LDS Home Health Data Dictionary

No.	Field Short Name	Field Long Name	Label	Type	Length
		Base Claim File			
1	DSYSRTKY	DESY_SORT_KEY	LDS Beneficiary ID	NUM	9
2	CLAIMNO	CLAIM_NO	Claim number	NUM	12
3	PROVIDER	PRVDR_NUM	Provider Number	CHAR	10
4	THRU_DT	CLM_THRU_DT	Claim Through Date (Determines Year of Claim)	DATE	8
5	RIC_CD	NCH_NEAR_LINE_REC_IDENT_CD	NCH Near Line Record Identification Code	CHAR	1
6	CLM_TYPE	NCH_CLM_TYPE_CD	NCH Claim Type Code	CHAR	2
7	FAC_TYPE	CLM_FAC_TYPE_CD	Claim Facility Type Code	CHAR	1
8	TYPESRVC	CLM_SRVC_CLSFCTN_TYPE_CD	Claim Service classification Type Code	CHAR	1
9	FREQ_CD	CLM_FREQ_CD	Claim Frequency Code	CHAR	1
10	FI_NUM	FI_NUM	FI Number	CHAR	5
11	NOPAY_CD	CLM_MDCR_NON_PMT_RSN_CD	Claim Medicare Non Payment Reason Code	CHAR	2
12	PMT_AMT	CLM_PMT_AMT	Claim Payment Amount	NUM	12
13	PRPAYAMT	NCH_PRMRY_PYR_CLM_PD_AMT	NCH Primary Payer Claim Paid Amount	NUM	12
14	PRPAY_CD	NCH_PRMRY_PYR_CD	NCH Primary Payer Code	CHAR	1
15	PRSTATE	PRVDR_STATE_CD	NCH Provider State Code	CHAR	2
16	ORGNPINM	ORG_NPI_NUM	Organization NPI Number	CHAR	10
17	AT_UPIN	AT_PHYSN_UPIN	Claim Attending Physician UPIN Number	CHAR	12
18	AT_NPI	AT_PHYSN_NPI	Claim Attending Physician NPI Number	CHAR	12
19	STUS_CD	PTNT_DSCHRG_STUS_CD	Patient Discharge Status Code	CHAR	2
20	PPS_IND	CLM_PPS_IND_CD	Claim PPS Indicator Code	CHAR	1
21	TOT_CHRG	CLM_TOT_CHRG_AMT	Claim Total Charge Amount	NUM	12
22	PRNCPAL_DGNS_CD	PRNCPAL_DGNS_CD	Primary Claim Diagnosis Code	CHAR	7
23	PRNCPAL_DGNS_VRSN_CD	PRNCPAL_DGNS_VRSN_CD	Primary Claim Diagnosis Code Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
24	ICD DGNS CD1	ICD_DGNS_CD1	Claim Diagnosis Code I	CHAR	7
25	ICD DGNS VRSN CD1	ICD_DGNS_VRSN_CD1	Claim Diagnosis Code I Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
26	ICD DGNS CD2	ICD_DGNS_CD2	Claim Diagnosis Code II	CHAR	7
27	ICD DGNS VRSN CD2	ICD_DGNS_VRSN_CD2	Claim Diagnosis Code II Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
28	ICD DGNS CD3	ICD_DGNS_CD3	Claim Diagnosis Code III	CHAR	7
29	ICD DGNS VRSN CD3	ICD_DGNS_VRSN_CD3	Claim Diagnosis Code III Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
30	ICD DGNS CD4	ICD_DGNS_CD4	Claim Diagnosis Code IV	CHAR	7
31	ICD DGNS VRSN CD4	ICD_DGNS_VRSN_CD4	Claim Diagnosis Code IV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
32	ICD DGNS CD5	ICD_DGNS_CD5	Claim Diagnosis Code V	CHAR	7
33	ICD DGNS VRSN CD5	ICD_DGNS_VRSN_CD5	Claim Diagnosis Code V Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
34	ICD DGNS CD6	ICD_DGNS_CD6	Claim Diagnosis Code VI	CHAR	7
35	ICD DGNS VRSN CD6	ICD_DGNS_VRSN_CD6	Claim Diagnosis Code VI Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
36	ICD DGNS CD7	ICD_DGNS_CD7	Claim Diagnosis Code VII	CHAR	7
37	ICD DGNS VRSN CD7	ICD_DGNS_VRSN_CD7	Claim Diagnosis Code VII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
38	ICD DGNS CD8	ICD_DGNS_CD8	Claim Diagnosis Code VIII	CHAR	7
39	ICD DGNS VRSN CD8	ICD_DGNS_VRSN_CD8	Claim Diagnosis Code VIII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
40	ICD DGNS CD9	ICD_DGNS_CD9	Claim Diagnosis Code IX	CHAR	7

LDS Home Health Data Dictionary

No.	Field Short Name	Field Long Name	Label	Type	Length
41	ICD DGNS VRSN CD9	ICD_DGNS_VRSN_CD9	Claim Diagnosis Code IX Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
42	ICD DGNS CD10	ICD_DGNS_CD10	Claim Diagnosis Code X	CHAR	7
43	ICD DGNS VRSN CD10	ICD_DGNS_VRSN_CD10	Claim Diagnosis Code X Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
44	ICD DGNS CD11	ICD_DGNS_CD11	Claim Diagnosis Code XI	CHAR	7
45	ICD DGNS VRSN CD11	ICD_DGNS_VRSN_CD11	Claim Diagnosis Code XI Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
46	ICD DGNS CD12	ICD_DGNS_CD12	Claim Diagnosis Code XII	CHAR	7
47	ICD DGNS VRSN CD12	ICD_DGNS_VRSN_CD12	Claim Diagnosis Code XII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
48	ICD DGNS CD13	ICD_DGNS_CD13	Claim Diagnosis Code XIII	CHAR	7
49	ICD DGNS VRSN CD13	ICD_DGNS_VRSN_CD13	Claim Diagnosis Code XIII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
50	ICD DGNS CD14	ICD_DGNS_CD14	Claim Diagnosis Code XIV	CHAR	7
51	ICD DGNS VRSN CD14	ICD_DGNS_VRSN_CD14	Claim Diagnosis Code XIV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
52	ICD DGNS CD15	ICD_DGNS_CD15	Claim Diagnosis Code XV	CHAR	7
53	ICD DGNS VRSN CD15	ICD_DGNS_VRSN_CD15	Claim Diagnosis Code XV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
54	ICD DGNS CD16	ICD_DGNS_CD16	Claim Diagnosis Code XVI	CHAR	7
55	ICD DGNS VRSN CD16	ICD_DGNS_VRSN_CD16	Claim Diagnosis Code XVI Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
56	ICD DGNS CD17	ICD_DGNS_CD17	Claim Diagnosis Code XVII	CHAR	7
57	ICD DGNS VRSN CD17	ICD_DGNS_VRSN_CD17	Claim Diagnosis Code XVII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
58	ICD DGNS CD18	ICD_DGNS_CD18	Claim Diagnosis Code XVIII	CHAR	7
59	ICD DGNS VRSN CD18	ICD_DGNS_VRSN_CD18	Claim Diagnosis Code XVIII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
60	ICD DGNS CD19	ICD_DGNS_CD19	Claim Diagnosis Code XIV	CHAR	7
61	ICD DGNS VRSN CD19	ICD_DGNS_VRSN_CD19	Claim Diagnosis Code XIV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
62	ICD DGNS CD20	ICD_DGNS_CD20	Claim Diagnosis Code XX	CHAR	7
63	ICD DGNS VRSN CD20	ICD_DGNS_VRSN_CD20	Claim Diagnosis Code XX Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
64	ICD DGNS CD21	ICD_DGNS_CD21	Claim Diagnosis Code XXI	CHAR	7
65	ICD DGNS VRSN CD21	ICD_DGNS_VRSN_CD21	Claim Diagnosis Code XXI Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
66	ICD DGNS CD22	ICD_DGNS_CD22	Claim Diagnosis Code XXII	CHAR	7
67	ICD DGNS VRSN CD22	ICD_DGNS_VRSN_CD22	Claim Diagnosis Code XXII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
68	ICD DGNS CD23	ICD_DGNS_CD23	Claim Diagnosis Code XXIII	CHAR	7
69	ICD DGNS VRSN CD23	ICD_DGNS_VRSN_CD23	Claim Diagnosis Code XXIII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
70	ICD DGNS CD24	ICD_DGNS_CD24	Claim Diagnosis Code XXIV	CHAR	7
71	ICD DGNS VRSN CD24	ICD_DGNS_VRSN_CD24	Claim Diagnosis Code XXIV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
72	ICD DGNS CD25	ICD_DGNS_CD25	Claim Diagnosis Code XXV	CHAR	7
73	ICD DGNS VRSN CD25	ICD_DGNS_VRSN_CD25	Claim Diagnosis Code XXV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
74	FST_DGNS_E_CD	FST_DGNS_E_CD	First Claim Diagnosis E Code	CHAR	7
75	FST_DGNS_E_VRSN_CD	FST_DGNS_E_VRSN_CD	First Claim Diagnosis E Code Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
76	ICD DGNS E CD1	ICD_DGNS_E_CD1	Claim Diagnosis E Code I	CHAR	7
77	ICD DGNS E VRSN CD1	ICD_DGNS_E_VRSN_CD1	Claim Diagnosis E Code I Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
78	ICD DGNS E CD2	ICD_DGNS_E_CD2	Claim Diagnosis E Code II	CHAR	7
79	ICD DGNS E VRSN CD2	ICD_DGNS_E_VRSN_CD2	Claim Diagnosis E Code II Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
80	ICD DGNS E CD3	ICD_DGNS_E_CD3	Claim Diagnosis E Code III	CHAR	7
81	ICD DGNS E VRSN CD3	ICD_DGNS_E_VRSN_CD3	Claim Diagnosis E Code III Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1

LDS Home Health Data Dictionary

No.	Field Short Name	Field Long Name	Label	Type	Length
82	ICD DGNS E CD4	ICD_DGNS_E_CD4	Claim Diagnosis E Code IV	CHAR	7
83	ICD DGNS E VRSN CD4	ICD_DGNS_E_VRSN_CD4	Claim Diagnosis E Code IV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
84	ICD DGNS E CD5	ICD_DGNS_E_CD5	Claim Diagnosis E Code V	CHAR	7
85	ICD DGNS E VRSN CD5	ICD_DGNS_E_VRSN_CD5	Claim Diagnosis E Code V Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
86	ICD DGNS E CD6	ICD_DGNS_E_CD6	Claim Diagnosis E Code VI	CHAR	7
87	ICD DGNS E VRSN CD6	ICD_DGNS_E_VRSN_CD6	Claim Diagnosis E Code VI Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
88	ICD DGNS E CD7	ICD_DGNS_E_CD7	Claim Diagnosis E Code VII	CHAR	7
89	ICD DGNS E VRSN CD7	ICD_DGNS_E_VRSN_CD7	Claim Diagnosis E Code VII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
90	ICD DGNS E CD8	ICD_DGNS_E_CD8	Claim Diagnosis E Code VIII	CHAR	7
91	ICD DGNS E VRSN CD8	ICD_DGNS_E_VRSN_CD8	Claim Diagnosis E Code VIII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
92	ICD DGNS E CD9	ICD_DGNS_E_CD9	Claim Diagnosis E Code VIX	CHAR	7
93	ICD DGNS E VRSN CD9	ICD_DGNS_E_VRSN_CD9	Claim Diagnosis E Code VIX Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
94	ICD DGNS E CD10	ICD_DGNS_E_CD10	Claim Diagnosis E Code X	CHAR	7
95	ICD DGNS E VRSN CD10	ICD_DGNS_E_VRSN_CD10	Claim Diagnosis E Code X Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
96	ICD DGNS E CD11	ICD_DGNS_E_CD11	Claim Diagnosis E Code XI	CHAR	7
97	ICD DGNS E VRSN CD11	ICD_DGNS_E_VRSN_CD11	Claim Diagnosis E Code XI Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
98	ICD DGNS E CD12	ICD_DGNS_E_CD12	Claim Diagnosis E Code XII	CHAR	7
99	ICD DGNS E VRSN CD12	ICD_DGNS_E_VRSN_CD12	Claim Diagnosis E Code XII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
100	LUPAIND	CLM_HHA_LUPA_IND_CD	Claim HHA Low Utilization Payment Adjustment (LUPA) Indicator Code	CHAR	1
101	HHA_RFRL	CLM_HHA_RFRL_CD	Claim HHA Referral Code	CHAR	1
102	VISITCNT	CLM_HHA_TOT_VISIT_CNT	Claim HHA Total Visit Count	NUM	3
103	HHSTRTDT	CLM_ADMSN_DT	Claim HHA Care Start Date	DATE	8
104	DOB_DT	DOB_DT	LDS Age Category	NUM	1
105	GNDR_CD	GNDR_CD	Gender Code from Claim	CHAR	1
106	RACE_CD	BENE_RACE_CD	Race Code from Claim	CHAR	1
107	CNTY_CD	BENE_CNTY_CD	County Code from Claim (SSA)	CHAR	3
108	STATE_CD	BENE_STATE_CD	State Code from Claim (SSA)	CHAR	2
109	CWF_BENE_MDCR_STUS_CD	CWF_BENE_MDCR_STUS_CD	CWF Beneficiary Medicare Status Code	CHAR	2
110	QUERY_CD	CLM_QUERY_CD	Claim Query Code	CHAR	1
111	ACTIONCD	FI_CLM_ACTN_CD	FI Claim Action Code	CHAR	1

Condition Code File					
1	DSYSRTKY	DESY_SORT_KEY	LDS Beneficiary ID	NUM	9
2	CLAIMNO	CLAIM_NO	LDS Claim Number	NUM	12
3	RLTCNDSQ	RLT_COND_CD_SEQ	Claim Related Condition Code Sequence	CHAR	2
4	THRU_DT	CLM_THRU_DT	Claim Through Date (Determines Year of Claim)	DATE	8
5	CLM_TYPE	NCH_CLM_TYPE_CD	NCH Claim Type Code	CHAR	2
6	RLT_COND	CLM_RLT_COND_CD	Claim Related Condition Code	CHAR	2

Occurrence Code File					
1	DSYSRTKY	DESY_SORT_KEY	LDS Beneficiary ID	NUM	9

LDS Home Health Data Dictionary

No.	Field Short Name	Field Long Name	Label	Type	Length
2	CLAIMNO	CLAIM_NO	LDS Claim Number	NUM	12
3	RLTOCRSQ	RLT_OCRNC_CD_SEQ	Claim Related Occurrence Code Sequence	CHAR	2
4	THRU_DT	CLM_THRU_DT	Claim Through Date (Determines Year of Claim)	DATE	8
5	CLM_TYPE	NCH_CLM_TYPE_CD	NCH Claim Type Code	CHAR	2
6	OCRNC_CD	CLM_RLT_OCRNC_CD	Claim Related Occurrence Code	CHAR	2
7	OCRNCDT	CLM_RLT_OCRNC_DT	Claim Related Occurrence Date	DATE	8
Value Code File					
1	DSYSRTKY	DESY_SORT_KEY	LDS Beneficiary ID	NUM	9
2	CLAIMNO	CLAIM_NO	LDS Claim Number	NUM	12
3	RLTVALSQ	RLT_VAL_CD_SEQ	Claim Related Value Code Sequence	CHAR	2
4	THRU_DT	CLM_THRU_DT	Claim Through Date (Determines Year of Claim)	DATE	8
5	CLM_TYPE	NCH_CLM_TYPE_CD	NCH Claim Type Code	CHAR	2
6	VAL_CD	CLM_VAL_CD	Claim Value Code	CHAR	2
7	VAL_AMT	CLM_VAL_AMT	Claim Value Amount	NUM	12
Revenue Center File					
1	DSYSRTKY	DESY_SORT_KEY	LDS Beneficiary ID	NUM	9
2	CLAIMNO	CLAIM_NO	LDS Claim Number	NUM	12
3	CLM_LN	CLM_LINE_NUM	Claim Line Number	NUM	3
4	THRU_DT	CLM_THRU_DT	Claim Through Date (Determines Year of Claim)	DATE	8
5	CLM_TYPE	NCH_CLM_TYPE_CD	NCH Claim Type Code	CHAR	2
6	REV_CNTR	REV_CNTR	Revenue Center Code	CHAR	4
7	REV_DT	REV_CNTR_DT	Revenue Center Date	DATE	8
8	APCHIPPS	REV_CNTR_APC_HIPPS_CD	Revenue Center APC/HIPPS	CHAR	5
9	HCPCS_CD	HCPCS_CD	Revenue Center HCFA Common Procedure Coding System	CHAR	5
10	MDFR_CD1	HCPCS_1ST_MDFR_CD	Revenue Center HCPCS Initial Modifier Code	CHAR	5
11	MDFR_CD2	HCPCS_2ND_MDFR_CD	Revenue Center HCPCS Second Modifier Code	CHAR	5
12	PMTMTHD	REV_CNTR_PMT_MTHD_IND_CD	Revenue Center Payment Method Indicator Code	CHAR	2
13	REV_UNIT	REV_CNTR_UNIT_CNT	Revenue Center Unit Count	NUM	8
14	REV_RATE	REV_CNTR_RATE_AMT	Revenue Center Rate Amount	NUM	12
15	REVPMT	REV_CNTR_PMT_AMT_AMT	Revenue Center Payment Amount Amount	NUM	12
16	REV_CHRG	REV_CNTR_TOT_CHRG_AMT	Revenue Center Total Charge Amount	NUM	12
17	REV_NCVR	REV_CNTR_NCVRD_CHRG_AMT	Revenue Center Non-Covered Charge Amount	NUM	12
18	REVDEDCD	REV_CNTR_DDCTBL_COINSRNC_CD	Revenue Center Deductible Coinsurance Code	CHAR	1
19	REVSTIND	REV_CNTR_STUS_IND_CD	Revenue Center Status Indicator Code	CHAR	2

Base Claim File

Variable	Description	Possible Values	Notes
DSYSRTKY	This field contains the key to link data for each beneficiary across all claim files.		
CLAIMNO	The unique number used to identify a unique claim.		
PROVIDER	This variable is the provider identification number. The first two digits indicate the state where the provider is located, using the SSA state codes; the middle two characters indicate the type of provider; and the last two digits are used as a counter for the number of providers within that state and type of provider (i.e., this is a unique but not necessarily sequential number).		Refer to CCW Technical Guidance document: "Getting Started with Medicare Data" for additional information regarding setting classifications.
THRU_DT	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').		
RIC_CD	A code defining the type of claim record being processed.		
CLM_TYPE	The code used to identify the type of claim record being processed in NCH.	10 = Home Health Agency 20 = Non swing bed SNF 30 = Swing bed SNF 40 = Hospital Outpatient 50 = Hospice 60 = Inpatient 71 = Local carrier non-DMEPOS 72 = Local carrier DMEPOS 81 = Regional carrier non-DMEPOS 82 = Regional carrier DMEPOS	Effective with Version 'J', 3 new code values have been added to include a type code for the Medicare Advantage claims (IME/GME, no-pay and paid as FFS). During the Version 'J' conversion, these type codes were populated throughout history.
FAC_TYPE	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.	1 = Hospital 2 = Skilled Nursing Facility (SNF) 3 = Home Health Agency (HHA) 4 = Religious Non-medical (hospital) 6 = Intermediate Care 7 = Clinic services or hospital-based renal dialysis facility 8 = Ambulatory Surgery Center (ASC) or other special facility (e.g. Hospice)	
TYPESRVC	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.	For facility type codes 1-6: 1 = Inpatient 2 = Inpatient or Home Health (covered on Part B) 3 = Outpatient (or HHA - covered on Part A) 4 = Other (Part B) - Includes HHA medical services 5 = Intermediate Care - Level I 6 = Intermediate Care - Level II 7 = Subacute Inpatient (revenue code 019x required) 8 = Swing Bed For facility type code 7 (clinics): 1 = Rural Health Clinic 2 = Hospital based or indep renal dialysis facility 3 = Free-standing provider based FQHC 4 = Other Rehab Facility (ORF) 5 = Comprehensive Rehab Center (CORF) 6 = Community Mental Health Center (CMHC) 7 = Federally Qualified Health Center (FQHC) For facility type code 8 (special facility): 1 = Hospice (non-hospital based) 2 = Hospice (hospital based) 3 = Ambulatory Surgical Center (ASC) in hospital OPT 4 = Freestanding birthing center 5 = Critical Access Hospital - OPT services	

FREQ_CD	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.	0 = Non-payment / zero claim 1 = Admit thru discharge claim 2 = Interim - first claim 3 = Interim - continuing claim 4 = Interim - last claim 5 = Late charges only claim 7 = Replacement of prior claim 8 = Void / cancel prior claim 9 = Final claim (for HH PPS = process as debit/credit to RAP claim) G = Common Working File (CWF) adjustment claim H = CMS generated adjustment claim I = Misc adjustment claim (from QIO, etc) J = Other adjustment request M = Medicare secondary payer (MSP) adjustment P = Adjustment required by QIO	
FI_NUM	The identification number assigned by CMS to a fiscal intermediary authorized to process institutional claim records.		Effective October 2006, the Medicare Administrative Contractors (MACs) began replacing the existing fiscal intermediaries and started processing institutional claim records for states assigned to its jurisdiction. NOTE: The 5-position MAC number will be housed in the existing FI_NUM field. During the transition from an FI to a MAC the FI_NUM field could contain either a FI number or a MAC number. See the FI_NUM table of codes to identify the new MAC numbers and their effective dates.
NOPAY_CD	The reason that no Medicare payment is made for services on an institutional claim.		NOTE: Effective with Version 'J', the field has been expanded on the NCH claim to 2 bytes. With this expansion the NCH will no longer use the character values to represent the official two byte values being sent in by CWF since 4/2002. During the Version 'J' conversion, all character values were converted to the two byte values.
PMT_AMT	The Medicare claim payment amount. For hospital services, this amount does not include the claim pass-through per diem payments made by Medicare. To obtain the total amount paid by Medicare for the claim, the pass-through amount (which is the daily per diem amount) must be multiplied by the number of Medicare-covered days (i.e., multiply the CLM_PASS_THRU_PER_DIEM_AMT by the CLM_UTLZTN_DAY_CNT), and then added to the claim payment amount (this field). For non-hospital services (SNF, home health, hospice, and hospital outpatient) and for other non-institutional services (Carrier and DME), this variable equals the total actual Medicare payment amount, and pass-through amounts do not apply. For Part B non-institutional services (Carrier and DME), this variable equals the sum of all the line item-level Medicare payments (variable called the LINE_NCH_PMT_AMT).		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 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. After 4/1/03, the payment amount could also include a "new technology" add-on amount. 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 any other payer reimbursement. Under IRF PPS, inpatient rehabilitation services are paid based on a predetermined rate per discharge, using the Case Mix Group (CMG) classification system and the PRICER program. From the CMG on the IRF PPS claim, payment is based on a standard payment amount for operating and capital cost for that facility (including routine and ancillary services). The payment is adjusted for wage, the % of low-income patients (LIP), locality, transfers, interrupted stays, short stay cases, deaths, and high cost outliers. Some or all of these adjustments could apply. The CMG payment does NOT include certain pass- through costs (i.e. bad debts, approved education activities); beneficiary-paid amounts, other payer reimbursement,and other services outside of the scope of PPS.
PRPAYAMT	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 a non-institutional claim.		

PRPAY_CD	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 health insurance bills. The presence of a primary payer code indicates that some other payer besides Medicare covered at least some portion of the charges.	A = Working aged bene/spouse with employer group health plan (EGHP) B = End stage renal disease (ESRD) beneficiary in the 18 month coordination period with an EGHP C = Conditional payment by Medicare; future reimbursement expected D = Automobile no-fault E = Worker's Compensation F = Public Health Service or other federal agency (other than Dept of Veterans Affairs) G = Working disabled bene (under age 65 with LGHP) H = Black Lung I = Dept of Veterans Affairs L = Any liability insurance M = Override code: EGHP services involved N = Override code: non-EGHP services involved W = Worker's Compensation Medicare Set-Aside Arrangement (WCMSA) Blank = Medicare is primary payer	Values C, M, N and Blank indicate Medicare is primary payer.
PRSTATE	The two position SSA state code where provider facility is located.		
ORGNPINM	On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the institutional provider certified by Medicare to provide services to the beneficiary.		
AT_UPIN	On an institutional claim, the unique physician identification number (UPIN) of the physician who would normally be expected to 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).		Alert: Starting April 9, 2014 CMS is no longer encrypting physician identifiers, e.g., National Provider Identifiers (NPIs), on the SAFs. All new SAF requests will include actual NPI rather than an encrypted physician identifier. Researchers who have already purchased SAFs and have an active Data Use Agreement (DUA) with CMS may request a crosswalk linking encrypted physician identifiers to NPIs/UPINs. For more information on how to request the crosswalk visit: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/DUAs_-_more_actions.html
AT_NPI	On an institutional claim, the national provider identifier (NPI) number assigned to uniquely identify the physician who has overall responsibility for the beneficiary's care and treatment.		Alert: Starting April 9, 2014 CMS is no longer encrypting physician identifiers, e.g., National Provider Identifiers (NPIs), on the SAFs. All new SAF requests will include actual NPI rather than an encrypted physician identifier. Researchers who have already purchased SAFs and have an active Data Use Agreement (DUA) with CMS may request a crosswalk linking encrypted physician identifiers to NPIs/UPINs. For more information on how to request the crosswalk visit: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/DUAs_-_more_actions.html
STUS_CD	The code used to identify the status of the patient as of the CLM_THRU_DT.	0 = Unknown value (but present in data) 01 = Discharged to home/self care 02 = Discharged / transferred to short term hospital 03 = Discharged / transferred to SNF 04 = Discharged / transferred to intermediate care 05 = Discharged / transferred to other IPT care 06 = Discharged / transferred to HHA home care 07 = Left against medical advice or discontinue care 08 = Discharged / transferred to home IV drug care 09 = Admitted as an inpatient to hospital after OPT 20 = Expired (did not recover - Christian Science) 21 = Discharged / transferred to court /law enforce 30 = Still a patient 40 = Expired at home (hospice claims only) 41 = Expired in facility (hospice claims only) 42 = Expired place unknown (hospice claims only) 43 = Discharged / transferred to federal hospital 50 = Hospice - home 51 = Hospice - medical facility 61 = Discharged / transferred to swing bed internally 62 = Discharged / transferred to IPT Rehab 63 = Discharged / transferred to to LTC 64 = Discharged / transferred to Medicaid facility 65 = Discharged / transferred to Psychiatric Hospital 66 = Discharged / transferred to CAH 70 = Discharged / transferred to other misc facility 71 = Discharged / transferred to other OPT services 72 = Discharged / transferred internally for OPT svcs	

PPS_IND	The code indicating whether or not: (1) the claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee (MQGE).	Blank = Not a PPS bill 2 = PPS bill ; claim contains PPS indicator	
TOT_CHRG	The total charges for all services included on the institutional claim. This field is redundant with revenue center code 0001/total charges.		
PRNCPAL_DGNS_CD	The 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. This data is also redundantly stored as the first occurrence of the diagnosis code (variable called ICD_DGNS_CD1).		Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were acommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8). Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.
PRNCPAL_DGNS_VRSN_CD	Effective with Version 'J', the code used to indicate if the diagnosis is ICD-9 or ICD-10.	Blank = ICD-9 9 = ICD-9 0 = ICD-10	With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2015.
ICD DGNS CD1 to CD25	The diagnosis code identifying the beneficiary's principal or other diagnosis (including E code).		For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha /numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were acommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8). The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).
ICD DGNS VRSN CD1 to CD25	Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.	Blank = ICD-9 9 = ICD-9 0 = ICD-10	With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2015.
FST_DGNS_E_CD	The code used to identify the first external cause of injury, poisoning, or other adverse effect. This diagnosis E code is also stored as the first occurrence of the diagnosis E code trailer.		Prior to version 'J', this field was named: CLM_DGNS_E_CD. Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10, which is not scheduled for implementation until 10/2015.
FST_DGNS_E_VRSN_CD	Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.	Blank = ICD-9 9 = ICD-9 0 = ICD-10	With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2015.
ICD DGNS E CD1 to CD12	The code used to identify the external cause of injury, poisoning, or other adverse affect.		Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accomodate the implementation of ICD-10 in October of 2015.
ICD DGNS E VRSN CD1 to CD12	Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.	Blank = ICD-9 9 = ICD-9 0 = ICD-10	With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2015.
LUPAIND	The code used to identify those Home Health PPS claims that have 4 visits or less in a 60-day episode. If an HHA provides 4 visits or less, they will be reimbursed based on a national standardized per visit rate instead of Home Health Resource Groups (HHRGs).	L = Low Utilization Payment Adjustment (LUPA) Claim Blank = Not a LUPA Claim; process using Home Health resource groups (HHRGs)	Beginning 10/1/00, this field was populated with data. Claims processed prior to 10/1/00 contained spaces.

HHA_RFRL	The code used to identify the means by which the beneficiary was referred for Home Health services.	1 = Physician referral - The patient was admitted upon the recommendation of a personal physician. 2 = Clinic referral - The patient was admitted upon the recommendation of this facility's clinic physician. 3 = HMO referral - The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician. 4 = Transfer from hospital - The patient was admitted as an inpatient transfer from an acute care facility. 5 = Transfer from a skilled nursing facility (SNF) - The patient was admitted as an inpatient transfer from a SNF. 6 = Transfer from another health care facility - The patient was admitted as a transfer from a health care facility other than an acute care facility or SNF. 7 = Emergency room - The patient was admitted upon the recommendation of this facility's emergency room physician. 8 = Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative. 9 = Information not available - The means by which the patient was admitted is not known. A = Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital B = Transfer from another HHA - Beneficiaries are permitted to transfer from one HHA to another unrelated HHA under HH PPS.(eff.10/00) C = Readmission to same HHA - If a beneficiary is discharged from an HHA and then readmitted within the original 60-day episode, the original episode must be closed early and a new one created.	The use of this code will permit the agency to send a new RAP allowing all claims to be accepted by Medicare. (eff. 10/00) Beginning 10/1/00, this field was populated with data. Claims processed prior to 10/1/00 contained spaces in this field.
VISITCNT	The count of the number of HHA visits as derived by CMS.		Derivation rule (units associated with revenue center codes 042X, 043X, 044X, 055X, 056X, 057X, 058X and 059X). Value '999' will be displayed if the sum of the revenue center unit count equals or exceeds '999'. NOTE: Effective 7/1/99, all HHA claims received with service from dates 7/1/99 and after were processed as if the units field contains the 15 minute interval count; and each visit revenue code line item was counted as ONE visit. This field is calculated correctly; but those users who derive the count themselves will have to revise their routine. NO LONGER IS THE COUNT DERIVED BY ADDING UP THE UNITS FIELDS ASSOCIATED WITH THE HHA VISIT REVENUE CODES.
HHSTRTDT	The date the home health plan of care was established or last reviewed as reported on the institutional claim. The Balanced Budget Act (BBA) required that this field be present on all HHA claims. Field is not well populated until after 2011.		NOTE: Effective with Version 'I', the start of care date was moved from the 1st eight positions of the Claim Treatment Authorization Number. Prior to Version 'I' this date was moved from Occurrence Code 27 date field. --Regarding an issue in the 2011 HHA claims, CMS has determined that the Start of Care date is imbedded in the Treatment Authorization field. Unfortunately, this field is not loaded into the CCW. CMS has corrected this issue (begun pulling the date into the correct field) but there are no plans to reissue any previously delivered data.
DOB_DT	The beneficiary's date of birth, coded as a range.	0 = Unknown 1 = <65 2 = 65 Thru 69 3 = 70 Thru 74 4 = 75 Thru 79 5 = 80 Thru 84 6 = >84	For the Limited Data Set Standard View, the beneficiary's date of birth is coded as a range.
GNDR_CD	The sex of a beneficiary.	0 = Unknown 1 = Male 2 = Female	

RACE_CD	The race of a beneficiary.	0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = North American Native	
CNTY_CD	The 3-digit SSA standard county code of a beneficiary's residence.		A listing of county codes can be found on the US Census website; also CMS has core-based statistical area (CBSA) crosswalk files available on their website, which include state and county SSA codes.
STATE_CD	The 2-digit SSA standard state code of a beneficiary's residence.		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.
CWF_BENE_MDCR_STUS_CD	The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM_THRU_DT).	10 = Aged without ESRD 11 = Aged with ESRD 20 = Disabled without ESRD 21 = Disabled with ESRD 31 = ESRD only	
QUERY_CD	Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator).	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	
ACTIONCD	The type of action requested by the intermediary to be taken on an institutional claim.	1 = Original debit action 5 = Force action code 3 (secondary debit adjustment) 8 = Benefits refused	

Condition Code File

Variable	Description	Possible Values	Notes
DSYSRTKY	This field contains the key to link data for each beneficiary across all claim files.		
CLAIMNO	The unique number used to identify a unique claim.		
RLTCNDSQ	The sequence number of the claim related condition code (variable called CLM_RLT_COND_CD).		
THRU_DT	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').		
CLM_TYPE	The code used to identify the type of claim record being processed in NCH.	10 = Home Health Agency 20 = Non swing bed SNF 30 = Swing bed SNF 40 = Hospital Outpatient 50 = Hospice 60 = Inpatient 71 = Local carrier non-DMEPOS 72 = Local carrier DMEPOS 81 = Regional carrier non-DMEPOS 82 = Regional carrier DMEPOS	Effective with Version 'J', 3 new code values have been added to include a type code for the Medicare Advantage claims (IME/GME, no-pay and paid as FFS). During the Version 'J' conversion, these type codes were populated throughout history.
RLT_COND	The code that indicates a condition relating to an institutional claim that may affect payer processing.	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 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	

Occurrence Code File

Variable	Description	Possible Values	Notes
DSYSRTKY	This field contains the key to link data for each beneficiary across all claim files.		

CLAIMNO	The unique number used to identify a unique claim.		
RLTOCRSQ	The sequence number of the claim related occurrence code (variable called CLM_RLT_OCRNC_CD).		
THRU_DT	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').		
CLM_TYPE	The code used to identify the type of claim record being processed in NCH.	10 = Home Health Agency 20 = Non swing bed SNF 30 = Swing bed SNF 40 = Hospital Outpatient 50 = Hospice 60 = Inpatient 71 = Local carrier non-DMEPOS 72 = Local carrier DMEPOS 81 = Regional carrier non-DMEPOS 82 = Regional carrier DMEPOS	Effective with Version 'J', 3 new code values have been added to include a type code for the Medicare Advantage claims (IME/GME, no-pay and paid as FFS). During the Version 'J' conversion, these type codes were populated throughout history.
OCRNC_CD	The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date.	01 THRU 09 = Accident 10 THRU 19 = Medical condition 20 THRU 39 = Insurance related 40 THRU 69 = Service related A1-A3 = Miscellaneous	
OCRNCDT	The date associated with a significant event related to an institutional claim that may affect payer processing. The date for the event that appears in the claim related occurrence code field.		For the Limited Data Set Standard View, the claim procedure performed date is coded as when the procedure was performed.

Value Code File

Variable	Description	Possible Values	Notes
DSYSRTKY	This field contains the key to link data for each beneficiary across all claim files.		
CLAIMNO	The unique number used to identify a unique claim.		
RLTVALSQ	The sequence number of the claim related condition code (variable called CLM_RLT_COND_CD).		
THRU_DT	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').		
CLM_TYPE	The code used to identify the type of claim record being processed in NCH.	10 = Home Health Agency 20 = Non swing bed SNF 30 = Swing bed SNF 40 = Hospital Outpatient 50 = Hospice 60 = Inpatient 71 = Local carrier non-DMEPOS 72 = Local carrier DMEPOS 81 = Regional carrier non-DMEPOS 82 = Regional carrier DMEPOS	Effective with Version 'J', 3 new code values have been added to include a type code for the Medicare Advantage claims (IME/GME, no-pay and paid as FFS). During the Version 'J' conversion, these type codes were populated throughout history.
VAL_CD	The code indicating the value of a monetary condition which was used by the intermediary to process an institutional claim. The associated monetary value is in the claim value amount field (CLM_VAL_AMT).		
VAL_AMT	The amount related to the condition identified in the CLM_VAL_CD field which was used by the intermediary to process the institutional claim.		

Revenue Center File

Variable	Description	Possible Values	Notes
DSYSRTKY	This field contains the key to link data for each beneficiary across all claim files.		
CLAIMNO	The unique number used to identify a unique claim.		
CLM_LN	This variable identifies an individual line number on a claim. Each revenue center record or claim line has a sequential line number to distinguish distinct services that are submitted on the same claim. All revenue center records or claim lines on a given claim have the same CLM_ID.		
THRU_DT	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').		
CLM_TYPE	The code used to identify the type of claim record being processed in NCH.	10 = Home Health Agency 20 = Non swing bed SNF 30 = Swing bed SNF 40 = Hospital Outpatient 50 = Hospice 60 = Inpatient 71 = Local carrier non-DMEPOS 72 = Local carrier DMEPOS 81 = Regional carrier non-DMEPOS 82 = Regional carrier DMEPOS	Effective with Version 'J', 3 new code values have been added to include a type code for the Medicare Advantage claims (IME/GME, no-pay and paid as FFS). During the Version 'J' conversion, these type codes were populated throughout history.

REV_CNTR	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.		
REV_DT	This is the date of service for the revenue center record. However, it is populated only for home health claims, hospice claims, and Part B institutional (HOP) claims. For home health claims, which are paid based on episodes that can last up to 60 days, this variable indicates the dates for the individual visits.		
APCHIPPS	This field contains one of two potential pieces of data; the Ambulatory Payment Classification (APC) code or the Health Insurance Prospective Payment System (HIPPS) code, which corresponds with the revenue center line for the claim. The APC codes are used as the basis for payment for outpatient prospective payment (OPPS) service (e.g., Part B institutional). Some Part A claim types (e.g., home health and SNF) use resource groupings, which are similar to case-mix groups, as the basis for payment (e.g., HHRG, SNF RUGs). For home health (HH) claims, when the revenue center code (variable called REV_CNTR) is 0023, the HHRG is located in this field and is a HIPPS code. This field is only meaningful for a HH claim when CMS determines the claim should be paid using a different HIPPS code than the one submitted by the provider. When this happens, the revised HIPPS code (the one actually used for payment purposes) appears in this field and the original HIPPS code submitted by the provider remains in the HCPCS_CD field. Otherwise, this variable will always be null or have a value of “00000” for HH revenue center records. The resource utilization group for the particular revenue center is located in the data field called the APC or HIPPS code variable. The APC is a four byte field. The HIPPS code is a five byte field. (such as 1AFKS).	HIPPS codes can be downloaded from the CMS website Prospective Payment Systems page: (see: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html).	NOTE1: The APC field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward. NOTE2: Under SNFPPS, HHPPS & IRFPPS, HIPPS codes are stored in the HCPCS field. **EXCEPTION: if a HHPPS HIPPS code is downcoded/upcoded the downcoded/ upcoded HIPPS will be stored in this field.
HCPCS_CD	The HCFA 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. In the Institutional Claim Revenue Center Files, this variable can indicate the specific case-mix grouping that Medicare used to pay for skilled nursing facility (SNF), home health, or inpatient rehabilitation facility (IRF) services. These groupings are sometimes known as Health Insurance Prospective Payment System (HIPPS) codes. This field will contain a HIPPS code if the revenue center code (REV_CNTR) equals 0022 for SNF care, 0023 for home health, or 0024 for IRF care. For home health claims, please also see the revenue center APC/HIPPS code variable (REV_CNTR_APC_HIPPS_CD).		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 CMS/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, Fifth Edition (CDT-5). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of CMS, 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.
MDFR_CD1	A first modifier to the HCPCS procedure code to enable a more specific procedure identification for the revenue center or line item service for the claim.		
MDFR_CD2	A second modifier to the HCPCS procedure code to make it more specific than the first modifier code to identify the revenue center or line item service for the claim.		

PMTMTHD	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 status indicator and the 2nd position being the payment indicator.	0 = Unknown Value (but present in data) 1 = Paid standard hospital OPPS amount (status indicators K, S,T,V,X) 2 = Services not paid under OPPS (status indicator A, or no HCPCS code and not certain revenue center codes) 3 = Not paid (status indicator M,W,Y,E) or not paid under OPPS (status indicator B,C & Z) 4 = Paid at reasonable cost (status indicator F,L) 5 = Additional payment for drug or biological (status indicator G) 6 = Additional payment for device (status indicator H) 7 = Additional payment for new drug or new biological (status indicator J) 8 = Paid partial hospitalization per diem (status indicator P) 9 = No additional payment, payment included in line items with APCs (status indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy) or G0177 (partial hospitalization program services)	NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward. NOTE2: Effective 10/2005, this field will no longer represent the service indicator and the payment indicator. This field will now house the 2-byte payment indicator. The status indicator will be housed in a new field named: REV_CNTR_STUS_IND_CD.
REV_UNIT	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.		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.
REV_RATE	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'), CMS 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, CMS 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'), CMS 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 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. NOTE4: For IRF PPS claims (when revenue center code equals '0024'), CMS has developed a PRICER to compute the rate based on the HIPPS/CMG (HIPPS code, stored in revenue center HCPCS code field).
REVPMT	To obtain the Medicare payment amount for the services reoprted on the revenue center record, it is more accurate to use a different variable called the revenue center Medicare provider payment amount (REV_CNTR_PRVDR_PMT_AMT). For Home Health, use the claim-level Medicare payment amount (variable that is the total of all revenue center records on the claim, which is called CLM_PMT_AMT), since each visit is not paid separately.		NOTE: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

REV_CHRG	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 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: (1) 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). (2) For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero. (3) For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line. (4) 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'). (5) For Inpatient Rehabilitation Facility (IFR) PPS, when the revenue center code = '0024', the total charges will be zero. For accommodation revenue codes (010X - 021X), total charges must equal the rate times the units. (6) 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).
REV_NCVR	The charge amount related to a revenue center code for services that are not covered by Medicare.		
REVDEDCD	Code indicating whether the revenue center charges are subject to deductible and/or coinsurance.	0 = Charges are subject to deductible and coinsurance 1 = Charges are not subject to deductible 2 = Charges are not subject to coinsurance 3 = Charges are not subject to deductible or coinsurance 4 = No charge or units associated with this revenue center code. (For multiple HCPCS per single revenue center code) For revenue center code 0001, the following MSP override values may be present: M = Override code; EGHP (employer group health plan) services involved N = Override code; non-EGHP services involved X = Override code: MSP (Medicare is secondary payer) cost avoided	

REVSTIND	This variable indicates how the service listed on the revenue center record was priced for payment purposes. The revenue center status indicator code is most useful with outpatient hospital claims, where multiple methods may be used to determine the payment amount for the various revenue center records on the claim (for example, some lines may be bundled into an APC and paid under the outpatient PPS, while other lines may be paid under other fee schedules).	A = Services not paid under OPPS B = Non-allowed item or service for OPPS C = Inpatient procedure E = Non-allowed item or service F = Corneal tissue acquisition and certain CRNA services G = Drug/bilogical pass-through H = Device pass-through J = New drug or new biological pass-through K = Non pass-through drug/biological, radio-pharmaceutical agent, certain brachytherapy sources L = Flu/PPV vaccines M = Service not billable to Fiscal Inter N = Packaged incidental service P = Paid partial hospitalization per diem APC payment Q1 = Separate payment made; OPPS - APC (effective 2009) Q2 = No separate payment made; OPPS - APC were packaged into payment for other serivces (effective 2009) Q3 = May be paid through a composite APC-based on composite-specific criteria or separately through single code APCs when the criteria are not met (effective 2009) S = Significant procedure not subject to multiple procedure discounting T = Significant procedure subject to multiple procedure discounting V = Medical visit to clinic or emergency department W = Invalid HCPCS or invalid revenue code with blank HCPCS X = Ancillary service Y = Non-implantable DME, Therapeutic shoes Z = Valid revenue with blank HCPCS and no other SI assigned	NOTE1: This 2-byte indicator is being added due to an expansion of a field that currently exist on the revenue center trailer. The status indicator is currently the 1st position of the Revenue Center Payment Method Indicator Code. The payment method indicator code is being split into two 2-byte fields (payment indicator and status indicator). The expanded payment indicator will continue to be stored in the existing payment method indicator field. The split of the current payment method indicator field is due to the expansion of both pieces of date from 1-byte to 2-bytes. NOTE2: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field. Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services.