Research Data Distribution Center
LDS SNF Claim Record
Data Dictionary

Variable Name	Label

CLAIM_NO

CLAIM NUMBER

The unique number used to identify a unique claim.
SAS ALIAS: CLAIM_NO
STANDARD ALIAS: CLAIM_NO

DSYSRTKY

DESY SORT KEY

This field contains the key to link data for each beneficiary across all claim files.
SAS ALIAS: DSYSRTKY
STANDARD ALIAS: DESY_SORT_KEY

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

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
STANDARD ALIAS: NCH_NEAR_LINE_RIC_CD

Variable Name	*Label*	
		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: (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.

Variable Name	*Label*
	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 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' 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 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'

Variable Name	*Label*	
		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 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 FOLLOWING CONDITIONS ARE MET: 1. CARR_NUM = 80882 AND 2. CLM_DEMO_ID_NUM = 38 SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'M' 2. HCPCS_CD not on DMEPOS table

Variable Name	*Label*	
		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
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 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 EDIT-RULES FOR ENCRYPTED DATA: CCYYMMDD WHERE CCYY REPRESENTS THE YEAR. SOURCE: CWF

Variable Name	*Label*
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:

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

Variable Name	*Label*

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. 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

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 ofthe 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

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

Variable Name	*Label*	
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: 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
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

Variable Name	*Label*
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

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:
0000000R
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

Variable Name	*Label*

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
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 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:
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 sent; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible
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 daily per diem rate no matter what the charges are.)

Under IP PPS, inpatient hospital services are paid based a predetermined rate per discharge, using the DRG classification system and the PRICER program. On the PPS claim, the payment amount includes the DRG approved payment amount, disproportionate share 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 '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 adjustment and the beneficiary deductible and
amounts. NOTE: There is no CWF edit check to validate the revenue center Medicare payment amount equals the claim
level Medicare payment amount.

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

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

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

Exceptions: For claims involving demos and BBA data, the amount reported in this field may not

Variable Name	*Label*	
		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: +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 theprovider 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

Variable Name	*Label*	
		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 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 1991).

DB2 ALIAS: NCH_PRVDR_STATE_CD
SAS ALIAS: PRSTATE
STANDARD ALIAS: NCH_PRVDR_STATE_CD
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'.

Variable Name	*Label*	
		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 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). 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 10 positions (6-position UPIN and 4-position physician surname). SOURCE: CWF
OP_UPIN	*Claim Operating Physician UPIN Number*	
		On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal procedure. This 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

Variable Name	*Label*

OT_UPIN — *Claim Other Physician UPIN Number*

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

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

Variable Name	*Label*	
		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 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 pop-ulated 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 SAS ALIAS: TOT_CHRG STANDARD ALIAS: CLM_TOT_CHRG_AMT TITLE ALIAS: CLAIM_TOTAL_CHARGES

Variable Name	*Label*	
		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 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 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: Prior to Version H this field was named: CLM_PRCDR_CD_CNT. SOURCE: CWF

Variable Name	*Label*
IPCONCNT	*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: IPCONCNT
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

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.

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

Variable Name	*Label*
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.

For the Limited Data Set Standard View of the Inpatient/SNF files, the admission date for the claim is coded as 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 ENCRYPTED DATA:
CCYYMMDD WHERE CCYY REPRESENTS THE YEAR.

SOURCE:
CWF

Variable Name	*Label*
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.

DB2 ALIAS: SRC_IP_ADMSN_CD
SAS ALIAS: SRC_ADMS
STANDARD ALIAS: CLM_SRC_IP_ADMSN_CD
TITLE ALIAS: IP_ADMISSION_SOURCE

CODES:
For Inpatient/SNF Claims

0 = ANOMALY: invalid value, if present, translate to '9'
1 = Non-Health Care Facility Point of Origin (Physician Referral) - The patient was admitted to this facility upon an order of a physician.
2 = Clinic referral - The patient was admitted upon the recommendation of this facility's clinic physician.
3 = HMO referral - Reserved for national Prior to 3/08, HMO referral - The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician.
4 = Transfer from hospital (Different Facility) - The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient.
5 = Transfer from a skilled nursing facility (SNF) or Intermediate Care Facility (ICF) - The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.
6 = Transfer from another health care facility - The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list where he or she was an inpatient.
7 = Emergency room - The patient was admitted to this facility after receiving services in this facility's emergency room department.
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 = Reserved for National Assignment. (eff. 3/08) Prior to 3/08 defined as: 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 Home Health Agency - The patient was admitted to this home health agency as a transfer from another home health agency.(Discontinued July 1,2010- See Condition Code 47)
C = Readmission to Same Home Health Agency - The patient was readmitted to this home health agency within the same home health episode period. (Discontinued July 1,2010)
D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer - The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.

For Newborn Type of Admission

1 = Normal delivery - A baby delivered without complications.
2 = Premature delivery - A baby delivered with time and/or weight factors qualifying it for premature status.
3 = Sick baby - A baby delivered with medical complications, other than those relating to premature status.
4 = Extramural birth - A baby delivered in a nonsterile environment.
5-8 = Reserved for national assignment.
9 = Information not available.

SOURCE:
CWF

Variable Name	*Label*
AD_DGNS	*Claim Admitting Diagnosis Code*

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

DB2 ALIAS: CLM_ADMTG_DGNS_CD
SAS ALIAS: AD_DGNS
STANDARD ALIAS: CLM_ADMTG_DGNS_CD
TITLE ALIAS: ADMITTING_DIAGNOSIS

SOURCE:
CWF

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

Variable Name	*Label*	
		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 institutional claim. 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
BLDDEDAM	*NCH Beneficiary Blood Deductible Liability Amount*	The amount of money for which the intermediary determined the beneficiary is liable for the blood 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

Variable Name	*Label*	
		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 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

Variable Name	*Label*	
		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 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 Clm_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
Variable Name	*Label*	

Variable Name	*Label*
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 to 1991), but the derivation rule applied was in-complete 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
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 for capital.

Variable Name	*Label*
	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: +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

Variable Name	*Label*
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

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 review 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)

Variable Name	*Label*	
		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 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
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*

Number of whole pints of blood replaced. 3 DIGITS

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:

Variable Name	*Label*	
		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: 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

Variable Name	*Label*	
		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 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 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 ENCRYPTED DATA: CCYYMMDD WHERE CCYY REPRESENTS THE 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

Variable Name	*Label*
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 when the discharge 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 ENCRYPTED DATA:
CCYYMMDD WHERE CCYY REPRESENTS THE 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 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

AT_NPI	*Claim Attending Physician NPI Number*

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.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, NPIs, OSCAR provider numbers, etc.) on the standard HIPPA claim transactions. (During the

Variable Name	*Label*
	NPI transition phase (4/3/06 – 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number. NOTE1: CMS has determined that dual provider identifiers (legacy numbers and NPIs) must be available on the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims) so there will only be NPIs sent in to the NCH for those physicians. SAS ALIAS: AT_NPI STANDARD ALIAS: CLM_ATNDG_PHYSN_NPI_NUM
OP_NPI	*Claim Operating Physician NPI Number* On an institutional claim, the national provider identifier (NPI) number assigned to uniquely identify the physician with the primary responsibility for performing the surgical procedure(s). NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, NPIs, OSCAR provider numbers, etc.) on the standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 – 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number. NOTE1: CMS has determined that dual provider identifiers (legacy numbers and NPIs) must be available on the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims) so there will only be NPIs sent in to the NCH for those physicians. SAS ALIAS: OP_NPI STANDARD ALIAS: CLM_OPRTG_PHYSN_NPI_NUM
OT_NPI	*Claim Other Physician NPI Number* On an institutional claim, the national provider identifier (NPI) number assigned to uniquely identify the other physician associated with the institutional claim. NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, NPIs, OSCAR provider numbers, etc.) on the standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 – 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number. NOTE1: CMS has determined that dual provider identifiers (legacy numbers and NPIs) must be available on the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims) so there will only be NPIs sent in to the NCH for those physicians. SAS ALIAS: OT_NPI STANDARD ALIAS: CLM_OTHR_PHYSN_NPI_NUM
ORGNPINM	*Organization NPI Number* 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.

Variable Name	*Label*

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, NPIs, OSCAR provider numbers, etc.) on the standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 – 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number.

NOTE1: CMS has determined that dual provider identifiers (legacy numbers and NPIs) must be available on the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims) so there will only be NPIs sent in to the NCH for those physicians.
SAS ALIAS: ORGNPINM
STANDARD ALIAS: ORG_NPI_NUM

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: DGNSCD{x}
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: PRCDRCD{x}
STANDARD ALIAS: CLM_PRCDR_CD
TITLE ALIAS: PROCEDURE_CODE

EDIT-RULES:
ICD-9-CM

SOURCE:
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.

Variable Name	*Label*	
		For the Limited Data Set Standard View of the Inpatient/SNF files, the claim procedure performed date is coded as when the procedure was performed. 8 DIGITS UNSIGNED DB2 ALIAS: CLM_PRCDR_PRFRM_DT SAS ALIAS: PRCDRDT{x} STANDARD ALIAS: CLM_PRCDR_PRFRM_DT TITLE ALIAS: PROCEDURE_DATE EDIT-RULES FOR ENCRYPTED DATA: CCYYMMDD WHERE CCYY REPRESENTS THE YEAR. SOURCE: CWF
RLTCND{x} *where { x } ranges from 1 to 30*	*Claim Related Condition Code*	The code that indicates a condition relating to an institutional claim that may affect payer processing. DB2 ALIAS: CLM_RLT_COND_CD SAS ALIAS: RLTCOND{x} 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 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} *where { x } ranges from 1 to 30*	*Claim Related Occurrence Code*	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. DB2 ALIAS: CLM_RLT_OCRNC_CD SAS ALIAS: OCRCCD{x} 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

Variable Name	*Label*	
		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 when the procedure was performed. 8 DIGITS UNSIGNED DB2 ALIAS: CLM_RLT_OCRNC_DT SAS ALIAS: OCRCDT{x} STANDARD ALIAS: CLM_RLT_OCRNC_DT TITLE ALIAS: RLT_OCRNC_DT EDIT-RULES FOR ENCRYPTED DATA: CCYYMMDD WHERE CCYY REPRESENTS THE 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{x} 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 SAS ALIAS: VALAMT{x} STANDARD ALIAS: CLM_VAL_AMT TITLE ALIAS: VALUE_AMOUNT

Variable Name	*Label*	
		EDIT-RULES: +9(9).99 SOURCE: CWF
RVCNTR{x} *where { x } ranges from 1 to 45*	*Revenue Center Code*	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 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: RVCNTR{x} 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} *where { x } ranges from 1 to 45*	*Revenue Center Date*	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 Inpatient/SNF, the date applicable to the service represented by the revenue center code is coded as 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.

Variable Name	*Label*	
		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 ENCRYPTED DATA: CCYYMMDD WHERE CCYY REPRESENTS THE YEAR. SOURCE: CWF
APCPPS{x} *where { x } ranges from 1 to 45*	*Revenue Center APC/HIPPS Code*	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 used to calculate payment for services under OPPS. Effective with Home Health PPS (HHPPS), this field will only be populated with a HIPPS code if the HIPPS 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 HHPPS, HIPPS codes are stored in the HCPCS field. **EXCEPTION: if a HHPPS HIPPS code is downcoded the downcoded HIPPS 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: APCPPS{x} 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

Variable Name	*Label*
HCPSCD{x} *where { x } ranges from 1 to 45*	*Revenue Center HCFA Common Procedure Coding*

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: HCPSCD{x}
STANDARD ALIAS: REV_CNTR_HCPCS_CD
SYSTEM ALIAS: LTHIPPS
TITLE ALIAS: HCPCS_CD

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 pur-poses.

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 bythe 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.

Variable Name	*Label*
	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 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.
MDCD1_{x} *where { x } ranges from 1 to 45*	*Revenue Center HCPCS Initial Modifier Code* 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: MDCD1_{x} STANDARD ALIAS: 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
MDCD2_{x} *where { x } ranges from 1 to 45*	*Revenue Center HCPCS Second Modifier Code* 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. DB2 ALIAS: REV_HCPCS_2ND_CD SAS ALIAS: MDCD2_{x} STANDARD ALIAS: REV_CNTR_HCPCS_2ND_MDFR_CD TITLE ALIAS: SECOND_MODIFIER

Variable Name	*Label*	
		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
MDCD3_{x} *where { x } ranges from 1 to 45*	*Revenue Center HCPCS Third Modifier Code*	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: MDCD3_{x} 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
MDCD4_{x} *where { x } ranges from 1 to 45*	*Revenue Center HCPCS Fourth Modifier Code*	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. DB2 ALIAS: REV_HCPCS_4TH_CD SAS ALIAS: MDCD4{x} 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

Variable Name	*Label*
MDCD5_{x} *where { x } ranges from 1 to 45*	*Revenue Center HCPCS Fifth Modifier Code*

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 procedures performed on the beneficiary for the claim.

DB2 ALIAS: REV_HCPCS_5TH_CD
SAS ALIAS: MDCD5_{x}
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} *where { x } ranges from 1 to 45*	*Revenue Center Payment Method Indicator Code*

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.

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: PMTTHD{x}
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} *where { x } ranges from 1 to 45*	*Revenue Center Discount Indicator Code*

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45

Variable Name	*Label*
	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: DSCTND{x} 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
PCKGND{x} *where { x } ranges from 1 to 45*	*Revenue Center Packaging Indicator Code* 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: PCKGND{x} 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

Variable Name	*Label*
	SOURCE: CWF
PRICNG{x} *where { x } ranges from 1 to 45*	*Revenue Center Pricing Indicator Code*
	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{x} STANDARD ALIAS: REV_CNTR_PRICNG_IND_CD SYSTEM ALIAS: LTPRICNG TITLE ALIAS: REV_CNTR_PRICNG_IND CODES: REFER TO: REV_CNTR_PRICNG_IND_TB IN THE CODES APPENDIX SOURCE: CWF
OTAF1_{x} *where { x } ranges from 1 to 45*	*Revenue Center Obligation to Accept As Full (OTAF)*
	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 re- ceived 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: OTAF1_{x} 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} *where { x } ranges from 1 to 45*	*Revenue Center IDE, NDC, UPC Number*
	If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45

Variable Name	Label	
		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 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 (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{x} STANDARD ALIAS: REV_CNTR_IDE_NDC_UPC_NUM TITLE ALIAS: IDE_NDC_UPC SOURCE: CWF
RVUNT{x} *where { x } ranges from 1 to 45*	*Revenue Center Unit Count*	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 to the revenue center/HCPCS code definition as an institutional claim. Depending on type of service, units are measured by 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. NOTE1: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each

Variable Name	*Label*	
		code and, if applicable, the number of visits for each rehab therapy code. 7 DIGITS SIGNED DB2 ALIAS: REV_CNTR_UNIT_CNT SAS ALIAS: RVUNT{x} STANDARD ALIAS: REV_CNTR_UNIT_CNT TITLE ALIAS: UNITS EDIT- RULES: +9(7) SOURCE: CWF
RVRT{x} *where { x } ranges from 1 to 45*	*Revenue Center Rate Amount*	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 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: RVRT{x} STANDARD ALIAS: REV_CNTR_RATE_AMT TITLE ALIAS: CHARGE_PER_UNIT EDIT-RULES: +9(9).99 EFFECTIVE-DATE: 10/01/1993

Variable Name	*Label*	
		COMMENT: Prior to Version H the size of this field was: S9(7)V99. SOURCE: CWF
RVBLD{x} *where { x } ranges from 1 to 45*	*Revenue Center Blood Deductible Amount*	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: RVBLD{x} STANDARD ALIAS: REV_CNTR_BLOOD_DDCTBL_AMT TITLE ALIAS: BLOOD_DDCTBL_AMT EDIT-RULES: +9(9).99 SOURCE: CWF
RVDTBL{x} *where { x } ranges from 1 to 45*	*Revenue Center Cash Deductible Amount*	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: RVDTBL{x} STANDARD ALIAS: REV_CNTR_CASH_DDCTBL_AMT TITLE ALIAS: CASH_DDCTBL EDIT-RULES: +9(9).99 SOURCE: CWF
WGDJ{x} *where { x } ranges from 1 to 45*	*Revenue Center Coinsurance/Wage Adjusted*	If there are more than 45 revenue center trailer elements from

Variable Name	*Label*	
		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 DB2 ALIAS: ADJSTD_COINSRNC SAS ALIAS: WGDJ{x} STANDARD ALIAS: REV_CNTR_WAGE_ADJSTD_COINS_AMT TITLE ALIAS: WAGE_ADJSTD_COINS EDIT-RULES: +9(9).99 SOURCE: CWF
RDCDCN{x} *where { x } ranges from 1 to 45*	*Revenue Center Reduced Coinsurance Amount*	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 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: RDCDCN{x}

Variable Name	*Label*	
		STANDARD ALIAS: REV_CNTR_RDCD_COINS_AMT TITLE ALIAS: REDUCED_COINS EDIT-RULES: +9(9).99 SOURCE: CWF
RVMS1_{x} *where { x } ranges from 1 to 45*	*Revenue Center 1st Medicare Secondary Payer Paid*	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 tertiary). 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_MSP1_PD_AMT SAS ALIAS: RVMS1_{x} STANDARD ALIAS: REV_CNTR_MSP1_PD_AMT TITLE ALIAS: MSP PAID AMOUNT EDIT-RULES: +9(9).99 SOURCE: CWF
RVMS2_{x} *where { x } ranges from 1 to 45*	*Revenue Center 2nd Medicare Secondary Payer Paid*	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: RVMS2_{x} STANDARD ALIAS: REV_CNTR_MSP2_PD_AMT TITLE ALIAS: MSP PAID AMOUNT EDIT-RULES: +9(9).99 SOURCE: CWF

Variable Name	*Label*
RPRPMT{x} *where { x } ranges from 1 to 45*	*Revenue Center Provider Payment Amount*

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.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_PRVDR_PMT_AMT
SAS ALIAS: RPRPMT{x}
STANDARD ALIAS: REV_CNTR_PRVDR_PMT_AMT
TITLE ALIAS: REV_PRVDR_PMT

EDIT-RULES:
+9(9).99

SOURCE:
CWF

RBNPMT{x} *where { x } ranges from 1 to 45*	*Revenue Center Beneficiary Payment Amount*

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: RBNPMT{x}
STANDARD ALIAS: REV_CNTR_BENE_PMT_AMT
TITLE ALIAS: REV_BENE_PMT

EDIT-RULES:
+9(9).99
SOURCE:
CWF

PTNRSP{x} *where { x } ranges from 1 to 45*	*Revenue Center Patient Responsibility Payment Amount*

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.

Variable Name	*Label*	
		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 SAS ALIAS: PTNRSP{x} STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT TITLE ALIAS: REV_PTNT_RESP EDIT-RULES: +9(9).99 SOURCE: CWF
REVPMT{x} *where { x } ranges from 1 to 45*	*Revenue Center Payment Amount*	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{x} STANDARD ALIAS: REV_CNTR_PMT_AMT TITLE ALIAS: REIMBURSEMENT EDIT-RULES: +9(9).99 SOURCE: CWF
RVCHRG{x} *where { x } ranges from 1 to 45*	*Revenue Center Total Charge Amount*	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

Variable Name	*Label*	
		the 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 center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have 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 code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023'). (5) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the charges will be $1 (rate) times units (days). 9.2 DIGITS SIGNED DB2 ALIAS: REV_TOT_CHRG_AMT SAS ALIAS: RVCHRG{x} 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} *where { x } ranges from 1 to 45*	*Revenue Center Non-Covered Charge Amount*	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 the element was only present on the Inpatient/SNF As of NCH weekly process date 10/3/97 this field was to all institutional claim types. 9.2 DIGITS SIGNED DB2 ALIAS: REV_NCVR_CHRG_AMT SAS ALIAS: RVNCVR{x} STANDARD ALIAS: REV_CNTR_NCVR_CHRG_AMT TITLE ALIAS:

Variable Name	*Label*	
		EDIT-RULES: +9(9).99 SOURCE: CWF
RVDDCD{x} *where { x } ranges from 1 to 45*	*Revenue Center Deductible Coinsurance Code*	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: RVDDCD{x} STANDARD ALIAS: TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD CODES: REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB IN THE CODES APPENDIX SOURCE: CWF