NAME	TYPE	LENGTH
LDS Beneficiary Identifier	NUM	9

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

SHORT NAME: DSYSRTKY
LONG NAME: DESY_SORT_KEY

LDS Claim Number	NUM	12

The unique number used to identify a unique claim.

SAS ALIAS: CLAIM_NO
STANDARD ALIAS: CLAIM_NO

NCH Near Line Record Identification Code	CHAR	1

A code defining the type of claim record being processed.

SHORT NAME: RIC_CD
LONG NAME: NCH_NEAR_LINE_REC_IDENT_CD

CODES:
NCH Near-Line Record Identification Code Table

O = Part B physician/supplier claim record (processed by local carriers; can include DMEPOS services)
V = Part A institutional claim record (inpatient (IP), skilled nursing facility (SNF), christian science (CS), home health agency (HHA), or hospice)
W = Part B institutional claim record (outpatient (OP), HHA)
U = Both Part A and B institutional home health agency (HHA) claim records -- due to HHPPS and HHA A/B split. (effective 10/00)
M = Part B DMEPOS claim record (processed by DME Regional Carrier) (effective 10/93)

SOURCE:

NCH

NCH Claim Type Code CHAR 2

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.

SHORT NAME: CLM_TYPE
LONG NAME: NCH_CLM_TYPE_CD

DERIVATION:
FFS CLAIM TYPE CODES DERIVED FROM:
- NCH_NEAR_LINE_REC_IDENT_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.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(AVAILABLE IN NMUD)
- CARR_NUM
- CLM_DEMO_ID_NUM

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

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
DERIVED FROM:  (AVAILABLE IN NMUD)
  FI_NUM
  CLM_FAC_TYPE_CD
  CLM_SRVC_CLSFCTN_TYPE_CD
  CLM_FREQ_CD

DERIVATION RULES:

  SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
  FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
  2.   PMT_EDIT_RIC_CD EQUAL 'F'
  3.   CLM_TRANS_CD EQUAL '5'

  SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
  WHERE THE FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
  2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
  3.   CLM_TRANS_CD EQUAL '0' OR '4'
  4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
       OR 'Z'

  SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
  WHERE THE FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
  2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
  3.   CLM_TRANS_CD EQUAL '0' OR '4'
  4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
       OR 'Z'

  SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
  WHERE THE FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
  2.   PMT_EDIT_RIC_CD EQUAL 'D'
  3.   CLM_TRANS_CD EQUAL '6'

  SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
  ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
  THE FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
  2.   PMT_EDIT_RIC_CD EQUAL 'D'
  3.   CLM_TRANS_CD EQUAL '6'
  4.   FI_NUM = 80881

  SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
  ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
  1.   FI_NUM = 80881
  2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
```

```
     CLSFCTN_TYPE_CD = '2', '3' OR '4' &
     CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'I'
3.   CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_MCO_PD_SW = '1'
2.   CLM_RLT_COND_CD = '04'
3.   MCO_CNTRCT_NUM
     MCO_OPTN_CD = 'C'
     CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
     MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
     ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
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 DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

CODES:
NCH Claim Type Table
---
10 = HHA claim
20 = Non swing bed SNF claim
30 = Swing bed SNF claim
40 = Outpatient claim
41 = Outpatient 'Full-Encounter' claim (available in NMUD)
42 = Outpatient 'Abbreviated-Encounter' claim (available in NMUD)
50 = Hospice claim
60 = Inpatient claim
61 = Inpatient 'Full-Encounter' claim
62 = Inpatient 'Abbreviated-Encounter claim (available in NMUD)
71 = RIC O local carrier non-DMEPOS claim
72 = RIC O local carrier DMEPOS claim
73 = Physician 'Full-Encounter' claim (available in NMUD)
81 = RIC M DMERC non-DMEPOS claim
82 = RIC M DMERC DMEPOS claim

SOURCE:
NCH

NAME	TYPE	LENGTH
Claim From Date	DATE	8

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

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial

claim) must always match.

8 DIGITS UNSIGNED

SHORT NAME: FROM_DT
LONG NAME: CLM_FROM_DT

EDIT-RULES:

YYYYMMDD

SOURCE:
CWF

Claim Through Date DATE 8

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

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

If the year of the original Claim Through Date (THRU_DT) was future to the year of the Weekly Processing Date (WKLY_DT), the CCW Claim Through Date (THRU_DT) has been changed to 12/31/YYYY with YYYY representing the year of the Weekly Processing Date (WKLY_DT).

8 DIGITS UNSIGNED

SHORT NAME: THRU_DT
LONG NAME: CLM_THRU_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

Provider Number CHAR 6

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

SHORT NAME: PROVIDER
LONG NAME: PRVDR_NUM

Provider Number Table

- First two positions are the GEO SSA State Code.
  Exception: 55 = California
  67 = Texas
  68 = Florida

- Positions 3 and sometimes 4 are used as a category identifier. The remaining positions are serial numbers. The following blocks of numbers are reserved for the facilities indicated (NOTE: may have different meanings dependent on the Type of Bill (TOB):

0001-0879	Short-term (general and specialty) hospitals where TOB = 11X; ESRD clinic where TOB = 72X
0880-0899	Reserved for hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB = 72X
0900-0999	Multiple hospital component in a medical complex (numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1000-1199	Reserved for future use
1200-1224	Alcohol/drug hospitals (excluded from PPS-numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1225-1299	Medical assistance facilities (Montana project); ESRD clinic where TOB = 72X
1300-1399	Rural Primary Care Hospital (RCPH) - eff. 10/97 changed to Critical Access Hospitals (CAH)
1400-1499	Continuation of 4900-4999 series (CMHC)
1500-1799	Hospices
1800-1989	Federally Qualified Health Centers (FQHC) where TOB = 73X; SNF (IP PTB) where TOB = 22X; HHA where TOB = 32X, 33X, 34X
1990-1999	Christian Science Sanatoria (hospital services)
2000-2299	Long-term hospitals (excluded from PPS)
2300-2499	Chronic renal disease facilities (hospital based)
2500-2899	Non-hospital renal disease treatment centers
2900-2999	Independent special purpose renal dialysis facility (1)
3000-3024	Formerly tuberculosis hospitals (numbers retired)
3025-3099	Rehabilitation hospitals (excluded

	from PPS)
3100-3199	Continuation of Subunits of Nonprofit and Proprietary Home Health Agencies (7300-7399) Series (3) (eff. 4/96)
3200-3299	Continuation of 4800-4899 series (CORF)
3300-3399	Children's hospitals (excluded from PPS) where TOB = 11X; ESRD clinic where TOB = 72X
3400-3499	Continuation of rural health clinics (provider-based) (3975-3999)
3500-3699	Renal disease treatment centers (hospital satellites)
3700-3799	Hospital based special purpose renal dialysis facility (1)
3800-3974	Rural health clinics (free-standing)
3975-3999	Rural health clinics (provider-based)
4000-4499	Psychiatric hospitals (excluded from PPS)
4500-4599	Comprehensive Outpatient Rehabilitation Facilities (CORF)
4600-4799	Community Mental Health Centers (CMHC); 9/30/91 - 3/31/97 used for clinic OPT where TOB = 74X
4800-4899	Continuation of 4500-4599 series (CORF) (eff. 10/95)
4900-4999	Continuation of 4600-4799 series (CMHC) (eff. 10/95); 9/30/91 - 3/31/97 used for clinic OPT where TOB = 74X
5000-6499	Skilled Nursing Facilities
6500-6989	CMHC / Outpatient physical therapy services where TOB = 74X; CORF where TOB = 75X
6990-6999	Christian Science Sanatoria (skilled nursing services)
7000-7299	Home Health Agencies (HHA) (2)
7300-7399	Subunits of 'nonprofit' and 'proprietary' Home Health Agencies (3)
7400-7799	Continuation of 7000-7299 series
7800-7999	Subunits of state and local governmental Home Health Agencies (3)
8000-8499	Continuation of 7400-7799 series (HHA)
8500-8899	Continuation of rural health center (provider based) (3400-3499)
8900-8999	Continuation of rural health center (free-standing) (3800-3974)
9000-9499	Continuation of 8000-8499 series (HHA) (eff. 10/95)
9500-9999	Reserved for future use (eff. 8/1/98) NOTE: 10/95-7/98 this series was assigned to HHA's but rescinded - no HHA's were ever assigned a number from this series.

Exception:

P001-P999 Organ procurement organization

(1) These facilities (SPRDFS) will be assigned the same provider number whenever they are recertified.

(2) The 6400-6499 series of provider numbers in Iowa (16), South Dakota (43) and Texas (45) have been used in reducing acute care costs (RACC) experiments.

(3) In Virginia (49), the series 7100-7299 has been reserved for statewide subunit components of the Virginia state home health agencies.

(4) Parent agency must have a number in the 7000-7299, 7400-7799 or 8000-8499 series.

NOTE:
There is a special numbering system for units of hospitals that are excluded from prospective payment system (PPS) and hospitals with SNF swing-bed designation. An alpha character in the third position of the provider number identifies the type of unit or swing-bed designation as follows:

S = Psychiatric unit (excluded from PPS)
T = Rehabilitation unit (excluded from PPS)
U = Short term/acute care swing-bed hospital
V = Alcohol drug unit (prior to 10/87 only)
W = Long term SNF swing-bed hospital (eff 3/91)
Y = Rehab hospital swing-bed (eff 9/92)
Z = Rural primary care swing-bed hospital

There is also a special numbering system for assigning emergency hospital identification numbers (non participating hospitals). The sixth position of the provider number is as follows:

E = Non-federal emergency hospital
F = Federal emergency hospital

SOURCE:
OSCAR

NAME	TYPE	LENGTH
Claim Facility Type Code	CHAR	1

The first digit of the type of bill submitted on an

institutional claim used to identify the type of facility
that provided care to the beneficiary.

SHORT NAME: FAC_TYPE
LONG NAME: CLM_FAC_TYPE_CD

CODES:
Claim Facility Type Table
---
1 = Hospital
2 = Skilled nursing facility (SNF)
3 = Home health agency (HHA)
4 = Religious Nonmedical (Hospital)
(eff. 8/1/00); prior to 8/00 referenced Christian Science (CS)
5 = Religious Nonmedical (Extended Care)
(eff. 8/1/00); prior to 8/00 referenced CS
6 = Intermediate care
7 = Clinic or hospital-based renal dialysis facility
8 = Special facility or ASC surgery
9 = Reserved

SOURCE:
CWF

Claim Service Classification Type Code — CHAR 1

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

SHORT NAME: TYPESRVC
LONG NAME: CLM_SRVC_CLSFCTN_TYPE_CD

CODES:
Claim Service Classification Type Table

For facility type code 1 thru 6, and 9

1 = Inpatient (including Part A)
2 = Hospital based or Inpatient (Part B only)
or home health visits under Part B
3 = Outpatient (HHA-A also)
4 = Other (Part B)
5 = Intermediate care - level I
6 = Intermediate care - level II
7 = Subacute Inpatient
(formerly Intermediate care - level III)
8 = Swing beds (used to indicate billing for
SNF level of care in a hospital with an
approved swing bed agreement)
9 = Reserved for national assignment

For facility type code 7

1 = Rural health
2 = Hospital based or independent renal
dialysis facility
3 = Free-standing provider based federally
qualified health center (eff 10/91)
4 = Other Rehabilitation Facility (ORF) and
Community Mental Health Center (CMHC)
(eff 10/91 - 3/97); ORF only (eff. 4/97)
5 = Comprehensive Rehabilitation Center
(CORF)
6 = Community Mental Health Center (CMHC) (eff 4/97)
7-8 = Reserved for national assignment
9 = Other

For facility type code 8

1 = Hospice (non-hospital based)
2 = Hospice (hospital based)
3 = Ambulatory surgical center in hospital
outpatient department
4 = Freestanding birthing center
5 = Critical Access Hospital (eff. 10/99)
formerly Rural primary care hospital
(eff. 10/94)
6-8 = Reserved for national use
9 = Other

SOURCE:
CWF

Claim Frequency Code CHAR 1

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.

SHORT NAME: FREQ_CD
LONG NAME: CLM_FREQ_CD

CODES:
Claim Frequency Table
---
0 = Non-payment/zero claims
1 = Admit thru discharge claim
2 = Interim - first claim
3 = Interim - continuing claim
4 = Interim - last claim
5 = Late charge(s) only claim
6 = Adjustment of prior claim
7 = Replacement of prior claim; eff 10/93, provider debit
8 = Void/cancel prior claim. eff 10/93, provider cancel
9 = Final claim -- used in an HH PPS
episode to indicate the claim

should be processed like debit/
credit adjustment to RAP (initial
claim) (eff. 10/00)
A = Admission notice - used when hospice is submitting the
HCFA-1450 as an admission notice - hospice NOE only
B = Hospice termination/revocation notice - hospice NOE only
(eff 9/93)
C = Hospice change of provider notice - hospice NOE only
(eff 9/93)
D = Hospice election void/cancel - hospice NOE only (eff 9/93)
E = Hospice change of ownership - hospice NOE only (eff 1/97)
F = Beneficiary initiated adjustment (eff 10/93)
G = CWF generated adjustment (eff 10/93)
H = HCFA generated adjustment (eff 10/93)
I = Misc adjustment claim (other than PRO
or provider) - used to identify a
debit adjustment initiated by HCFA or
an intermediary - eff 10/93, used to
identify intermediary initiated
adjustment only
J = Other adjustment request (eff 10/93)
K = OIG initiated adjustment (eff 10/93)
M = MSP adjustment (eff 10/93)
P = Adjustment required by peer review organization (PRO)
X = Special adjustment processing - used for QA editing (eff 8/92)
Z = Hospital Encounter Data alternate sub-
mission (TOB '11Z') used for MCO enrollee
hospital discharges 7/1/97-12/31/98; not
stored in NCH. Exception: Problem in
startup months may have resulted in this
abbreviated UB-92 being erroneously
stored in NCH.

SOURCE:
CWF

FI Number CHAR 5

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

SHORT NAME: FI_NUM
LONG NAME: FI_NUM

CODES:
Fiscal Intermediary Number Table

00010 = Alabama BC
00020 = Arkansas BC
00030 = Arizona BC
00040 = California BC (term. 12/00)
00050 = New Mexico BC/CO
00060 = Connecticut BC

00070 = Delaware BC - terminated 2/98
00080 = Florida BC
00090 = Florida BC
00101 = Georgia BC
00121 = Illinois - HCSC
00123 = Michigan - HCSC
00130 = Indiana BC/Administar Federal
00131 = Illinois - Administar
00140 = Iowa - Wellmark (term. 6/2000)
00150 = Kansas BC
00160 = Kentucky/Administar
00180 = Maine BC
00181 = Maine BC - Massachusetts
00190 = Maryland BC
00200 = Massachusetts BC - terminated 7/97
00210 = Michigan BC - terminated 9/94
00220 = Minnesota BC
00230 = Mississippi BC
00231 = Mississippi BC/LA
00232 = Mississippi BC
00241 = Missouri BC - terminated 9/92
00250 = Montana BC
00260 = Nebraska BC
00270 = New Hampshire/VT BC
00280 = New Jersey BC (term. 8/2000)
00290 = New Mexico BC - terminated 11/95
00308 = Empire BC
00310 = North Carolina BC
00320 = North Dakota BC
00332 = Community Mutual Ins Co; Ohio-Administar
00340 = Oklahoma BC
00350 = Oregon BC
00351 = Oregon BC/ID.
00355 = Oregon-CWF
00362 = Independence BC - terminated 8/97
00363 = Veritus, Inc (PITTS)
00370 = Rhode Island BC
00380 = South Carolina BC
00390 = Tennessee BC
00400 = Texas BC
00410 = Utah BC
00423 = Virginia BC; Trigon
00430 = Washington/Alaska BC
00450 = Wisconsin BC
00452 = Michigan - Wisconsin BC
00454 = United Government Services -
Wisconsin BC (eff. 12/00)
00460 = Wyoming BC
00468 = N Carolina BC/CPRTIVA
00993 = BC/BS Assoc.
17120 = Hawaii Medical Service
50333 = Travelers; Connecticut United Healthcare
(terminated - date unknown)
51051 = Aetna California - terminated 6/97

51070 = Aetna Connecticut - terminated 6/97
51100 = Aetna Florida - terminated 6/97
51140 = Aetna Illinois - terminated 6/97
51390 = Aetna Pennsylvania - terminated 6/97
52280 = Mutual of Omaha
57400 = Cooperative, San Juan, PR
61000 = Aetna

SOURCE:
CWF

NAME	TYPE	LENGTH
Claim Medicare Non Payment Reason Code	CHAR	1

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.

SHORT NAME: NOPAY_CD
LONG NAME: CLM_MDCR_NON_PMT_RSN_CD

EDIT-RULES:
OPTIONAL

CODES:
Claim Medicare Non-Payment Reason Table

A = Covered worker's compensation (Obsolete)
B = Benefit exhausted
C = Custodial care - noncovered care (includes all 'beneficiary at fault' waiver cases) (Obsolete)
E = HMO out-of-plan services not emergency or urgently needed (Obsolete)
E = MSP cost avoided - IRS/SSA/HCFA Data Match (eff. 7/00)
F = MSP cost avoid HMO Rate Cell (eff. 7/00)
G = MSP cost avoided Litigation Settlement (eff. 7/00)
H = MSP cost avoided Employer Voluntary Reporting (eff. 7/00)
J = MSP cost avoid Insurer Voluntary Reporting (eff. 7/00)
K = MSP cost avoid Initial Enrollment Questionnaire (eff. 7/00)
N = All other reasons for nonpayment
P = Payment requested
Q = MSP cost avoided Voluntary Agreement

(eff. 7/00)
R = Benefits refused, or evidence not submitted
T = MSP cost avoided - IEQ contractor (eff. 9/76) (obsolete 6/30/00)
U = MSP cost avoided - HMO rate cell adjustment (eff. 9/76) (Obsolete 6/30/00)
V = MSP cost avoided - litigation settlement (eff. 9/76) (Obsolete 6/30/00)
W = Worker's compensation (Obsolete)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data match project (obsolete 6/30/00)
Z = Zero reimbursement RAPs -- zero reimbursement made due to medical review intervention or where provider specific zero payment has been determined. (effective with HHPPS - 10/00)

SOURCE:
CWF

Claim Payment Amount NUM 12

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 present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)

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

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

sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount.

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

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

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

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

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

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

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

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

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

9.2 DIGITS SIGNED

SHORT NAME: PMT_AMT
LONG NAME: CLM_PMT_AMT

EDIT-RULES:
$$$$$$$$$CC

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.

NCH Primary Payer Claim Paid Amount NUM 12

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

9.2 DIGITS SIGNED

SHORT NAME: PRPAYAMT
LONG NAME: NCH_PRMRY_PYR_CLM_PD_AMT

EDIT-RULES:
$$$$$$$$$CC

SOURCE:
NCH

NCH Primary Payer Code CHAR 1

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.

SHORT NAME: PRPAY_CD
LONG NAME: NCH_PRMRY_PYR_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:
Beneficiary Primary Payer Table

A = Working aged bene/spouse with employer group health plan (EGHP)
B = End stage renal disease (ESRD) beneficiary in the 18 month
coordination period with an employer group health plan
C = Conditional payment by Medicare; future reimbursement expected
D = Automobile no-fault (eff. 4/97; Prior to 3/94, also included
any liability insurance)
E = Workers' compensation
F = Public Health Service or other federal agency (other than Dept.
of Veterans Affairs)
G = Working disabled bene (under age 65 with LGHP)
H = Black Lung
I = Dept. of Veterans Affairs
J = Any liability insurance (eff. 3/94 - 3/97)
L = Any liability insurance (eff. 4/97) (eff. 12/90 for carrier
claims

and 10/93 for FI claims; obsoleted for all claim types 7/1/96)
M = Override code: EGHP services involved (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)
N = Override code: non-EGHP services involved (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)

BLANK = Medicare is primary payer (not sure of effective date: in use 1/91, if not earlier)

T = MSP cost avoided - IEQ contractor (eff. 7/96 carrier claims only)
U = MSP cost avoided - HMO rate cell adjust- ment contractor (eff. 7/96 carrier claims only)
V = MSP cost avoided - litigation settlement contractor (eff. 7/96 carrier claims only)
X = MSP cost avoided override code (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)

Prior to 12/90

Y = Other secondary payer investigation shows Medicare as primary payer
Z = Medicare is primary payer

NOTE: Values C, M, N, Y, Z and BLANK indicate Medicare is primary payer.
(values Z and Y were used prior to 12/90. BLANK was suppose to be effective after 12/90, but may have been used prior to that date.)

SOURCE:
NCH

NAME	TYPE	LENGTH
NCH Provider State Code	CHAR	2

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

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

SHORT NAME: PRSTATE
LONG NAME: PRVDR_STATE_CD

SOURCE:
NCH

Organization NPI Number CHAR 10

A placeholder field (effective with Version H) for storing the NPI assigned to the institutional provider.

SHORT NAME: ORGNPINM
LONG NAME: ORG_NPI_NUM

SOURCE:
CWF

Claim Attending Physician UPIN Number CHAR 6

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).

SHORT NAME: AT_UPIN
LONG NAME: AT_PHYSN_UPIN

SOURCE:
CWF

Claim Attending Physician NPI Number CHAR 10

A placeholder field (effective with Version H) for storing the NPI assigned to the attending physician.

SHORT NAME: AT_NPI
LONG NAME: AT_PHYSN_NPI

SOURCE:
CWF

NAME	TYPE	LENGTH
Patient Discharge Status Code	CHAR	2

The code used to identify the status of the patient as of the CLM_THRU_DT.

SHORT NAME: STUS_CD
LONG NAME: PTNT_DSCHRG_STUS_CD

CODES:
Patient Discharge Status Table

01 = Discharged to home/self care (routine charge).
02 = Discharged/transferred to other short term general hospital for inpatient care.
03 = Discharged/transferred to skilled nursing facility (SNF) - (For hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF.
04 = Discharged/transferred to intermediate care facility (ICF).
05 = Discharged/transferred to another type of institution for inpatient care (including distinct parts).
06 = Discharged/transferred to home care of organized home health service organization.
07 = Left against medical advice or discontinued care.
08 = Discharged/transferred to home under care of a home IV drug therapy provider.
09 = Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
20 = Expired (did not recover - Christian Science patient).
30 = Still patient.
40 = Expired at home (hospice claims only)
41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
42 = Expired - place unknown (Hospice claims only)
50 = Hospice - home (eff. 10/96)
51 = Hospice - medical facility (eff. 10/96)
61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (to be implemented in 1999)
71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (to be implemented in 1999).
72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (to be implemented in 1999).

SOURCE:
CWF

Claim PPS Indicator Code CHAR 1

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.

SHORT NAME: PPS_IND
LONG NAME: CLM_PPS_IND_CD

CODES:
Claim PPS Indicator Table

Effective NCH weekly process date 10/3/97 - 5/29/98

0 = not PPS bill (claim contains no PPS indicator)
2 = PPS bill (claim contains PPS indicator)

Effective NCH weekly process date 6/5/98

0 = not applicable (claim contains neither PPS nor deemed insured MQGE status indicators)
1 = Deemed insured MQGE (claim contains deemed insured MQGE indicator but not PPS indicator)
2 = PPS bill (claim contains PPS indicator but no deemed insured MQGE status indicator)
3 = Both PPS and deemed insured MQGE (contains both PPS and deemed insured MQGE indicators)

SOURCE:
CWF

Claim Total Charge Amount NUM 12

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

SHORT NAME: TOT_CHRG

LONG NAME: CLM_TOT_CHRG_AMT

SOURCE:
CWF

DATE OF BIRTH FROM CLAIM NUM 1

Age Category Calculated from Date of Birth from Claim

1 DIGIT

SHORT NAME: DOB_DT
LONG NAME: DOB_DT

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

LIMITATIONS:
DATE OF BIRTH WILL BE POPULATED FOR CLAIMS PROCESSED BETWEEN 1999-2004 AND CLAIMS PROCESSED AFTER FEBRUARY 2008. THESE FIELDS WILL LIKELY BE NULL FOR CLAIMS PROCESSED BETWEEN 2005-2007 (THESE FIELDS ARE MORE LIKELY TO BE POPULATED IN CLAIMS WITH SERVCIE DATES IN THE LATTER PART OF 2007-FORWARD).

GENDER CODE FROM CLAIM CHAR 1

THIS FIELD INDICATES THE SEX OF THE BENEFICIARY AS NOTED ON THE CLAIM.

SHORT NAME: GNDR_CD
LONG NAME: GNDR_CD

CODES:
0 = UNKNOWN
1 = MALE
2 = FEMALE

LIMITATIONS:
GENDER CODE WILL BE POPULATED FOR CLAIMS PROCESSED BETWEEN 1999-2004 AND CLAIMS PROCESSED AFTER FEBRUARY 2008. THESE FIELDS WILL LIKELY BE NULL FOR CLAIMS PROCESSED BETWEEN 2005-2007 (THESE FIELDS ARE MORE LIKELY TO BE POPULATED IN CLAIMS WITH SERVCIE DATES IN THE LATTER PART

OF 2007-FORWARD).

RACE CODE FROM CLAIM CHAR 1

THE RACE OF A BENEFICIARY AS NOTED ON
THE CLAIM.

SHORT NAME: RACE_CD
LONG NAME: BENE_RACE_CD

CODES:
0 = UNKNOWN
1 = WHITE
2 = BLACK
3 = OTHER
4 = ASIAN
5 = HISPANIC
6 = NORTH AMERICAN NATIVE

SQL-INFO:
CHAR(1) NOT NULL

LIMITATIONS:
RACE CODE WILL BE POPULATED FOR CLAIMS PROCESSED
BETWEEN 1999-2004 AND CLAIMS PROCESSED AFTER
FEBRUARY 2008. THESE FIELDS WILL LIKELY BE
NULL FOR CLAIMS PROCESSED BETWEEN 2005-2007
(THESE FIELDS ARE MORE LIKELY TO BE POPULATED
IN CLAIMS WITH SERVCIE DATES IN THE LATTER PART
OF 2007-FORWARD).

COUNTY CODE FROM CLAIM (SSA) CHAR 3

THIS CODE SPECIFIES THE SSA CODE FOR THE
COUNTY OF RESIDENCE OF THE BENEFICIARY AS
NOTED ON THE CLAIM.EACH STATE HAS A SERIES
OF CODES BEGINNING WITH '000' FOR EACH
COUNTY WITHIN THAT STATE.CERTAIN CITIES
WITHIN THAT STATE HAVE THEIR OWN CODE.
COUNTY CODES MUST BE COMBINED WITH STATE
CODES IN ORDER TO LOCATE THE SPECIFIC COUNTY.
THE CODING SYSTEM IS THE SSA SYSTEM, NOT
THE FEDERAL INFORMATION PROCESSING
SYSTEM (FIPS).

SHORT NAME: CNTY_CD
LONG NAME: BENE_CNTY_CD

EDIT-RULES:
NUMERIC

LIMITATIONS:
SOME CODES MAY BE INVALID, UNKNOWN, OR '999'.
(DIFFERENT FROM FIPS)

COUNTY CODE WILL BE POPULATED FOR CLAIMS PROCESSED BETWEEN 1999-2004 AND CLAIMS PROCESSED AFTER JANUARY 2009. THESE FIELDS WILL LIKELY BE NULL FOR CLAIMS PROCESSED BETWEEN 2005-2008 (THESE FIELDS ARE MORE LIKELY TO BE POPULATED IN CLAIMS WITH SERVICE DATES IN THE LATTER PART OF 2008-FORWARD).

STATE CODE FROM CLAIM (SSA) CHAR 2

THIS FIELD SPECIFIES THE STATE OF RESIDENCE OF THE BENEFICIARY AND IS BASED ON THE MAILING ADDRESS USED FOR CASH BENEFITS OR THE MAILING ADDRESS USED FOR OTHER PURPOSES AS NOTED ON THE CLAIM (FOR EXAMPLE,PREMIUM BILLING).THIS INFORMATION IS MAINTAINED FROM CHANGE OF ADDRESS NOTICES SENT IN BY THE BENEFICIARIES, AND IS APPENDED TO THE RECORD AT TIME OF PROCESSING IN CENTRAL OFFICE. THE CODING SYSTEM IS THE SSA SYSTEM, NOT THE FEDERAL INFORMATION PROCESSING STANDARD (FIPS).

SHORT NAME: STATE_CD
LONG NAME: BENE_STATE_CD

LIMITATIONS:
IN SOME CASES, THE CODE MAY NOT BE THE ACTUAL STATE OF RESIDENCE. (FOR EXAMPLE, IF THE BENEFICIARY HAS A REPRESENTATIVE PAYEE).

STATE CODE WILL BE POPULATED FOR CLAIMS PROCESSED BETWEEN 1999-2004 AND CLAIMS PROCESSED AFTER JANUARY 2009. THESE FIELDS WILL LIKELY BE NULL FOR CLAIMS PROCESSED BETWEEN 2005-2008 (THESE FIELDS ARE MORE LIKELY TO BE POPULATED IN CLAIMS WITH SERVICE DATES IN THE LATTER PART OF 2008-FORWARD).

CWF Beneficiary Medicare Status Code CHAR 2

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

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

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

FI Claim Action Code CHAR 1

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

SHORT NAME: ACTIONCD
LONG NAME: FI_CLM_ACTN_CD

CODES:
Fiscal Intermediary Claim Action Table
---
1 = Original debit action (includes non-adjustment RTI correction items) - it will always be a 1 in regular bills.
2 = Cancel by credit adjustment - used only in credit/debit pairs (under HHPPS, updates the RAP).
3 = Secondary debit adjustment - used only in credit/debit pairs (under HHPPS, would be the final claim or an adjustment on a LUPA).
4 = Cancel only adjustment (under HHPPS, RAP/final claim/LUPA).
5 = Force action code 3
6 = Force action code 2
8 = Benefits refused (for inpatient bills, an 'R' nonpayment code must also be present
9 = Payment requested (used on bills that replace previously-submitted benefits-refused bills, action code 8. In such cases a debit/credit pair is not required. For inpatient bills, a 'P' should be entered in the nonpayment

code.)

SOURCE:
CWF

NAME	TYPE	LENGTH
Primary Claim Diagnosis Code	CHAR	5

The ICD-9-CM based code identifying the beneficiary's principal diagnosis.

SHORT NAME: DGNSCD1
LONG NAME: ICD9_DGNS_CD1

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code II	CHAR	5

The ICD-9-CM based code identifying the beneficiary's second diagnosis.

SHORT NAME: DGNSCD2
LONG NAME: ICD9_DGNS_CD2

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code III	CHAR	5

The ICD-9-CM based code identifying the beneficiary's third diagnosis.

SHORT NAME: DGNSCD3
LONG NAME: ICD9_DGNS_CD3

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code IV	CHAR	5

The ICD-9-CM based code identifying the beneficiary's fourth diagnosis.

SHORT NAME: DGNSCD4
LONG NAME: ICD9_DGNS_CD4

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code V	CHAR	5

The ICD-9-CM based code identifying the beneficiary's fifth diagnosis.

SHORT NAME: DGNSCD5
LONG NAME: ICD9_DGNS_CD5

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code VI CHAR 5

The ICD-9-CM based code identifying the beneficiary's sixth diagnosis.

SHORT NAME: DGNSCD6
LONG NAME: ICD9_DGNS_CD6

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code VII CHAR 5

The ICD-9-CM based code identifying the beneficiary's seventh diagnosis.

SHORT NAME: DGNSCD7
LONG NAME: ICD9_DGNS_CD7

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code VIII CHAR 5

The ICD-9-CM based code identifying the beneficiary's eighth diagnosis.

SHORT NAME: DGNSCD8
LONG NAME: ICD9_DGNS_CD8

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code IX CHAR 5

The ICD-9-CM based code identifying the beneficiary's ninth diagnosis.

SHORT NAME: DGNSCD9
LONG NAME: ICD9_DGNS_CD9

EDIT-RULES:
ICD-9-CM

Claim Diagnosis Code X CHAR 5

The ICD-9-CM based code identifying the beneficiary's tenth diagnosis.

SHORT NAME: DGNSCD10
LONG NAME: ICD9_DGNS_CD10

EDIT-RULES:
ICD-9-CM

NAME	TYPE	LENGTH
Claim HHA Low Utilization Payment Adjustment (LUPA) Indicator Code	CHAR	1

Effective with Version I, the code used to identify those Home Health PPS claims that have 4 visits or less in a 60-day episode. If an HHA provides 4 visits or less, they will be reimbursed based on a national standardized per visit rate instead of HHRGs.

NOTE: Beginning 10/1/00, this field will be populated with data. Claims processed prior to 10/1/00 will contain spaces.

SHORT NAME: LUPAIND
LONG NAME: CLM_HHA_LUPA_IND_CD

CODES:
L = LUPA Claim
blank = Not a LUPA claim

SOURCE:
CWF

Claim HHA Referral Code CHAR 1

Effective with Version 'I', the code used to identify the means by which the beneficiary was referred for Home Health services.

NOTE: Beginning 10/1/00, this field will be populated with data. Claims processed prior to 10/1/00 will contain spaces in this field.

SHORT NAME: HHA_RFRL
LONG NAME: CLM_HHA_RFRL_CD

CODES:

Claim Home Health Referral Table

1 = Physician referral - The patient was admitted upon the recommendation of a personal physician.

2 = Clinic referral - The patient was admitted upon the recommendation of this facility's clinic physician.

3 = HMO referral - The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician.

4 = Transfer from hospital - The patient was admitted as an inpatient transfer from an acute care facility.

5 = Transfer from a skilled nursing facility (SNF) - The patient was admitted as an inpatient transfer from a SNF.

6 = Transfer from another health care facility - The patient was admitted as a transfer from a health care facility other than an acute care facility or SNF.

7 = Emergency room - The patient was admitted upon the recommendation of this facility's emergency room physician.

8 = Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative.

9 = Information not available - The means by which the patient was admitted is not known.

A = Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.

B = Transfer from another HHA - Beneficiaries are permitted to transfer from one HHA to another unrelated HHA under HH PPS. (eff. 10/00)

C = Readmission to same HHA - If a beneficiary is discharged from an HHA and then re-admitted within the original 60-day episode, the original episode must be closed early and a new once created. NOTE: the use of this code will permit the agency to send a new RAP allowing all claims to be accepted by Medicare. (eff. 10/00)

SOURCE:
CWF

Claim HHA Total Visit Count NUM 3

Effective with Version H, the count of the number of HHA visits as derived by CWF.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991) using the CWF derivation rule (units associated with revenue center codes 042X, 043X, 044X, 055X, 056X, 057X, 058X and 059X. Value '999' will be displayed if the sum of the revenue center unit count equals or exceeds '999'.

NOTE2: Effective 7/1/99, all HHA claims received with service from dates 7/1/99 and after will be processed as if the units field contains the 15 minute interval count; and each visit revenue code line item will be counted as ONE visit. This field is calculated correctly; but those users who derive the count themselves they will have to revise their routine. NO LONGER IS THE COUNT DERIVED BY ADDING UP THE UNITS FIELDS ASSOCIATED WITH THE HHA VISIT REVENUE CODES.

3 DIGITS SIGNED

SHORT NAME: VISITCNT
LONG NAME: CLM_HHA_TOT_VISIT_CNT

SOURCE:
CWF

Claim Related Condition Code Sequence CHAR 2

This number identifies the position of the related condition code in the event that multiple related condition codes are recorded.

SHORT NAME: RLTCNDSQ
LONG NAME: RLT_COND_CD_SEQ

SOURCE:
CCW

Claim Related Condition Code CHAR 2

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

SHORT NAME: RLT_COND
LONG NAME: CLM_RLT_COND_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

SOURCE:
CWF

NAME	TYPE	LENGTH
Claim Related Occurrence Code Sequence	CHAR	2

This number identifies the position of the related occurrence code in the event that multiple related occurrence codes are recorded.

SHORT NAME: RLTOCRSQ
LONG NAME: RLT_OCRNC_CD_SEQ

SOURCE:
CCW

NAME	TYPE	LENGTH
Claim Related Occurrence Code	CHAR	2

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.

SHORT NAME: OCRNC_CD
LONG NAME: CLM_RLT_OCRNC_CD

CODES:

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

SOURCE:
CWF

Claim Related Occurrence Date DATE 8

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

8 DIGITS UNSIGNED

SHORT NAME: OCRNCDT
LONG NAME: CLM_RLT_OCRNC_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

Claim Related Value Code Sequence CHAR 2

This number identifies the position of the related value code in the event that multiple related value codes are recorded.

SHORT NAME: RLTVALSQ
LONG NAME: RLT_VAL_CD_SEQ

SOURCE:
CCW

Claim Value Code CHAR 2

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

SHORT NAME: VAL_CD
LONG NAME: CLM_VAL_CD

SOURCE:
CWF

Claim Value Amount NUM 12

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

SHORT NAME: VAL_AMT
LONG NAME: CLM_VAL_AMT

EDIT-RULES:
$$$$$$$$$CC

SOURCE:
CWF

NAME	TYPE	LENGTH
Claim Line Number	NUM	3

This number identifies the line number of the claim.

SHORT NAME: CLM_LN
LONG NAME: CLM_LINE_NUM

SOURCE:
CCW

Revenue Center Code	CHAR	4

The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

SHORT NAME: REV_CNTR
LONG NAME: REV_CNTR

SOURCE:
CWF

Revenue Center Date	DATE	8

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.

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

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

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

8 DIGITS UNSIGNED

SHORT NAME: REV_DT
LONG NAME: REV_CNTR_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

NAME	TYPE	LENGTH
Revenue Center APC/HIPPS Code	CHAR	5

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.

SHORT NAME: APCHIPPS
LONG NAME: REV_CNTR_APC_HIPPS_CD

SOURCE:
CWF

Line HCPCS Code CHAR 5

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

SHORT NAME: HCPCS_CD
LONG NAME: HCPCS_CD

COMMENT:
Prior to Version H this line item 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 noninstitutional: LINE).

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

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

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

Line HCPCS Initial Modifier Code — CHAR 2

A first modifier to the HCPCS procedure code to enable a more specific procedure identification for the line item service on the noninstitutional claim.

SHORT NAME: MDFR_CD1
LONG NAME: HCPCS_1ST_MDFR_CD

EDIT-RULES:
CARRIER INFORMATION FILE

SOURCE:
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NAME	TYPE	LENGTH
Line HCPCS Second Modifier Code	CHAR	2

A second modifier to the HCPCS procedure code to make it more specific than the first modifier code to identify the line item procedures for this claim.

SHORT NAME: MDFR_CD2
LONG NAME: HCPCS_2ND_MDFR_CD

EDIT-RULES:
CARRIER INFORMATION FILE

SOURCE:
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NAME	TYPE	LENGTH

Revenue Center Payment Method Indicator Code	CHAR	2

This field contains the payment indicator.

Effective with Version 'I', the code used to identify how the service is priced for payment.

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.

For CCW data delivered prior to May 2007, PMTMTHD included both service indicator (first byte) and payment indicator (second byte). For CCW data delivered during or after May 2007, PMTMTHD will only contain the payment indicator. The service indicator will be stored in Revenue Status Indicator Code (REVSTIND), a separate variable.

SHORT NAME: PMTMTHD
LONG NAME: REV_CNTR_PMT_MTHD_IND_CD

CODES:
Revenue Center Payment Method Indicator Table

**********Payment Indicator**********

1 = Paid standard hospital OPPS amount (service indicators S,T,V,X)
2 = Services not paid under OPPS (service indicator A, or no HCPCS code and not certain revenue center codes)
3 = Not paid (service indicators C & E)
4 = Acquisition cost paid (service indicator F)
5 = Additional payment for current drug or biological (service indicator G)
6 = Additional payment for device (service indicator H)
7 = Additional payment for new drug or new biological (service indicator J)
8 = Paid partial hospitalization per diem (service indicator P)
9 = No additional payment, payment included in line items with APCs (service indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization training)

SOURCE:
CWF

NAME	TYPE	LENGTH
Revenue Center Unit Count	NUM	8

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

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

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

7 DIGITS SIGNED

SHORT NAME: REV_UNIT
LONG NAME: REV_CNTR_UNIT_CNT

SOURCE:
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NAME	TYPE	LENGTH
Revenue Center Rate Amount	NUM	12

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

SHORT NAME: REV_RATE
LONG NAME: REV_CNTR_RATE_AMT

EFFECTIVE-DATE: 10/01/1993

SOURCE:
CWF

Revenue Center Payment Amount NUM 12

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 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

SHORT NAME: REVPMT
LONG NAME: REV_CNTR_PMT_AMT_AMT

EDIT-RULES:
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SOURCE:
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Revenue Center Total Charge Amount NUM 12

The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided. NOTE: For accommodation revenue center total charges must equal the rate times units (days).

EXCEPTIONS:
(1) For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo).

(2) For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero.

(3) For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line.

(4) For Home Health PPS (final claim), when revenue center code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023').

(5) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be $1 (rate) times units (days).

9.2 DIGITS SIGNED

SHORT NAME: REV_CHRG
LONG NAME: REV_CNTR_TOT_CHRG_AMT

EDIT-RULES:
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SOURCE:
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Revenue Center Non-Covered Charge Amount NUM 12

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

NOTE: Prior to Version H the field size was S9(7)V99 and the element was only present on the Inpatient/SNF format. As of NCH weekly process date 10/3/97 this field was added to all institutional claim types.

9.2 DIGITS SIGNED

SHORT NAME: REV_NCVR
LONG NAME: REV_CNTR_NCVRD_CHRG_AMT

EDIT-RULES:
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SOURCE:
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Revenue Center Deductible Coinsurance Code CHAR 1

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

SHORT NAME: REVDEDCD
LONG NAME: REV_CNTR_DDCTBL_COINSRNC_CD

CODES:

Revenue Center Deductible Coinsurance Code	
0	Charges are subject to deductible and coinsurance
1	Charges are not subject to deductible
2	Charges are not subject to coinsurance
3	Charges are not subject to deductible or coinsurance
4	No charge or units associated with this revenue center code. (For multiple HCPCS per single revenue center code)

For revenue center code 0001, the following MSP override values may be present:

M = Override code; EGHP services involved (eff 12/90 for non-institutional claims; 10/93 for institutional claims)
N = Override code; non-EGHP services involved (eff 12/90 for non-institutional claims; 10/93 for institutional claims)
X = Override code: MSP cost avoided (eff 12/90 for non-institutional claims; 10/93 for institutional claims)

SOURCE:
CWF

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