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

Claim Query Code CHAR 1

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

SHORT NAME: QUERY_CD
LONG NAME: CLAIM_QUERY_CODE

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 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
10. 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
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

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
Claim Operating Physician UPIN Number	CHAR	6

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.

SHORT NAME: OP_UPIN
LONG NAME: OP_PHYSN_UPIN

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

Claim Operating Physician NPI Number — CHAR 10

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

SHORT NAME: OP_NPI
LONG NAME: OP_PHYSN_NPI

SOURCE:
CWF

Claim Other Physician UPIN Number — CHAR 6

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

SHORT NAME: OT_UPIN
LONG NAME: OT_PHYSN_UPIN

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

Claim Other Physician NPI Number — CHAR 10

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

SHORT NAME: OT_NPI

LONG NAME: OT_PHYSN_NPI

SOURCE:
CWF

NAME	TYPE	LENGTH
Claim MCO Paid Switch	CHAR	1

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

SHORT NAME: MCOPDSW
LONG NAME: CLM_MCO_PD_SW

CODES:
1 = MCO has paid the provider for a claim
Blank or 0 = MCO has not paid the provider for a claim

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

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

Claim Admission Date DATE 8

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

8 DIGITS UNSIGNED

SHORT NAME: ADMSN_DT
LONG NAME: CLM_ADMSN_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

NAME	TYPE	LENGTH
Claim Source Inpatient Admission Code	CHAR	1

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

SHORT NAME: SRC_ADMS
LONG NAME: CLM_SRC_IP_ADMSN_CD

CODES:
Claim Source Of Inpatient Admission Table

For Inpatient/SNF Claims:

0 = ANOMALY: invalid value, if present, translate to '9'
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.

For Newborn Type of Admission

1 = Normal delivery - A baby delivered with out 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

Claim Admitting Diagnosis Code CHAR 5

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

SHORT NAME: AD_DGNS
LONG NAME: ADMTNG_ICD9_DGNS_CD

SOURCE:
CWF

NCH Patient Status Indicator Code CHAR 1

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).

SHORT NAME: PTNTSTUS
LONG NAME: NCH_PTNT_STATUS_IND_CD

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

Claim Pass Thru Per Diem Amount — NUM 12

The amount of the established reimbursable costs for the current year divided by the estimated Medicare days for the current year (all PPS claims), as calculated by the FI and reimbursement staff. Items reimbursed as a pass through include capital-related costs; direct medical education costs; kidney acquisition costs for hospitals approved as RTCs; and bad debts (per Provider Reimbursement Manual, Part 1, Section 2405.2). **Note: Pass throughs are not included in the Claim Payment Amount.

9.2 DIGITS SIGNED

SHORT NAME: PER_DIEM
LONG NAME: CLM_PASS_THRU_PER_DIEM_AMT

SOURCE:
CWF

NCH Beneficiary Inpatient Deductible Amount — NUM 12

The amount of the deductible the beneficiary paid for inpatient services, as originally submitted on the institutional claim.

9.2 DIGITS SIGNED

SHORT NAME: DED_AMT
LONG NAME: NCH_BENE_IP_DDCTBL_AMT

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to
A1, B1, or C1 move the corresponding value
amount to the NCH_BENE_IP_DDCTBL_AMT.

SOURCE:
NCH

NAME	TYPE	LENGTH
NCH Beneficiary Part A Coinsurance Liability Amount	NUM	12

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

SHORT NAME: COIN_AMT
LONG NAME: NCH_BENE_PTA_COINSRNC_LBLTY_AM

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.

SOURCE:
NCH

NCH Beneficiary Blood Deductible Liability Amount	NUM	12

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

9.2 DIGITS SIGNED

SHORT NAME: BLDDEDAM
LONG NAME: NCH_BENE_BLOOD_DDCTBL_LBLTY_AM

DERIVATION:
DERIVED FROM:
  CLM_VAL_CD
  CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to
'06' move the corresponding value amount to
NCH_BENE_BLOOD_DDCTB_LBLTYL_AMT.

SOURCE:
NCH QA PROCESS

NCH Professional Component Charge Amount — NUM 12

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).

SHORT NAME: PCCHGAMT
LONG NAME: NCH_PROFNL_CMPNT_CHRG_AMT

LENGTH: 9.2
SIGNED: Y

DERIVATIONS :

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

Claim Total PPS Capital Amount NUM 12

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

SHORT NAME: PPS_CPTL
LONG NAME: CLM_TOT_PPS_CPTL_AMT

SOURCE:
CWF

Claim PPS Capital FSP Amount NUM 12

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

9.2 DIGITS SIGNED

SHORT NAME: CPTL_FSP
LONG NAME: CLM_PPS_CPTL_FSP_AMT

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

SOURCE:
CWF

Claim PPS Capital Outlier NUM 12

Amount

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

9.2 DIGITS SIGNED

SHORT NAME: CPTLOUTL
LONG NAME: CLM_PPS_CPTL_OUTLIER_AMT

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

SOURCE:
CWF

NAME	TYPE	LENGTH
Claim PPS Capital Disproportionate Share Amount	NUM	12

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

9.2 DIGITS SIGNED

SHORT NAME: DISP_SHR
LONG NAME: CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT

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

SOURCE:
CWF

Claim PPS Capital IME Amount	NUM	12

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

SHORT NAME: IME_AMT
LONG NAME: CLM_PPS_CPTL_IME_AMT

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

SOURCE:
CWF

Claim PPS Capital Exception Amount NUM 12

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

SHORT NAME: CPTL_EXP
LONG NAME: CLM_PPS_CPTL_EXCPTN_AMT

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

SOURCE:
CWF

Claim PPS Old Capital Hold Harmless Amount NUM 12

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

SHORT NAME: HLDHRMLS
LONG NAME: CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT

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

SOURCE:
CWF

Claim PPS Capital DRG Weight Number NUM 8

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

SHORT NAME: DRGWTAMT
LONG NAME: CLM_PPS_CPTL_DRG_WT_NUM

SOURCE:
CWF

NAME	TYPE	LENGTH
Claim Utilization Day Count	NUM	3

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

SHORT NAME: UTIL_DAY
LONG NAME: CLM_UTLZTN_DAY_CNT

SOURCE:
CWF

Beneficiary Total Coinsurance Days Count	NUM	3

The count of the total number of coinsurance days involved with the beneficiary's stay in a facility.

3 DIGITS SIGNED

SHORT NAME: COIN_DAY
LONG NAME: BENE_TOT_COINSRNC_DAYS_CNT

SOURCE:
CWF

Beneficiary LRD Used Count	NUM	3

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

SHORT NAME: LRD_USE
LONG NAME: BENE_LRD_USED_CNT

SOURCE:
CWF

Claim Non Utilization Days Count NUM 5

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

5 DIGITS SIGNED

SHORT NAME: NUTILDAY
LONG NAME: CLM_NON_UTLZTN_DAYS_CNT

SOURCE:
CWF

NCH Blood Pints Furnished Quantity NUM 3

Number of whole pints of blood furnished to the beneficiary.

3 DIGITS SIGNED

SHORT NAME: BLDFRNSH
LONG NAME: NCH_BLOOD_PNTS_FRNSHD_QTY

EDIT-RULES:
NUMERIC

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_PNTS_FRNSHD_QTY.

SOURCE:
NCH QA Process

NAME	TYPE	LENGTH

NCH Beneficiary Discharge Date DATE 8

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.)

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

8 DIGITS UNSIGNED

SHORT NAME: DSCHRGDT
LONG NAME: NCH_BENE_DSCHRG_DT

EDIT-RULES:
YYYYMMDD

DERIVATION:
DERIVED FROM:
NCH_PTNT_STATUS_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

Claim Diagnosis Related Group Code CHAR 3

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

SHORT NAME: DRG_CD
LONG NAME: CLM_DRG_CD

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

Claim Diagnosis Related Group Outlier Stay Code CHAR 1

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).

SHORT NAME: OUTLR_CD
LONG NAME: CLM_DRG_OUTLIER_STAY_CD

CODES:
Diagnosis Related Group Outlier Patient Stay Table

0 = No outlier
1 = Day outlier (condition code 60)
2 = Cost outlier, (condition code 61)
*** Non-PPS Only ***
6 = Valid diagnosis related groups (DRG) received from the intermediary
7 = HCFA developed DRG
8 = HCFA developed DRG using patient status code
9 = Not groupable

SOURCE:
CWF

NCH DRG Outlier Approved Payment Amount NUM 12

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

SHORT NAME: OUTLRPMT
LONG NAME: NCH_DRG_OUTLIER_APRVD_PMT_AMT

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_APRVD_PMT_AMT.

SOURCE:
NCH QA Process

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

Claim Present on Admission Indicator Code I CHAR 1

Effective September 1, 2008, with the implementation of CR#3, the code used to indicate a condition was present at the time the beneficiary was admitted to a general acute care facility.

SHORT NAME: CLMPOA1
LONG NAME: CLM_POA_IND_SW1

Y = Diagnosis was present at time of inpatient admission.
N = Diagnosis was not present at time of inpatient admission.
U = Documentation insufficient to determine if condition was present at the time of inpatient admission.
W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1 = Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1.

SOURCE:
CWF

Claim Present on Admission Indicator Code II CHAR 1

Effective September 1, 2008, with the implementation of CR#3, the code used to indicate a condition was present at the time the beneficiary was admitted

to a general acute care facility.

SHORT NAME: CLMPOA2
LONG NAME: CLM_POA_IND_SW2

Y = Diagnosis was present at time of inpatient admission.
N = Diagnosis was not present at time of inpatient admission.
U = Documentation insufficient to determine if condition was present at the time of inpatient admission.
W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1 = Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1.

SOURCE:
CWF

Claim Present on Admission Indicator Code III CHAR 1

Effective September 1, 2008, with the implementation of CR#3, the code used to indicate a condition was present at the time the beneficiary was admitted to a general acute care facility.

SHORT NAME: CLMPOA3
LONG NAME: CLM_POA_IND_SW3

Y = Diagnosis was present at time of inpatient admission.
N = Diagnosis was not present at time of inpatient admission.
U = Documentation insufficient to determine if condition was present at the time of inpatient admission.
W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1 = Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1.

SOURCE:
CWF

Claim Present on Admission CHAR 1
Indicator Code IV

Effective September 1, 2008, with the implementation of CR#3, the code used to indicate a condition was present at the time the beneficiary was admitted to a general acute care facility.

SHORT NAME: CLMPOA4
LONG NAME: CLM_POA_IND_SW4

Y = Diagnosis was present at time of inpatient admission.
N = Diagnosis was not present at time of inpatient admission.
U = Documentation insufficient to determine if condition was present at the time of inpatient admission.
W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1 = Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1.

SOURCE:
CWF

Claim Present on Admission CHAR 1
Indicator Code V

Effective September 1, 2008, with the implementation of CR#3, the code used to indicate a condition was present at the time the beneficiary was admitted to a general acute care facility.

SHORT NAME: CLMPOA5
LONG NAME: CLM_POA_IND_SW5

Y = Diagnosis was present at time of inpatient admission.
N = Diagnosis was not present at time of inpatient admission.
U = Documentation insufficient to determine if condition was present at the time of inpatient admission.
W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

1 = Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1.

SOURCE:
CWF

Claim Present on Admission Indicator Code VI CHAR 1

Effective September 1, 2008, with the implementation of CR#3, the code used to indicate a condition was present at the time the beneficiary was admitted to a general acute care facility.

SHORT NAME: CLMPOA6
LONG NAME: CLM_POA_IND_SW6

Y = Diagnosis was present at time of inpatient admission.
N = Diagnosis was not present at time of inpatient admission.
U = Documentation insufficient to determine if condition was present at the time of inpatient admission.
W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1 = Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1.

SOURCE:
CWF

Claim Present on Admission Indicator Code VII CHAR 1

Effective September 1, 2008, with the implementation of CR#3, the code used to indicate a condition was present at the time the beneficiary was admitted to a general acute care facility.

SHORT NAME: CLMPOA7
LONG NAME: CLM_POA_IND_SW7

Y = Diagnosis was present at time of inpatient

admission.
N = Diagnosis was not present at time of inpatient admission.
U = Documentation insufficient to determine if condition was present at the time of inpatient admission.
W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1 = Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1.

SOURCE:
CWF

Claim Present on Admission Indicator Code VIII CHAR 1

Effective September 1, 2008, with the implementation of CR#3, the code used to indicate a condition was present at the time the beneficiary was admitted to a general acute care facility.

SHORT NAME: CLMPOA8
LONG NAME: CLM_POA_IND_SW8

Y = Diagnosis was present at time of inpatient admission.
N = Diagnosis was not present at time of inpatient admission.
U = Documentation insufficient to determine if condition was present at the time of inpatient admission.
W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1 = Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1.

SOURCE:
CWF

Claim Present on Admission Indicator Code IX CHAR 1

Effective September 1, 2008, with the implementation of CR#3, the code used

to indicate a condition was present
at the time the beneficiary was admitted
to a general acute care facility.

SHORT NAME: CLMPOA9
LONG NAME: CLM_POA_IND_SW9

Y = Diagnosis was present at time of inpatient
admission.
N = Diagnosis was not present at time of
inpatient admission.
U = Documentation insufficient to determine if
condition was present at the time of inpatient
admission.
W = Clinically undetermined. Provider unable to
clinically determine whether the condition
was present at the time of inpatient admission.
1 = Exempt from POA reporting. This code is the
equivalent of a blank on the UB-04, however,
it was determined that blanks were undesirable
on Medicare claims when submitting this data
via the 004010/00410A1.

SOURCE:
CWF

Claim Present on Admission Indicator Code X CHAR 1

Effective September 1, 2008, with the
implementation of CR#3, the code used
to indicate a condition was present
at the time the beneficiary was admitted
to a general acute care facility.

SHORT NAME: CLMPOA10
LONG NAME: CLM_POA_IND_SW10

Y = Diagnosis was present at time of inpatient
admission.
N = Diagnosis was not present at time of
inpatient admission.
U = Documentation insufficient to determine if
condition was present at the time of inpatient
admission.
W = Clinically undetermined. Provider unable to
clinically determine whether the condition
was present at the time of inpatient admission.
1 = Exempt from POA reporting. This code is the
equivalent of a blank on the UB-04, however,
it was determined that blanks were undesirable
on Medicare claims when submitting this data
via the 004010/00410A1.

SOURCE:
CWF

Primary Claim Procedure Code CHAR 5

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

SHORT NAME: PRCDRCD1
LONG NAME: ICD9_PRCDR_CD1

EDIT-RULES:
ICD-9-CM

SOURCE:
CWF

Claim Procedure Code II CHAR 5

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

SHORT NAME: PRCDRCD2
LONG NAME: ICD9_PRCDR_CD2

EDIT-RULES:
ICD-9-CM

SOURCE:
CWF

Claim Procedure Code III CHAR 5

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

SHORT NAME: PRCDRCD3
LONG NAME: ICD9_PRCDR_CD3

EDIT-RULES:
ICD-9-CM

SOURCE:
CWF

Claim Procedure Code IV CHAR 5

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

SHORT NAME: PRCDRCD4
LONG NAME: ICD9_PRCDR_CD4

EDIT-RULES:
ICD-9-CM

SOURCE:
CWF

Claim Procedure Code V CHAR 5

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

SHORT NAME: PRCDRCD5
LONG NAME: ICD9_PRCDR_CD5

EDIT-RULES:
ICD-9-CM

SOURCE:
CWF

Claim Procedure Code VI CHAR 5

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

SHORT NAME: PRCDRCD6
LONG NAME: ICD9_PRCDR_CD6

EDIT-RULES:
ICD-9-CM

SOURCE:
CWF

Primary Claim Procedure Performed Date DATE 8

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

8 DIGITS UNSIGNED

SHORT NAME: PRCDRDT1
LONG NAME: PRCDR_DT1

EDIT-RULES:
YYYYMMDD

SOURCE:

CWF

Claim Procedure Performed Date DATE 8
Date II

On an institutional claim, the date on which the second procedure was performed.

8 DIGITS UNSIGNED

SHORT NAME: PRCDRDT2
LONG NAME: PRCDR_DT2

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

Claim Procedure Performed Date DATE 8
Date III

On an institutional claim, the date on which the third procedure was performed.

8 DIGITS UNSIGNED

SHORT NAME: PRCDRDT3
LONG NAME: PRCDR_DT3

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

Claim Procedure Performed Date DATE 8
Date IV

On an institutional claim, the date on which the fourth procedure was performed.

8 DIGITS UNSIGNED

SHORT NAME: PRCDRDT4
LONG NAME: PRCDR_DT4

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

Claim Procedure Performed Date DATE 8

Date V

On an institutional claim, the date on which the fifth procedure was performed.

8 DIGITS UNSIGNED

SHORT NAME: PRCDRDT5
LONG NAME: PRCDR_DT5

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

Claim Procedure Performed DATE 8

Date VI

On an institutional claim, the date on which the sixth procedure was performed.

8 DIGITS UNSIGNED

SHORT NAME: PRCDRDT6
LONG NAME: PRCDR_DT6

EDIT-RULES:
YYYYMMDD

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 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

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

NAME	TYPE	LENGTH
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.

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:
CWF

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

NAME	TYPE	LENGTH
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:
$$$$$$$$$CC

SOURCE:
CWF

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:
$$$$$$$$CC

SOURCE:
CWF

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

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

****