+999

DERIVATION:

DERIVED FROM:

CLM\_VAL\_CD

CLM\_VAL\_AMT

DERIVATION RULES:

Based on the presence of value code equal to

37 move the related value amount to the

NCH\_BLOOD\_PT\_FRNSH\_QTY.

COMMENT:

Prior to Version H this field was named:

CLM\_BLOOD\_PT\_FRNSH\_QTY. Also for outpatient

claims this field was stored in a blood

trailer. Version H eliminated the outpatient

blood trailer.

SOURCE:

NCH QA Process

*BLD\_RPLC*

*NCH Blood Pints Replaced Quantity*

*Variable Name*

*Label*

Number of whole pints of blood replaced. 3 DIGITS SIGNED

DB2 ALIAS: BLOOD\_PT\_RPLC\_QTY

SAS ALIAS: BLD\_RPLC

STANDARD ALIAS: NCH\_BLOOD\_PT\_RPLC\_QTY

TITLE ALIAS: BLOOD\_PINTS\_REPLACED

EDIT -

RULES: +999

DERIVATION:

DERIVED FROM:

CLM\_VAL\_CD

CLM\_VAL\_AMT

DERIVATION RULES:

Based on the presence of value code equal to

39 move the related value amount to the

NCH\_BLOOD\_PT\_RPLC\_QTY.

COMMENT:

Prior to Version H this field was named:

CLM\_BLOOD\_PT\_RPLC\_QTY. Also for outpatient

claims this field was stored in a blood

trailer. Version H eliminated the outpatient

blood trailer.

SOURCE:

NCH QA Process

*BLDNRPLC*

*NCH Blood Pints Not Replaced Quantity*

Number of whole pints of blood not replaced. 3 DIGITS SIGNED

DB2 ALIAS: BLOOD\_PT\_NRPLC\_QTY

SAS ALIAS: BLDNRPLC

STANDARD ALIAS: NCH\_BLOOD\_PT\_NRPLC\_QTY

TITLE ALIAS: BLOOD\_PINTS\_NOT\_REPLACED

EDIT -

RULES: +999

DERIVATION:

DERIVED FROM:

CLM\_VAL\_CD

CLM\_VAL\_AMT

DERIVATION RULES:

Subtract value code 39 amount from value code

37 amount and move the result to

NCH\_BLOOD\_PT\_NRPLC\_QTY.

COMMENT:

*Variable Name*

*Label*

Prior to Version H this field was named:  
CLM\_BLOOD\_PT\_NRPLC\_QTY. Also for outpatient  
claims this field was stored in a blood  
trailer. Version H eliminated the outpatient  
blood trailer.

SOURCE:  
NCH QA Process

*BLDDEDPT*

*NCH Blood Deductible Pints Quantity*

The quantity of blood pints applied (blood deductible).  
3 DIGITS SIGNED

DB2 ALIAS: BLOOD\_DDCTBL\_QTY  
SAS ALIAS: BLDDEDPT  
STANDARD ALIAS: NCH\_BLOOD\_DDCTBL\_PT\_QTY  
TITLE ALIAS: BLOOD\_PINTS\_DEDUCTIBLE

EDIT -

RULES: +999

DERIVATION:  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to  
38 move the related value amount to the  
NCH\_BLOOD\_DDCTBL\_PT\_QTY.

COMMENT:  
Prior to Version H this field was named:  
CLM\_BLOOD\_DDCTBL\_PT\_QTY. Also for outpatient  
claims this field was stored in a blood  
trailer. Version H eliminated the outpatient  
blood trailer.

SOURCE:  
NCH QA Process

*QLFYTHRU*

*NCH Qualify Stay Through Date*

Effective with Version H, the ending date of the beneficiary's  
qualifying stay (used for internal CWFMQA editing purposes.) For  
inpatient claims, the  
date relates to the PPS portion of the inlier for  
which there is no utilization to benefits. For  
SNF claims, the date relates to a qualifying stay  
from a hospital that is at least two days in a row  
if the source of admission is an 'A', or at least

*Variable Name*

*Label*

three days in a row if the source of admission is other than 'A'.

For the Limited Data Set Standard View of the Inpatient/SNF files, the beneficiary's qualifying stay through date is coded as the quarter of calendar year when the stay through date occurred.

NOTE: During the Version H, conversion this field was populated with data throughout history (back to service year 1991).

8 DIGITS UNSIGNED

DB2 ALIAS: QLFY\_STAY\_THRU\_DT

SAS ALIAS: QLFYTHRU

STANDARD ALIAS: NCH\_QLFY\_STAY\_THRU\_DT

TITLE ALIAS: QLFYG\_STAY\_THRU\_DT

EDIT-RULES FOR LIMITED DATA SET DATA:

YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES.

1 = FIRST QUARTER OF THE CALENDAR YEAR

2 = SECOND QUARTER OF THE CALENDAR YEAR

3 = THIRD QUARTER OF THE CALENDAR YEAR

4 = FOURTH QUARTER OF THE CALENDAR YEAR

DERIVATION:

DERIVED FROM:

CLM\_OCRNC\_SPAN\_CD

CLM\_OCRNC\_SPAN\_THRU\_DT

DERIVATION RULES:

Based on the presence of occurrence code 70

move the related occurrence thru date to

NCH\_QLFY\_STAY\_THRU\_DT.

SOURCE:

NCH QA Process

*DSCHRGDT*

*NCH Beneficiary Discharge Date*

Effective with Version H, on an inpatient and HHA claim, the date the beneficiary was discharged from the facility or died (used for internal CWFMQA editing purposes.)

For the Limited Data Set Standard View of the Inpatient/SNF files, the beneficiary's discharge date is coded as the quarter of the calendar year when the discharge

*Variable Name*

*Label*

occurred.

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991.)

8 DIGITS UNSIGNED

DB2 ALIAS: NCH\_BENE\_DSCHRG\_DT  
SAS ALIAS: DSCHRGDT  
STANDARD ALIAS: NCH\_BENE\_DSCHRG\_DT  
TITLE ALIAS: DISCHARGE\_DT

EDIT-RULES FOR LIMITED DATA SET DATA:  
YYYYQ000 WHERE Q IS ONE OF THE  
FOLLOWING VALUES.

1 = FIRST QUARTER OF THE CALENDAR YEAR  
2 = SECOND QUARTER OF THE CALENDAR YEAR  
3 = THIRD QUARTER OF THE CALENDAR YEAR  
4 = FOURTH QUARTER OF THE CALENDAR YEAR

DERIVATION:  
DERIVED FROM:  
NCH\_PTNT\_STUS\_IND\_CD  
CLM\_THRU\_DT

DERIVATION RULES:  
Based on the presence of patient discharge status code not equal to 30 (still patient), move the claim thru date to the NCH\_BENE\_DSCHRG\_DT.

SOURCE:  
NCH QA Process

*DRG\_CD*

*Claim Diagnosis Related Group Code*

The diagnostic related group to which a hospital claim belongs for prospective payment purposes.

COMMON ALIAS: DRG DB2  
ALIAS: CLM\_DRG\_CD SAS  
ALIAS: DRG\_CD  
STANDARD ALIAS:  
CLM\_DRG\_CD TITLE ALIAS: DRG

EDIT-RULES:  
DRG DEFINITIONS MANUAL

COMMENT:  
GROUPER is the software that determines the DRG from data elements reported by the hospital. Once determined, the DRG code is one of the elements used to determine the price upon which to base the reimbursement to the hospitals under prospective payment. Nonpayment claims (zero reimbursement) may not have a DRG present.

SOURCE:  
CWF

*Variable Name*

*Label*

*OUTLR\_CD*

*Claim Diagnosis Related Group Outlier Stay Code*

On an institutional claim, the code that indicates the beneficiary stay under the prospective payment system which, although classified into a specific diagnosis related group, has an unusually long length (day outlier) or exceptionally high cost (cost outlier).

DB2 ALIAS: DRG\_OUTLIER\_CD

SAS ALIAS: OUTLR\_CD

STANDARD ALIAS: CLM\_DRG\_OUTLIER\_STAY\_CD

TITLE ALIAS: DRG\_OUTLIER\_STAY\_CODE

CODES:

REFER TO: DRG\_OUTLIER\_STAY\_TB

SOURCE:

CWF

*OUTLRPMT*

*NCH DRG Outlier Approved Payment Amount*

On an institutional claim, the additional payment amount approved by the Peer Review Organization due to an outlier situation for a beneficiary's stay under the prospective payment system, which has been classified into a specific diagnosis related group.

9.2 DIGITS SIGNED

DB2 ALIAS: DRG\_OUTLIER\_AMT

SAS ALIAS: OUTLRPMT

STANDARD ALIAS: NCH\_DRG\_OUTLIER\_APRV\_PMT\_AMT

TITLE ALIAS: DRG\_OUTLIER\_PMT

EDIT-RULES:

+9(9).99

DERIVATION:

DERIVED FROM:

CLM\_VAL\_CD

CLM\_VAL\_AMT

DERIVATION RULES:

Based on the presence of value code equal to 17 move the related amount to

***Variable Name***

***Label***

NCH\_DRG\_OUTLIER\_APRV\_PMT\_AMT.

COMMENT:

Prior to Version H this field was named:

CLM\_DRG\_OUTLIER\_APRV\_PMT\_AMT and field size was S9(7)V99.

SOURCE:

NCH QA Process

***DGNSCD{x} Claim Diagnosis Code where { x } ranges from 1 to 10***

The ICD-9-CM based code identifying the beneficiary's principal or other diagnosis (including E code).

NOTE:

Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM\_PRNCPAL\_DGNS\_CD was added as the first occurrence.

DB2 ALIAS: CLM\_DGNS\_CD

SAS ALIAS: DGNS\_CD

STANDARD ALIAS: CLM\_DGNS\_CD

TITLE ALIAS: DIAGNOSIS

EDIT-RULES:

ICD-9-CM

COMMENT:

Prior to Version H this field was named:

CLM\_OTHR\_DGNS\_CD.

***PRCDRCD{x} Claim Procedure Code where { x } ranges from 1 to 6***

The ICD-9 -CM code that indicates the principal or other procedure performed during the period covered by the institutional claim.

DB2 ALIAS: CLM\_PRCDR\_CD

SAS ALIAS: PRCDR\_CD

STANDARD ALIAS: CLM\_PRCDR\_CD

TITLE ALIAS: PROCEDURE\_CODE

EDIT-RULES:

ICD-9-CM

SOURCE:

**Variable Name**

**Label**

CWF

*PRCDRDT{x}*

*Claim Procedure Performed Date*

where {x} ranges from 1 to 6

On an institutional claim, the date on which the principal or other procedure was performed.

For the Limited Data Set Standard View of the Inpatient/SNF files, the claim procedure performed date is coded as the quarter of the calendar year when the procedure was performed.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM\_PRCDR\_PRFRM\_DT

SAS ALIAS: PRCDR\_DT

STANDARD ALIAS: CLM\_PRCDR\_PRFRM\_DT

TITLE ALIAS: PROCEDURE\_DATE

EDIT-RULES FOR LIMITED DATA SET DATA:

YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES.

1 = FIRST QUARTER OF THE CALENDAR YEAR

2 = SECOND QUARTER OF THE CALENDAR YEAR

3 = THIRD QUARTER OF THE CALENDAR YEAR

4 = FOURTH QUARTER OF THE CALENDAR YEAR

SOURCE:

CWF

*RLTCND{x} Claim Related Condition Code* where {x} ranges

from 1 to 30

The code that indicates a condition relating to an institutional claim that may affect payer processing.

DB2 ALIAS: CLM\_RLT\_COND\_CD

SAS ALIAS: RLT\_COND

STANDARD ALIAS: CLM\_RLT\_COND\_CD

SYSTEM ALIAS: LTCOND

TITLE ALIAS: RELATED\_CONDITION\_CD

CODES:

01 THRU 16 = Insurance related

17 THRU 30 = Special condition

31 THRU 35 = Student status codes which are required when a patient is a dependent child over 18 years old

36 THRU 45 = Accommodation

***Variable Name***

***Label***

46 THRU 54 = CHAMPUS information  
55 THRU 59 = Skilled nursing facility  
60 THRU 70 = Prospective payment  
71 THRU 99 = Renal dialysis setting  
A0 THRU B9 = Special program codes  
C0 THRU C9 = PRO approval services  
D0 THRU W0 = Change conditions

CODES:  
REFER TO: CLM\_RLT\_COND\_TB  
IN THE CODES APPENDIX  
SOURCE:  
CWF

***OCRCCD{x} Claim Related Occurrence Code where {x} ranges  
from 1 to 30***

The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes claim-related occurrences that are related to a specific date.

DB2 ALIAS: CLM\_RLT\_OCRNC\_CD  
SAS ALIAS: OCRNC\_CD  
STANDARD ALIAS: CLM\_RLT\_OCRNC\_CD  
SYSTEM ALIAS: LTOCRNC  
TITLE ALIAS: OCCURRENCE\_CD

CODES:  
01 THRU 09 = Accident  
10 THRU 19 = Medical condition  
20 THRU 39 = Insurance related  
40 THRU 69 = Service related  
A1-A3 = Miscellaneous

CODES:  
REFER TO: CLM\_RLT\_OCRNC\_TB  
IN THE CODES APPENDIX  
SOURCE:  
CWF

***OCRCDT{x} Claim Related Occurrence Date where {x} ranges  
from 1 to 30***

The date associated with a significant event related to an institutional claim that may affect payer processing.

For the Limited Data Set Standard View of the Inpatient/SNF files, the claim procedure performed date is coded as the quarter

*Variable Name*

*Label*

of the calendar year when the procedure was performed.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM\_RLT\_OCRNC\_DT

SAS ALIAS: OCRNCDT

STANDARD ALIAS: CLM\_RLT\_OCRNC\_DT

TITLE ALIAS: RLT\_OCRNC\_DT

EDIT-RULES FOR LIMITED DATA SET DATA:  
YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES.

1 = FIRST QUARTER OF THE CALENDAR YEAR

2 = SECOND QUARTER OF THE CALENDAR YEAR

3 = THIRD QUARTER OF THE CALENDAR YEAR

4 = FOURTH QUARTER OF THE CALENDAR YEAR

SOURCE:

CWF

*VAL\_CD{x} Claim Value Code where { x } ranges from 1 to 36*

The code indicating the value of a monetary condition which was used by the intermediary to process an institutional claim.

DB2 ALIAS: CLM\_VAL\_CD

SAS ALIAS: VAL\_CD

STANDARD ALIAS: CLM\_VAL\_CD

SYSTEM ALIAS: LTVALUE

TITLE ALIAS: VALUE\_CD

CODES:

REFER TO: CLM\_VAL\_TB

IN THE CODES APPENDIX

SOURCE:

CWF

*VALAMT{x} Claim Value Amount where { x } ranges from 1 to 36*

The amount related to the condition identified in the CLM\_VAL\_CD which was used by the intermediary to process the institutional claim.

9.2 DIGITS SIGNED

DB2 ALIAS: CLM\_VAL\_AMT

*Variable Name*

*Label*

SAS ALIAS: VAL\_AMT  
STANDARD ALIAS: CLM\_VAL\_AMT  
TITLE ALIAS: VALUE\_AMOUNT

EDIT-RULES:  
+9(9).99

SOURCE:  
CWF

*RVCNTR{x}*

*Revenue Center Code*

*where { x } ranges from 1 to 45*

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology).

EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

COBOL ALIAS: REV\_CD  
DB2 ALIAS: REV\_CNTR\_CD  
SAS ALIAS: REV\_CNTR  
STANDARD ALIAS: REV\_CNTR\_CD  
SYSTEM ALIAS: LTRC  
TITLE ALIAS: REVENUE\_CENTER\_CD

CODES:  
REFER TO: REV\_CNTR\_TB  
IN THE CODES APPENDIX

SOURCE:  
CWF

*REV\_DT{x}*

*Revenue Center Date*

*where { x } ranges from 1 to 45*

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version H, the date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS.

For the Limited Data Set Standard View of the

*Variable Name*

*Label*

Inpatient/SNF, the date applicable to the service represented by the revenue center code is coded as the quarter of the calendar year when the service represented by the revenue center code occurred.

NOTE1: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

NOTE2: When revenue center code equals '0022' (SNF PPS) and revenue center HCPCS code not equal to 'AAA00' (default for no assessment), date represents the MDS RAI assessment reference date.

NOTE3: When revenue center code equals '0023' (HHPPS), the date on the initial claim (RAP) must represent the first date of service in the episode. The final claim will match the '0023' information submitted on the initial claim. The SCIC (significant change in condition) claims may show additional '0023' revenue lines in which the date represents the date of the first service under the revised plan of treatment.

8 DIGITS UNSIGNED

DB2 ALIAS: REV\_CNTR\_DT

SAS ALIAS: REV\_DT

STANDARD ALIAS: REV\_CNTR\_DT

TITLE ALIAS: REV\_CNTR\_DATE

EDIT-RULES FOR LIMITED DATA SET DATA:

YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES.

1 = FIRST QUARTER OF THE CALENDAR YEAR

2 = SECOND QUARTER OF THE CALENDAR YEAR

3 = THIRD QUARTER OF THE CALENDAR YEAR

4 = FOURTH QUARTER OF THE CALENDAR YEAR

SOURCE:

CWF

*APCPPS{x}*

*Revenue Center APC/HIPPS Code*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Outpatient PPS (OPPS), the Ambulatory Payment Classification (APC) code used to identify groupings of outpatient services. APC codes are

*Variable Name*

*Label*

used to calculate payment for services under OPSS.

Effective with Home Health PPS (HPPS), this field will only be populated with a HPPS code if the HPPS code that is stored in the HCPCS field has been downcoded and the new code will be placed in this field.

NOTE1: Under SNF PPS and HPPS, HPPS codes are stored in the HCPCS field. \*\*EXCEPTION: if a HPPS code is downcoded the downcoded HPPS will be stored in this field.

NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV\_APC\_HIPPS\_CD

SAS ALIAS: APCHIPPS

STANDARD ALIAS: REV\_CNTR\_APC\_HIPPS\_CD

SYSTEM ALIAS: LTAPC

TITLE ALIAS: APC\_HIPPS

CODES:

REFER TO: REV\_CNTR\_APC\_TB

IN THE CODES APPENDIX

SOURCE:

CWF

*HCPCSD{x}*

*Revenue Center HCFA Common Procedure Coding*

*where { x } ranges from 1 to 45*

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

HCFA's Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described below:

DB2 ALIAS: REV\_CNTR\_HCPCS\_CD

SAS ALIAS: HCPCS\_CD

STANDARD ALIAS: REV\_CNTR\_HCPCS\_CD

SYSTEM ALIAS: LTHIPPS

TITLE ALIAS: HCPCS\_CD

*Variable Name*

*Label*

CODES:  
REFER TO: CLM\_HIPPS\_TB  
IN THE CODES APPENDIX

COMMENT:  
Prior to Version H this field was named:  
HCPCS\_CD. With Version H, a prefix  
was added to denote the location of this field  
on each claim type (institutional: REV\_CNTR and  
non-institutional: LINE).

NOTE: When revenue center code = '0022' (SNF PPS)  
or '0023' (HH PPS), this field contains the Health  
Insurance PPS (HIPPS) code. The HIPPS code for  
SNF PPS contains the rate code/assessment type that  
identifies (1) RUG-III group the beneficiary was  
classified into as of the RAI MDS assessment  
reference date and (2) the type of assessment for  
payment purposes.

The HIPPS code for Home Health PPS identifies  
(1) the three case-mix dimensions of the HHRG  
system, clinical, functional and utilization, from which a  
beneficiary is assigned to one of the 80 HHRG  
categories and (2) it identifies whether or not  
the elements of the code were computed or derived.  
The HHRGs, represented by the HIPPS coding, will  
be the basis of payment for each episode.

For both SNF PPS & HH PPS HIPPS values see CLM\_HIPPS\_TB.

Level I

Codes and descriptors copyrighted by the American  
Medical Association's Current Procedural  
Terminology, Fourth Edition (CPT-4). These are  
5 position numeric codes representing physician  
and nonphysician services.

\*\*\*\* Note: \*\*\*\*

CPT-4 codes including both long and short  
descriptions shall be used in accordance with the  
HCFA/AMA agreement. Any other use violates the  
AMA copyright.

Level II

Includes codes and descriptors copyrighted by  
the American Dental Association's Current Dental  
Terminology, Second Edition (CDT-2). These are  
5 position alpha-numeric codes comprising

*Variable Name*

*Label*

the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

Level III

Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not represented in the level I or level II codes.

*MDFCD1{x}*

*Revenue Center HCPCS Initial Modifier Code*

where {x} ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

A first modifier to the procedure code to enable a more specific procedure identification for the claim.

DB2 ALIAS: REV\_HCPCS\_MDFR\_CD

SAS ALIAS: MDFR\_CD1

STANDARD ALIAS: REV\_CNTR\_HCPCS\_INITL\_MDFR\_CD

TITLE ALIAS: INITIAL\_MODIFIER

EDIT-RULES:

Carrier Information File

COMMENT:

Prior to Version H this field was named: HCPCS\_INITL\_MDRFR\_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV\_CNTR and non-institutional: LINE).

SOURCE:

CWF

*MDFCD2{x}*

*Revenue Center HCPCS Second Modifier Code*

where {x} ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

A second modifier to the procedure code to make it more specific than the first modifier code to identify the procedures performed on the beneficiary for the claim.

*Variable Name*

*Label*

DB2 ALIAS: REV\_HCPCS\_2ND\_CD  
SAS ALIAS: MDFR\_CD2  
STANDARD ALIAS: REV\_CNTR\_HCPCS\_2ND\_MDFR\_CD  
TITLE ALIAS: SECOND\_MODIFIER  
  
EDIT-RULES:  
CARRIER INFORMATION FILE  
  
COMMENT:  
Prior to Version H this field was named:  
HCPCS\_2ND\_MDFR\_CD. With Version H, a prefix  
was added to denote the location of this field  
on each claim type (institutional: REV\_CNTR and  
non-institutional: LINE).  
  
SOURCE:  
CWF

*MDFCD3{x}*

*Revenue Center HCPCS Third Modifier Code*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version I, a third modifier to the procedure code to make it more specific than the second modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS: REV\_HCPCS\_3RD\_CD  
SAS ALIAS: MDFR\_CD3  
STANDARD ALIAS: REV\_CNTR\_HCPCS\_3RD\_MDFR\_CD  
TITLE ALIAS: THIRD\_MODIFIER

EDIT-RULES:  
CARRIER INFORMATION FILE

COMMENT:  
NOTE: Beginning with NCH weekly process date  
8/18/00, this field will be populated with data.  
Claims processed prior to 8/18/00 will contain  
spaces in this field.

SOURCE:  
CWF

*MDFCD4{x}*

*Revenue Center HCPCS Fourth Modifier Code*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version I, a fourth modifier to the procedure code to make it more specific than the third modifier code to identify the procedures performed on the beneficiary for the claim.

*Variable Name*

*Label*

DB2 ALIAS: REV\_HCPCS\_4TH\_CD  
SAS ALIAS: MDFR\_CD4  
STANDARD ALIAS: REV\_CNTR\_HCPCS\_4TH\_MDFR\_CD  
TITLE ALIAS: FOURTH\_MODIFIER

EDIT-RULES:  
CARRIER INFORMATION FILE

COMMENT:  
NOTE: Beginning with NCH weekly process date  
8/18/00, this field will be populated with data.  
Claims processed prior to 8/18/00 will contain  
spaces in this field.

SOURCE:  
CWF

*MDFCD5{x}*

*Revenue Center HCPCS Fifth Modifier Code*

where {x} ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version I, a fifth modifier to the procedure code to make it more specific than the fourth modifier code to identify the performed on the beneficiary for the claim.

DB2 ALIAS: REV\_HCPCS\_5TH\_CD  
SAS ALIAS: MDFR\_CD5  
STANDARD ALIAS: REV\_CNTR\_HCPCS\_5TH\_MDFR\_CD  
TITLE ALIAS: FIFTH\_MODIFIER

EDIT-RULES:  
CARRIER INFORMATION FILE

COMMENT:  
NOTE: Beginning with NCH weekly process date  
8/18/00, this field will be populated with data.  
Claims processed prior to 8/18/00 will contain  
spaces in this field.

SOURCE:  
CWF

*PMTTHD{x}*

*Revenue Center Payment Method Indicator Code*

where {x} ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', the code used to identify how the service is priced for payment. This field is made up of two pieces of data, 1st position being the service indicator and the 2nd position being the payment indicator.

*Variable Name*

*Label*

NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV\_PMT\_MTHD\_CD  
SAS ALIAS: PMTMTHD  
STANDARD ALIAS: REV\_CNTR\_PMT\_MTHD\_IND\_CD  
SYSTEM ALIAS: LTPMTHD  
TITLE ALIAS: PMT\_MTHD

CODES:  
REFER TO: REV\_CNTR\_PMT\_MTHD\_IND\_TB  
IN THE CODES APPENDIX

SOURCE:  
CWF

*DSCTND{x}*

*Revenue Center Discount Indicator Code*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', for all services subject to Outpatient PPS, this code represents a factor that specifies the amount of any APC discount. The discounting factor is applied to a line item with a service indicator (part of the REV\_CNTR\_PMT\_MTHD\_IND\_CD) of 'T'. The flag is applicable when more than one significant procedure is performed. \*\*If there is no discounting the factor will be 1.0.\*\*

NOTE1: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV\_DSCNT\_IND\_CD  
SAS ALIAS: DSCNTIND  
STANDARD ALIAS: REV\_CNTR\_DSCNT\_IND\_CD  
SYSTEM ALIAS: LTDSCNT  
TITLE ALIAS: REV\_CNTR\_DSCNT\_IND\_CD

CODES:  
\*DISCOUNTING FORMULAS\*

- 1 = 1.0
- 2 =  $(1.0 + D(U-1))/U$
- 3 = T/U
- 4 =  $(1 + D)/U$
- 5 = D
- 6 = TD/U
- 7 =  $D(1 + D)/U$
- 8 =  $2.0/U$

SOURCE:  
CWF

*Variable Name*

*Label*

*PCKGND{x}*

*Revenue Center Packaging Indicator Code*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', for all services subject to Outpatient PPS, the code used to identify those services that are packaged/ bundled with another service.

NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV\_PACKG\_IND\_CD  
SAS ALIAS: PACKGIND  
STANDARD ALIAS: REV\_CNTR\_PACKG\_IND\_CD  
SYSTEM ALIAS: LTPACKG  
TITLE ALIAS: REV\_CNTR\_PACKG\_IND

CODES:

0 = Not packaged  
1 = Packaged service (service indicator N)  
2 = Packaged as part of partial hospitalization per diem or daily mental health service per diem

SOURCE:  
CWF

*PRICNG{x}*

*Revenue Center Pricing Indicator Code*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', the code used to identify if there was a deviation from the standard method of calculating payment amount.

NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV\_PRICNG\_IND\_CD  
SAS ALIAS: PRICNG  
STANDARD ALIAS: REV\_CNTR\_PRICNG\_IND\_CD

*Variable Name*

*Label*

SYSTEM ALIAS: LTPRICNG  
TITLE ALIAS: REV\_CNTR\_PRICNG\_IND  
  
CODES:  
REFER TO: REV\_CNTR\_PRICNG\_IND\_TB  
IN THE CODES APPENDIX  
  
SOURCE:  
CWF

*OTAF\_1{x}*

*Revenue Center Obligation to Accept As Full (OTAF)*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I' the code used to indicate that the provider was obligated to accept as full payment the amount received from the primary (or secondary) payer.

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS: REV\_OTAF1\_IND\_CD  
SAS ALIAS: OTAF\_1  
STANDARD ALIAS: REV\_CNTR\_OTAF\_1\_IND\_CD  
TITLE ALIAS: REV\_CNTR\_OTAF\_1\_IND\_CD

EDIT-RULES:  
Y = provider is obligated to accept the payment as payment in full for the service.  
N or blank = provider is not obligated to accept the payment, or there is no payment by a prior payer.

SOURCE:  
CWF

*IDENDC{x}*

*Revenue Center IDE, NDC, UPC Number*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. CMS established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95. IDE's are always

*Variable Name*

*Label*

associated with revenue center code '0624'.

NOTE1: Prior to Version H a 'dummy' revenue center code '0624' trailer was created to store IDE's. The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'. There can be up to 7 distinct IDE numbers associated with an '0624' dummy trailer. During the Version H conversion IDE's were moved from the dummy '0624' trailer to this dedicated field.

NOTE2: Effective with Version 'I', this field was renamed to eventually accommodate the National Drug Code (NDC) and the Universal Product Code (UPC). This field could contain either of these 3 fields (there would never be an instance where more than one would come in on a claim). The size of this field was expanded to X(24) to accommodate either of the new fields (under Version 'H' it was X(7)). DATA ANAMOLY/LIMITATION: During an CWFMQA review an edit revealed the IDE was missing. The problem occurs in claim with an NCH weekly process dates of 6/9/00 through 9/8/00. During processing of the new format the program receives the IDE but then blanked out the data.

DB2 ALIAS: IDE\_NDC\_UPC\_NUM

SAS ALIAS: IDENDC

STANDARD ALIAS: REV\_CNTR\_IDE\_NDC\_UPC\_NUM

TITLE ALIAS: IDE\_NDC\_UPC

SOURCE:

CWF

*RVUNT{x}*

*Revenue Center Unit Count*

*where { x } ranges from 1 to 45*

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

A quantitative measure (unit) of the number of times the service or procedure being reported was performed according to the revenue center/HCPCS code definition as described on an institutional claim.

Depending on type of service, units are measured by number of covered days in a particular accommodation, pints of blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests.

*Variable Name*

*Label*

NOTE1: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code.

7 DIGITS SIGNED

DB2 ALIAS: REV\_CNTR\_UNIT\_CNT

SAS ALIAS: REV\_UNIT

STANDARD ALIAS: REV\_CNTR\_UNIT\_CNT

TITLE ALIAS: UNITS

EDIT- RULES:

+9(7)

SOURCE:

CWF

*RVRT{x}*

*Revenue Center Rate Amount*

where {x} ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Charges relating to unit cost associated with the revenue center code. Exception (encounter data only): If plan (e.g. MCO) does not know the actual rate for the accommodations, \$1 will be reported in the field.

NOTE1: For SNF PPS claims (when revenue center code equals '0022'), HCFA has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue center HCPCS code field).

NOTE2: For OP PPS claims, HCFA has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index.

NOTE3: Under HH PPS (when revenue center code equals '0023'), HCFA has developed a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode.

On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or

***Variable Name***

***Label***

partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment. In cases of SCICs, there will be more than one '0023' revenue center line, each representing the payment made at each case-mix level.

9.2 DIGITS SIGNED

DB2 ALIAS: REV\_CNTR\_RATE\_AMT  
SAS ALIAS: REV\_RATE  
STANDARD ALIAS: REV\_CNTR\_RATE\_AMT  
TITLE ALIAS: CHARGE\_PER\_UNIT

EDIT-RULES:

+9(9).99

EFFECTIVE-DATE: 10/01/1993

COMMENT:

Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE:

CWF

***RVBLD{x}***

***Revenue Center Blood Deductible Amount***

*where { x } ranges from 1 to 45*

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', the amount of money for which the intermediary determined the beneficiary is liable for the blood deductible for the line item service.

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: REV\_BLOOD\_DDCTBL  
SAS ALIAS: REVBLOOD  
STANDARD ALIAS: REV\_CNTR\_BLOOD\_DDCTBL\_AMT  
TITLE ALIAS: BLOOD\_DDCTBL\_AMT

EDIT-RULES:

+9(9).99

SOURCE:

CWF

**Variable Name**

**Label**

*RVDTBL{x}*

*Revenue Center Cash Deductible Amount*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I' the amount of cash deductible the beneficiary paid for the line item service.

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data.

Claims processed prior to 7/7/00 will contain spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: REV\_CASH\_DDCTBL

SAS ALIAS: REVDCTBL

STANDARD ALIAS: REV\_CNTR\_CASH\_DDCTBL\_AMT

TITLE ALIAS: CASH\_DDCTBL

EDIT-RULES:

+9(9).99

SOURCE:

CWF

*WGDJ{x}*

*Revenue Center Coinsurance/Wage Adjusted*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', the amount of coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted.

NOTE1: This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification.

NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data.

Claims processed prior to 8/18/00 will contain spaces in this field.

9.2 DIGITS SIGNED

*Variable Name*

*Label*

DB2 ALIAS: ADJSTD\_COINSRNC  
SAS ALIAS: WAGEADJ  
STANDARD ALIAS: REV\_CNTR\_WAGE\_ADJSTD\_COINS\_AMT  
TITLE ALIAS: WAGE\_ADJSTD\_COINS  
EDIT-RULES:  
+9(9).99  
SOURCE:  
CWF

*RDCDCN{x}*

*Revenue Center Reduced Coinsurance Amount*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', for all services subject to Outpatient PPS, the amount of coinsurance applicable to the line for a particular service (HCPCS) for which the provider has elected to reduce the coinsurance amount.

NOTE1: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.

NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: RDCD\_COINSRNC  
SAS ALIAS: RDCDCOIN  
STANDARD ALIAS: REV\_CNTR\_RDCD\_COINS\_AMT  
TITLE ALIAS: REDUCED\_COINS

EDIT-RULES:  
+9(9).99

SOURCE:  
CWF

*RVMSPI{x}*

*Revenue Center 1st Medicare Secondary Payer Paid*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', the amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary or

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data.

*Variable Name*

*Label*

Claims processed prior to 7/7/00 will contain spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: REV\_MSP1\_PD\_AMT

SAS ALIAS: REV\_MSP1

STANDARD ALIAS: REV\_CNTR\_MSP1\_PD\_AMT

TITLE ALIAS: MSP PAID AMOUNT

EDIT-RULES:

+9(9).99

SOURCE:

CWF

*RVMSP2{x}*

*Revenue Center 2nd Medicare Secondary Payer Paid*

*where { x } ranges from 1 to 45*

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', the amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer).

NOTE: Beginning with NCH weekly process date

7/7/00, this field will be populated with data.

Claims processed prior to 7/7/00 will contain spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: REV\_MSP2\_PD\_AMT

SAS ALIAS: REV\_MSP2

STANDARD ALIAS: REV\_CNTR\_MSP2\_PD\_AMT

TITLE ALIAS: MSP PAID AMOUNT

EDIT-RULES:

+9(9).99

SOURCE:

CWF

*RPRPMT{x}*

*Revenue Center Provider Payment Amount*

*where { x } ranges from 1 to 45*

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', the amount paid to the provider for the services reported on the line item.

NOTE: Beginning with NCH weekly process date

7/7/00, this field will be populated with data.

Claims processed prior to 7/7/00 will contain spaces in this field.

*Variable Name*

*Label*

9.2 DIGITS SIGNED  
DB2 ALIAS: REV\_PRVDR\_PMT\_AMT  
SAS ALIAS: RPRVDPMT  
STANDARD ALIAS: REV\_CNTR\_PRVDR\_PMT\_AMT  
TITLE ALIAS: REV\_PRVDR\_PMT  
EDIT-RULES:  
+9(9).99  
SOURCE:  
CWF

*RBNPMT{x}*

*Revenue Center Beneficiary Payment Amount*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version I, the amount paid to the beneficiary for the services reported on the line item.

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

9.2 DIGITS SIGNED  
DB2 ALIAS: REV\_BENE\_PMT\_AMT  
SAS ALIAS: RBENEPMT  
STANDARD ALIAS: REV\_CNTR\_BENE\_PMT\_AMT  
TITLE ALIAS: REV\_BENE\_PMT  
EDIT-RULES:  
+9(9).99  
SOURCE:  
CWF

*PTNRSP{x}*

*Revenue Center Patient Responsibility Payment Amount*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version I, the amount paid by the beneficiary to the provider for the line item service.

NOTE: Beginning with NCH weekly process date 7/7/00 this field was populated with data. Claims processed prior to 7/7/00 will contain zeroes in this field.

9.2 DIGITS SIGNED  
DB2 ALIAS: REV\_PTNT\_RESP\_AMT

*Variable Name*

*Label*

SAS ALIAS: PTNTRESP  
STANDARD ALIAS: REV\_CNTR\_PTNT\_RESP\_PMT\_AMT  
TITLE ALIAS: REV\_PTNT\_RESP  
EDIT-RULES:  
+9(9).99  
SOURCE:  
CWF

*REVPMT{x}*

*Revenue Center Payment Amount*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Version 'I', the line item Medicare payment amount for the specific revenue center.

Under OP PPS, PRICER will compute the standard OPPS payment for a line item based on the payment APC.

Under OP PPS, PRICER will compute the standard OPPS payment for a line item based on the payment APC.

Under HH PPS, PRICER will compute/return

a line item payment amount for the case-mixed, wage-index adjusted HIPPS code assigned to the '0023' revenue center line. The HIPPS code will be stored in the Revenue Center HCPCS code field.

9.2 DIGITS SIGNED

COMMON ALIAS: REIMBURSEMENT  
DB2 ALIAS: REV\_CNTR\_PMT\_AMT  
SAS ALIAS: REVPMT  
STANDARD ALIAS: REV\_CNTR\_PMT\_AMT  
TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:  
+9(9).99

SOURCE:  
CWF

*RVCHRG{x}*

*Revenue Center Total Charge Amount*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and

*Variable Name*

*Label*

coinsurance amounts and before an adjustment for the cost of services provided. NOTE: For accommodation revenue center total charges must equal the rate times units (days).

EXCEPTIONS:

- 4. For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo).
- 5. For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero.
- 6. For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line.
- 7. For Home Health PPS (final claim), when revenue center code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023').
- 8. For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be \$1 (rate) times units (days).

9.2 DIGITS SIGNED

DB2 ALIAS: REV\_TOT\_CHRG\_AMT  
 SAS ALIAS: REV\_CHRG  
 STANDARD ALIAS: REV\_CNTR\_TOT\_CHRG\_AMT  
 TITLE ALIAS: REVENUE\_CENTER\_CHARGES

EDIT-RULES:

+9(9).99

COMMENT:

Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE:

CWF

*RVNCVR{x}*

*Revenue Center Non-Covered Charge Amount*

*where { x } ranges from 1 to 45*

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

The charge amount related to a revenue center code for services that are not covered by Medicare.

NOTE: Prior to Version H the field size was S9(7)V99 and the element was only present on the Inpatient/SNF format.

*Variable Name*

*Label*

As of NCH weekly process date 10/3/97 this field was added to all institutional claim types.

9.2 DIGITS SIGNED

DB2 ALIAS: REV\_NCVR\_CHRG\_AMT

SAS ALIAS: REV\_NCVR

STANDARD ALIAS: REV\_CNTR\_NCVR\_CHRG\_AMT

TITLE ALIAS: REV\_CENTER\_NONCOVERED\_CHARGES

EDIT-RULES:

+9(9).99

SOURCE:

CWF

*RVDDCD{x}*

*Revenue Center Deductible Coinsurance Code*

where {x} ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Code indicating whether the revenue center charges are subject to deductible and/or coinsurance.

DB2 ALIAS: DDCTBL\_COINSRNC\_CD

SAS ALIAS: REVDEDCD

STANDARD ALIAS: REV\_CNTR\_DDCTBL\_COINSRNC\_CD

TITLE ALIAS: REVENUE\_CENTER\_DEDUCTIBLE\_CD

CODES:

REFER TO: REV\_CNTR\_DDCTBL\_COINSRNC\_TB

IN THE CODES APPENDIX

SOURCE:

CWF