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CMS RIF REPORT  
AS OF: 04/04/2011

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*** Medicare Provider Analysis and Review	1000	1	1000	REC
				<p>THE REPRESENTATION OF A BENEFICIARY STAY IN AN INPATIENT HOSPITAL OR IN A SKILLED NURSING FACILITY (SNF) WHICH MAY INCLUDE ONE OR MORE FINAL ACTION CLAIMS.</p> <p>THE MEDICARE PROVIDER ANALYSIS AND REVIEW (MEDPAR) FILE CONTAINS DATA FROM CLAIMS FOR SERVICES PROVIDED TO MEDICARE BENEFICIARIES ADMITTED TO MEDICARE-CERTIFIED HOSPITALS AND SKILLED NURSING FACILITIES (SNF). THE FILE IS CREATED QUARTERLY IN MARCH, JUNE, SEPTEMBER, AND DECEMBER, AND IS GENERALLY AVAILABLE TWO WEEKS AFTER THE END OF THE QUARTER. EACH MEDPAR RECORD REPRESENTS A BENEFICIARY STAY IN AN INPATIENT HOSPITAL (WHERE DISCHARGED) OR IN A SNF (MAY BE 'STILL A PATIENT'; COMPLETE DISCHARGE DATA NOT ALWAYS RECEIVED), AND MAY INCLUDE ONE CLAIM OR MULTIPLE CLAIMS. (APPROXIMATELY 95% OF INPATIENT MEDPAR RECORDS AND 50% OF SNF MEDPAR RECORDS INVOLVE A SINGLE CLAIM.)</p> <p>BEGINNING IN JUNE 2007, THE MEDPAR FILE WAS REVISED TO IMPLEMENT A POLICY CHANGE THAT CHANGED HOW THE SSI DAY COUNT IS CALCULATED. THE LENGTH OF STAY IS NOW USED TO CALCULATE THE SSI DAY COUNT INSTEAD OF USING COVERED DAYS. OTHER CHANGES TO THE FILE INCLUDED: (1) ADDING THE NPI FIELD TO THE FILE; AND (2) FILLER WAS ADDED TO THE DIAGNOSIS AND PROCEDURE CODE GROUPS AND AT THE END OF THE RECORD.</p> <p>BEGINNING IN JUNE 1995, THE INPATIENT AND SNF CLAIMS FROM THE NATIONAL CLAIMS HISTORY (NCH) 100% NEARLINE FILE BECAME THE SOURCE OF MEDPAR. ALSO EFFECTIVE JUNE, 1995, A MEDPAR RECORD REPRESENTS FINAL ACTION CLAIMS DATA IN WHICH ALL ADJUSTMENTS HAVE BEEN RESOLVED (THEREBY ELIMINATING</p>

CREDIT-ONLY SITUATIONS).

(PRIOR TO JUNE 1995, MEDPAR WAS CREATED FROM CLAIMS FROM THE MEDICARE QUALITY ASSURANCE (MQA) SYSTEM; A MEDPAR RECORD REPRESENTED AN ACCUMULATION OF ADJUSTMENT CLAIMS, SOMETIMES INCLUDING CREDIT-ONLY STAYS.)

EFFECTIVE WITH THE 9/96 UPDATE  
THE 1995 MEDPAR WAS CREATED AS FOLLOWS:

1. EACH MONTH INPATIENT AND SNF CLAIMS ARE ACCUMULATED FROM THE NCH NEARLINE REPOSITORY.
2. AT THE END OF EACH QUARTER, THE MONTHLY FILES ARE MERGED INTO A DATABASE CONTAINING ALL CLAIMS FOR THE CURRENT YEAR AND PRIOR TWO YEARS. THE DATABASE IS PROCESSED THROUGH THE FINAL ACTION ALGORITHMS.
3. THE FINAL-ACTIONED DATABASE IS SPLIT INTO TWO SEGMENTS FOR EACH YEAR. INPATIENT CLAIMS WITH DISCHARGE DATES AND SNF CLAIMS WITH ADMISSION DATES IN JANUARY THROUGH SEPTEMBER ARE IN THE FIRST SEGMENT; CLAIMS WITH DATES IN OCTOBER THROUGH DECEMBER ARE IN THE SECOND SEGMENT. THIS ALLOWS FOR THE CREATION OF FISCAL YEAR OR CALENDAR YEAR FILES AS NEEDED.
4. THE CLAIMS REMAINING FROM THE FINAL ACTION PROCESSING ARE COLLAPSED BY CLAIM NUMBER, ADMISSION DATE, AND PROVIDER NUMBER (ALL IN ASCENDING ORDER) TO CREATE A STAY RECORD. THE RECORDS ARE FURTHER SORTED BY CLAIM FROM DATE, CLAIM THRU DATE, (BOTH IN ASCENDING ORDER), HCFA PROCESS DATE (DESCENDING), AND QUERY CODE (DESCENDING); AND THE RESULTS ARE USED TO CREATE MEDPAR.

FOR THE 6/95 THROUGH THE 6/96 UPDATES  
THE 1995 MEDPAR WAS CREATED AS FOLLOWS:

- \* EACH MONTH INPATIENT AND SNF CLAIMS ARE ACCUMULATED FROM THE NCH NEARLINE REPOSITORY.

\* AT THE END OF EACH QUARTER, THE MONTHLY FILES ARE MERGED INTO A DATABASE CONTAINING ALL CLAIMS FOR THE CURRENT YEAR AND PRIOR TWO YEARS. THE DATABASE IS SPLIT INTO TWO SEGMENTS FOR EACH YEAR. INPATIENT CLAIMS WITH DISCHARGE DATES AND SNF CLAIMS WITH ADMISSION DATES IN JANUARY THROUGH SEPTEMBER ARE IN THE FIRST SEGMENT; CLAIMS WITH DATES IN OCTOBER THROUGH DECEMBER ARE IN THE SECOND SEGMENT. THIS ALLOWS FOR THE CREATION OF FISCAL YEAR OR CALENDAR YEAR FILES AS NEEDED.

\* THE SEGMENTS ARE PROCESSED THROUGH THE FINAL ACTION ALGORITHMS. THE CLAIMS REMAINING FROM THE FINAL ACTION PROCESSING ARE COLLAPSED BY CLAIM NUMBER, ADMISSION DATE, AND PROVIDER NUMBER (ALL IN ASCENDING ORDER) TO CREATE A STAY RECORD. THE RECORDS ARE FURTHER SORTED BY CLAIM FROM DATE, CLAIM THRU DATE, (BOTH IN ASCENDING ORDER), HCFA PROCESS DATE (DESCENDING), AND QUERY CODE (DESCENDING); AND THE RESULTS ARE USED TO CREATE MEDPAR.

NOTE: THERE ARE 60%, 20% AND "OTHER" 20% FILES CREATED QUARTERLY FOR EACH FISCAL YEAR (FY) AND CALENDAR YEAR (CY) MEDPAR FILES. THESE FILES ARE DERIVED BASED ON THE FOLLOWING CRITERIA:

60% -- 9TH POS. OF HIC; SELECTION VALUES 1,2,3,6,7,9  
 20% -- 9TH POS. OF HIC; SELECTION VALUES 0, 5  
 OTHER 20% -- 9TH POS. OF HIC; SELECTION VALUES 4,8

SYSTEM ALIAS : MEDP1000

LIMITATIONS :

REFER TO :  
 MEDPAR\_MAR\_QTRLY\_UPDT\_LIM

1.	MEDPAR NCH Claim Type Code			
		2	1	2 CHAR

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 throughout 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).

NOTE3: Effective with Version 'J', 3 new code values have been added to include a type code for the Medicare Advantage claims (IME/GME, no-pay and paid as FFS). During the Version 'J' conversion, these type codes were populated throughout history.

DB2            ALIAS : UNDEFINED  
SAS            ALIAS : CLM\_TYPE

LENGTH            : 2

DERIVATIONS :

FFS CLAIM TYPE CODES DERIVED FROM:

NCH CLM\_NEAR\_LINE\_RIC\_CD  
NCH PMT\_EDIT\_RIC\_CD  
NCH CLM\_TRANS\_CD  
NCH PRVDR\_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(Pre-HDC processing -- AVAILABLE IN NCH)  
CLM\_MCO\_PD\_SW  
CLM\_RLT\_COND\_CD  
MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD  
MCO\_PRD\_EFCTV\_DT  
MCO\_PRD\_TRMNTN\_DT

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 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 (Medicare Advantage IME/GME CLAIMS - 10/1/05 - FORWARD)

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_MCO\_PD\_SW = '0'
2. CLM\_RLT\_COND\_CD = '04' & '69'
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 63 (HMO NO-PAY CLAIMS)

WHERE THE FOLLOWING CONDITIONS ARE MET:

CLAIMS PROCESSED ON OR AFTER 10/6/08

1. CLM\_THRU\_DT ON OR AFTER 10/1/06
2. CLM\_MCO\_PD\_SW = '1'
3. CLM\_RLT\_COND\_CD = '04'
4. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'A', 'B' OR 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS
5. ZERO REIMBURSEMENT (CLM\_PMT\_AMT)

SET CLM\_TYPE\_CD TO 63 (HMO NO-PAY CLAIMS)

WHERE THE FOLLOWING CONDITIONS ARE MET:

CLAIMS PROCESSED PRIOR to 10/6/08

1. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'A', 'B' OR 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS
2. ZERO REIMBURSEMENT (CLM\_PMT\_AMT)

SET CLM\_TYPE\_CD TO 64 (HMO CLAIMS PAID AS FFS)

WHERE THE FOLLOWING CONDITIONS ARE MET:

CLAIMS PROCESSED PRIOR to 10/6/08

1. MCO\_CNTRCT\_NUM

MCO\_OPTN\_CD = '1', '2' OR '4'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 64 (HMO CLAIMS PAID AS FFS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED on or after 10/6/08  
1. CLM\_RLT\_COND\_CD = '04'  
2. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = '1', '2' OR '4'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

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 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).

SOURCE : NCH

CODE TABLE : NCH\_CLM\_TYPE\_TB

2. MEDPAR Claim Locator Number Group  
11 3 13 GRP

This number uniquely identifies the beneficiary.

3. MEDPAR Beneficiary Claim Account Number  
9 3 11 CHAR

The number identifying the primary beneficiary under the SSA or RRB programs submitted.

NOTE: This field comes from the CAN that is present on the first claim record included in the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : CAN  
STANDARD ALIAS : MEDPAR\_BENE\_CLM\_ACNT\_NUM

LENGTH : 9

SOURCE : NCH

4. MEDPAR Category Equatable Beneficiary Identification Code  
2 12 13 CHAR

The code which categorizes groups of BICs representing similar relationships between the beneficiary and the primary wage earner.

The equatable BIC module electronically matches two records that contain different BICs where it is apparent that both are records for the same beneficiary. It validates the BIC and returns a base BIC under which to house the record in the national claims history (NCH) databases. (All records for a beneficiary are stored under a single BIC.)

NOTE: This field comes from the NCH category base BIC that is present on the first claim record included in the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : EQ\_BIC  
STANDARD ALIAS : MEDPAR\_CTGRY\_EQTBL\_BIC\_CD



				LENGTH	: 2
				SOURCE	: NCH
				CODE TABLE	: CTGRY_EQTBL_BENE_IDENT_TB
5.	MEDPAR Beneficiary Age Count	3	14	16	NUM
					The beneficiary's age as of date of admission.
				DB2	ALIAS : UNDEFINED
				STANDARD	ALIAS : MEDPAR_BENE_AGE_CNT
				LENGTH	: 3 SIGNED : N
				DERIVATIONS :	
					This field is derived by subtracting the bene date of birth from the admission date, present on the first claim record included in the stay. Exception: If the resulting age is 64, and the MSC = 10 or 11, the age is changed to 65.
				SOURCE	: NCH
6.	MEDPAR Beneficiary Sex Code	1	17	17	CHAR
					The sex of a beneficiary.
					NOTE: This field comes from the sex code that is present on the first claim record included in the stay.
				DB2	ALIAS : UNDEFINED
				SAS	ALIAS : SEX
				STANDARD	ALIAS : MEDPAR_BENE_SEX_CD
				LENGTH	: 1
				SOURCE	: NCH
				CODE TABLE	: BENE_SEX_IDENT_TB
7.	MEDPAR Beneficiary Race Code	1	18	18	CHAR

The race of a beneficiary.

NOTE: This field comes from the race code that is present on the first claim record included in the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : RACE  
STANDARD ALIAS : MEDPAR\_BENE\_RACE\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : BENE\_RACE\_TB

8. MEDPAR Beneficiary Medicare Status Code  
2 19 20

CHAR

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

DB2 ALIAS : UNDEFINED  
SAS ALIAS : MS\_CD  
STANDARD ALIAS : MEDPAR\_BENE\_MDCR\_STUS\_CD

LENGTH : 2

DERIVATIONS :

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.

SOURCE : NCH

CODE TABLE : BENE\_MDCR\_STUS\_TB

9. MEDPAR Beneficiary Residence SSA Standard State Code

2	21	22	CHAR
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The SSA standard state code of a beneficiary's residence.

NOTE: This field comes from the state code that is present on the first claim record included in the stay.

DB2	ALIAS	: UNDEFINED
SAS	ALIAS	: STATE_CD
STANDARD	ALIAS	: MEDPAR_BENE_RSDNC_SSA_STATE_CD

LENGTH : 2

SOURCE : NCH

CODE TABLE : GEO\_SSA\_STATE\_TB

10. MEDPAR Beneficiary Residence SSA Standard County Code

3	23	25	CHAR
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The SSA standard county code of a beneficiary's residence.

NOTE: This field comes from the county code that is present on the first claim record included in the stay.

DB2	ALIAS	: UNDEFINED
SAS	ALIAS	: CNTY_CD
STANDARD	ALIAS	: MEDPAR_BENE_RSDNC_SSA_CNTY_CD

LENGTH : 3

SOURCE : NCH

11. MEDPAR Beneficiary Mailing Contact Zip Code

5	26	30	CHAR
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The zip code of the mailing address where the beneficiary

may be contacted.

NOTE: This field comes from the zip code that is present on the first claim record included in the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : BENE\_ZIP  
STANDARD ALIAS : MEDPAR\_BENE\_MLG\_CNTCT\_ZIP\_CD

LENGTH : 5

SOURCE : NCH

12. FILLER  
4 31 34

CHAR  
DB2 ALIAS : FILLER  
LENGTH : 4

13. MEDPAR Admission Day Code  
1 35 35

NUM  
  
The code indicating the day of the week on which the beneficiary was admitted to a facility.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : ADMSNDAY  
STANDARD ALIAS : MEDPAR\_ADMSN\_DAY\_CD

LENGTH : 1 SIGNED : N

DERIVATIONS :  
This field is derived from the admission date that is present on the first claim record included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_ADMSN\_DAY\_TB

14. MEDPAR Beneficiary Discharge Status Code  
1 36 36

CHAR  
  
The code used to identify the status of the patient as of the CLM\_THRU\_DT.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DSCHRGCD  
STANDARD ALIAS : MEDPAR\_BENE\_DSCHRG\_STUS\_CD

LENGTH : 1

DERIVATIONS :  
This field is derived from the claim status code that is present on the last claim record included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_BENE\_DSCHRG\_STUS\_TB

15. MEDPAR GH0 Paid Code

1 37 37 CHAR

The code indicating whether or not a GH0 has paid the provider for the claim(s).

NOTE: This field comes from the GH0-paid indicator that is present on the first claim record included in the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : GHOPDCD  
STANDARD ALIAS : MEDPAR\_GHO\_PD\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : MEDPAR\_GHO\_PD\_TB

16. MEDPAR PPS Indicator Code

1 38 38 CHAR

The code indicating whether or not the facility is being paid under the prospective payment system (PPS).

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PPS\_IND  
STANDARD ALIAS : MEDPAR\_PPS\_IND\_CD

LENGTH : 1

DERIVATIONS :

If the condition code not equal 65 on all of the claims included in the stay and the third position of the provider number is numeric set MEDPAR\_PPS\_IND\_CD to 2 (PPS). Otherwise set it to 0 (Non PPS.)

SOURCE : NCH

CODE TABLE : MEDPAR\_PPS\_IND\_TB

17. MEDPAR Organization NPI Number  
10 39 48 CHAR

ON AN INSTITUTIONAL CLAIM, THE NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER ASSIGNED TO UNIQUELY IDENTIFY THE INSTITUTIONAL PROVIDER CERTIFIED BY MEDICARE TO PROVIDE SERVICES TO THE BENEFICIARY.

NOTE: EFFECTIVE MAY 23, 2007, THE NPI BECAME THE NATIONAL STANDARD IDENTIFIER FOR COVERED HEALTH CARE PROVIDERS. THE NPI WILL REPLACE CURRENT OSCAR PROVIDER NUMBERS, UPINS, NSC NUMBERS, AND LOCAL CONTRACTOR PROVIDER IDENTIFICATION NUMBERS (PINS) ON STANDARD HIPPA CLAIM TRANSACTIONS.

NOTE1: CMS HAS DETERMINED THAT DUAL PROVIDER IDENTIFIERS (LEGACY NUMBERS AND NEW NPI) MUST BE AVAILABLE IN THE NCH. AFTER THE 5/07 NPI IMPLEMENTATION, THE STANDARD SYSTEM MAINTAINERS WILL ADD THE LEGACY NUMBER TO THE CLAIM WHEN IT IS ADJUDICATED.

NOTE: THIS FIELD COMES FROM THE ORGANIZATION NPI THAT IS PRESENT ON THE FIRST CLAIM RECORD INCLUDED IN THE STAY.

DB2 ALIAS : UNDEFINED

SAS ALIAS : ORGNPINM

LENGTH : 10

18. MEDPAR Provider Number Group  
6 49 54 GRP

19. MEDPAR Provider State Code

2 49 50 NUM

The first two positions of the provider number, identifying the state of the institutional provider that furnished services to the beneficiary during the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PRVSTATE  
STANDARD ALIAS : MEDPAR\_PRVDR\_STATE\_CD

LENGTH : 2 SIGNED : N

DERIVATIONS :

This field comes from positions 1 & 2 of the provider number that is present on the first claim record included in the stay.

SOURCE : NCH

CODE TABLE : GEO\_SSA\_STATE\_TB

20. MEDPAR Provider Number Third Position Code

1 51 51 CHAR

The third position of the provider number, identifying the category of institutional provider that furnished services to the beneficiary during the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PRVNUM3  
STANDARD ALIAS : MEDPAR\_PRVDR\_NUM\_3RD\_CD

LENGTH : 1

DERIVATIONS :

This field is position 3 of the provider number from the first claim record included in the stay modified as follows:

Where position 3 is an alpha character (S, T, U, W or Y) move to the MEDPAR provider special unit code and replace with a '0'.

Where position 3 is an alpha character (M or R)

move to the MEDPAR provider special unit  
code and replace with a '1'.

SOURCE : NCH

21. MEDPAR Provider Number Serial Code  
3 52 54

CHAR

The last three positions of the provider number, identifying  
the specific serial numbers of the institutional provider  
that furnished services to the beneficiary during the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PRVDRSRL  
STANDARD ALIAS : MEDPAR\_PRVDR\_NUM\_SRL\_CD

LENGTH : 3

DERIVATIONS :

This field comes from positions 4 - 6 of the provider  
number on the first claim record included in the stay.

SOURCE : NCH

22. MEDPAR Provider Number Special Unit Code  
1 55 55

CHAR

The code identifying the special numbering system for units  
of hospitals that are excluded from PPS or hospitals with  
SNF swing-bed designation.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : SPCLUNIT  
STANDARD ALIAS : MEDPAR\_PRVDR\_NUM\_SPCL\_UNIT\_CD

LENGTH : 1

DERIVATIONS :

If the third position of the provider number from the  
first claim record included in the stay equals 'M',  
'R', 'S', 'T', 'U', 'W', 'Y' OR 'Z', it is moved  
to this field, otherwise it is blank.

SOURCE : NCH



CODE TABLE : MEDPAR\_PRVDR\_NUM\_SPCL\_UNIT\_TB

23. MEDPAR Short Stay/Long Stay/SNF Indicator Code

1 56 56 CHAR

The code indicating whether the stay is a short stay, long stay, or SNF.

DB2 ALIAS : UNDEFINED

SAS ALIAS : SSLSSNF

STANDARD ALIAS : MEDPAR\_SS\_LS\_SNF\_IND\_CD

LENGTH : 1

DERIVATIONS :

This field is derived from the third position of the provider number that is present on the first claim record included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_SS\_LS\_SNF\_IND\_TB

24. MEDPAR Stay Final Action Claims Count

2 57 58 PACK

The count of the number of claim records (final action) included in the stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : FACLMCNT

STANDARD ALIAS : MEDPAR\_STAY\_FINL\_ACTN\_CLM\_CNT

LENGTH : 3 SIGNED : Y

DERIVATIONS :

This field is derived by counting the number of final action claims used to create the stay.

SOURCE : NCH

25. MEDPAR Latest Claim Accretion Date

4 59 62 PACK

The date the latest claim record included in the stay was

accreted (posted/processed) to the beneficiary master record at the CWF host).

DB2 ALIAS : UNDEFINED  
SAS ALIAS : ACRTNDT  
STANDARD ALIAS : MEDPAR\_LTST\_CLM\_ACRTN\_DT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field comes from the highest accretion date that is present on the claim records included in the stay.

SOURCE : NCH

EDIT RULES :  
YYYYDDD

26. MEDPAR Beneficiary Medicare Benefit Exhausted Date  
4 63 66 PACK

The last date for which the beneficiary had Medicare coverage. This field is completed only where benefits were exhausted before the discharge date and during the period covered by stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : EXHST\_DT  
STANDARD ALIAS : MEDPAR\_BENE\_MDCR\_BNFT\_EXHST\_DT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field comes from the highest benefits exhausted date that is present on the claim records included in the stay.

SOURCE : NCH

EDIT RULES :  
YYYYDDD

27. MEDPAR SNF Qualification From Date  
4 67 70 PACK

The beginning date of the beneficiary's qualifying stay. For Inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization to benefits. For SNF claims, the date relates to the qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'a', or at least three days in a row if the source of admission is other than an 'a'.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : QLFYFROM  
STANDARD ALIAS : MEDPAR\_SNF\_QUALN\_FROM\_DT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field comes from occurrence span code = 70 and related occurrence span from date, if present on any of the claim records included in the stay. If more than one record has an occurrence span code = 70, with different span dates, the date from the last claim record included in the stay is used.

SOURCE : NCH

EDIT RULES :  
YYYYDDD

28. MEDPAR SNF Qualification Through Date  
4 71 74

PACK

The ending date of the beneficiary's qualifying stay. For Inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization to benefits. For SNF claims, the date relates to the qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission is other than an 'A'.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : QLFYTHRU  
STANDARD ALIAS : MEDPAR\_SNF\_QUALN\_THRU\_DT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field comes from the occurrence span code = 70 and related occurrence span thru date, if present on any of the claims included in the stay. If more than one record has an occurrence span code = 70, with different span dates, the date from the last claim record included in the stay is used.

SOURCE : NCH

EDIT RULES :  
YYYYDDD

29. MEDPAR Admission Date                    4        75        78    PACK

The date the beneficiary was admitted for Inpatient care or the date that care started.

NOTE: This field comes from the admission date that is present on the first claim record included in the stay.

DB2        ALIAS : UNDEFINED  
SAS        ALIAS : ADMSNDT  
STANDARD ALIAS : MEDPAR\_ADMSN\_DT

LENGTH : 7        SIGNED : Y

SOURCE : NCH

EDIT RULES :  
YYYYDDD

30. MEDPAR Discharge Date                   4        79        82    PACK

The date on which the beneficiary was discharged or died.

NOTE: This field comes from the highest claim thru date that is present on the claim records included in the stay, where the claim status code is other than '30' (still patient) on the last claim record included in the stay. Inpatient claims will always have a discharge date; SNF claims could have a zero date.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DSCHRGDT  
STANDARD ALIAS : MEDPAR\_DSCHRG\_DT

LENGTH : 7 SIGNED : Y

SOURCE : NCH

EDIT RULES :  
YYYYDDD

31. MEDPAR Covered Level Care Thru Date  
4 83 86

PACK

The date on which a covered level of care ended in a SNF.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : CVRLVLDT  
STANDARD ALIAS : MEDPAR\_CVR\_LVL\_CARE\_THRU\_DT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field comes from the date associated with  
occurrence code = 22 if present on any of the claims  
included in the stay. If multiple dates, the highest  
date is used. This field is only applicable to SNF claims.

SOURCE : NCH

EDIT RULES :  
YYYYDDD

32. MEDPAR Beneficiary Death Date  
4 87 90

PACK

The date the beneficiary died.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DEATHDT  
STANDARD ALIAS : MEDPAR\_BENE\_DEATH\_DT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field comes from the beneficiary death date, if present on the enrollment database, which is accessed prior to creation of the quarterly MEDPAR file.

SOURCE : EDB

LIMITATIONS :

REFER TO :  
MEDPAR\_DOD\_LIM

EDIT RULES :  
YYYYDDD

33. MEDPAR Beneficiary Death Date Verified Code

1 91 91 CHAR

The code indicating whether the beneficiary's date of death has been verified (SOURCE: SSA's MBR) or originated from a claim record.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DEATHCD  
STANDARD ALIAS : MEDPAR\_BENE\_DEATH\_DT\_VRFY\_CD

LENGTH : 1

DERIVATIONS :  
This field is derived from the enrollment database's beneficiary source death date code, or from the presence of a claim status code = '20' (expired) on the last claim record included in the stay.

SOURCE : EDB,NCH

CODE TABLE : MEDPAR\_BENE\_DEATH\_DT\_VRFY\_TB

34. MEDPAR Internal Use SSI Group

5 92 96 GRP

35. MEDPAR Internal Use SSI Indicator Code

1 92 92 CHAR

DB2 ALIAS : UNDEFINED

SAS ALIAS : SSICD  
STANDARD ALIAS : MEDPAR\_INTRNL\_USE\_SSI\_IND\_CD

LENGTH : 1

COMMENTS :  
Limited availability; for internal use only; applicable to  
Inpatient claims only. Where not available, this field is  
blank.

36. MEDPAR Internal Use SSI Day Count  
3 93

95 PACK

DB2 ALIAS : UNDEFINED  
SAS ALIAS : SSIDAY

LENGTH : 5 SIGNED : Y

COMMENTS :  
Limited availability; for internal use; applicable to Inpatient  
claims only. Where not available, this field will contain  
zeroes.

NOTE: IN JUNE 2007, A CHANGE WAS MADE TO USE THE LENGTH  
OF STAY COUNT IN THE CALCULATION OF THE SSI DAY COUNT.  
PRIOR TO JUNE 2007, THE UTILIZATION (COVERED) DAY COUNT  
WAS USED.

37. FILLER

1 96 96

CHAR

DB2 ALIAS : FILLER

LENGTH : 1

38. MEDPAR Length of Stay Day Count  
3 97

99 PACK

The count in days of the total length of a beneficiary's  
stay in a hospital or SNF.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : LOSCNT  
STANDARD ALIAS : MEDPAR\_LOS\_DAY\_CNT

LENGTH : 5 SIGNED : Y

DERIVATIONS :  
This field is derived by subtracting the date of discharge (or thru date in SNF cases where beneficiary is still a patient) from the date of admission. If difference is '0,' the value becomes a '1.'

SOURCE : NCH

39. MEDPAR Outlier Day Count  
2 100 101

PACK

The count of the number of days paid as outliers (either a day or cost outlier) under PPS beyond the DRG threshold.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : OUTLRDAY  
STANDARD ALIAS : MEDPAR\_OUTLIER\_DAY\_CNT

LENGTH : 3 SIGNED : Y

DERIVATIONS :  
This field is derived by checking the MEDPAR utilization day count against the DRG threshold table (DRG weights file).

SOURCE : MEDPAR

40. MEDPAR Utilization Day Count  
3 102 104

PACK

The count of the number of covered days of care that are chargeable to Medicare utilization for the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : UTIL\_DAY

LENGTH : 5 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the utilization day count that is present on any of the claim records included in the stay (i.e., the sum of utilization days reported on the claims that comprise the stay).



SOURCE : NCH

41. MEDPAR Beneficiary Total Coinsurance Day Count  
2 105 106 PACK

The count of the total number of coinsurance days involved with the beneficiary's stay in a facility. For Inpatient services, the beneficiary is liable for a daily coinsurance amount after the 60th day and before the 91st day in a single spell of illness; for SNF services, the beneficiary is liable for a daily coinsurance amount after the 20th day and before the 101st day in a single spell of illness.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : COIN\_DAY  
STANDARD ALIAS : MEDPAR\_TOT\_COINSRNC\_DAY\_CNT

LENGTH : 3 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the coinsurance day count that is present on any of the claim records included in the stay (i.e., the sum of coinsurance days reported on the claims that comprise the stay).

SOURCE : NCH

42. MEDPAR Beneficiary LRD Used Count  
2 107 108 PACK

The count of the number of lifetime reserve days (LRD) used by the beneficiary for this stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : LRD\_USE  
STANDARD ALIAS : MEDPAR\_BENE\_LRD\_USE\_CNT

LENGTH : 3 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the lifetime reserve days used count that is present on any of the claim records included in the stay (i.e., the sum of LRD reported on the claims that comprise the stay).

				SOURCE	: NCH
43.	FILLER			CHAR	
		12	109	120	
				DB2	ALIAS : FILLER
				LENGTH	: 12
44.	MEDPAR Beneficiary Part A Coinsurance Liability Amount				
		4	121	124	PACK
					The amount of money (rounded to whole dollars) identified as the beneficiary's liability for part A coinsurance for the stay.
				DB2	ALIAS : UNDEFINED
				SAS	ALIAS : COIN_AMT
				STANDARD	ALIAS : MEDPAR_BENE_PTA_COINSRNC_AMT
				LENGTH	: 7 SIGNED : Y
				DERIVATIONS :	
					This field is derived by accumulating the beneficiary's part a coinsurance liability amount that is present on any of the claim records included in the stay (i.e., the sum of coinsurance amounts reported on the claims that comprise the stay).
				SOURCE	: NCH
				EDIT RULES :	
					+\$\$\$\$\$\$
45.	MEDPAR Beneficiary Inpatient Deductible Liability Amount				
		4	125	128	PACK
					The amount of money (rounded to whole dollars) identified as the beneficiary's liability for the Inpatient deductible for the stay.
				DB2	ALIAS : UNDEFINED
				SAS	ALIAS : DED_AMT
				STANDARD	ALIAS : MEDPAR_BENE_IP_DDCTBL_AMT
				LENGTH	: 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the beneficiary  
Inpatient deductible amount that is present on any of the  
claim records included in the stay (i.e., the sum of the  
Inpatient deductibles reported on the claims that  
comprise the stay).

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
Rounded; On-size (overflow) Situation = All nines

46. MEDPAR Beneficiary Blood Deductible Liability Amount

4 129 132 PACK

The amount of money (rounded to whole dollars) identified as  
the beneficiary's liability for the blood deductible for the  
stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : BLDDDEDAM  
STANDARD ALIAS : MEDPAR\_BENE\_BLOOD\_DDCTBL\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the beneficiary  
blood deductible liability amount that is present on any  
of the claim records included in the stay (i.e., the sum  
of the blood deductibles reported on the claims  
that comprise the stay).

SOURCE : NCH

LIMITATIONS :

REFER TO :  
MEDPAR\_BLOOD\_DDCTBL\_AMT\_LIM

EDIT RULES :  
+\$\$\$\$\$\$  
Rounded; On-size (overflow) Situation = All nines

47. MEDPAR Beneficiary Primary Payer Amount

4 133 136 PACK

The amount of payment (rounded to whole dollars) made on behalf of the beneficiary by a primary payer other than Medicare, which has been applied to the covered Medicare charges for the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PRPAYAMT  
STANDARD ALIAS : MEDPAR\_BENE\_PRMRY\_PYR\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the beneficiary primary payer payment amount that is present on any of the claim records included in the stay (i.e., the sum of the primary payer amounts reported on the claims that comprise the stay).

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

Rounded; On-size (overflow) situation = All nines

48. MEDPAR DRG Outlier Approved Payment Amount

4 137 140 PACK

The amount of additional payment (rounded to whole dollars) approved due to an outlier situation over the DRG allowance for the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : OUTLRAMT  
STANDARD ALIAS : MEDPAR\_DRG\_OUTLIER\_PMT\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the DRG outlier approved payment amount (value code = 17 amount) that is present on any of the claim records included in the stay (i.e., the sum of outlier amounts reported on the claims

that comprise the stay).

COMMENTS :

THIS AMOUNT IS ALREADY INCLUDED IN THE MEDPAR  
MEDICARE PAYMENT AMOUNT.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

49. MEDPAR Inpatient Disproportionate Share Amount

4 141 144 PACK

The amount paid over the DRG amount (rounded to whole  
dollars) for the disproportionate share hospital for the  
stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : DISP\_SHR

STANDARD ALIAS : MEDPAR\_IP\_DSPRPRTNT\_SHR\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the value amount  
associated with value code = 18 that is present on any of  
the claim records included in the stay (i.e., the sum of  
value code 18 amounts reported on the claims that  
comprise the stay).

COMMENTS :

THIS AMOUNT IS ALREADY INCLUDED IN THE MEDPAR  
MEDICARE PAYMENT AMOUNT.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

50. MEDPAR Indirect Medical Education (IME) Amount

4 145 148 PACK

The amount of additional payment (rounded to whole dollars) made to teaching hospitals for IME for the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : IME\_AMT  
STANDARD ALIAS : MEDPAR\_IME\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the value amount associated with value code = 19 that is present on any of the claim records included in the stay (i.e., the sum of IME amounts - value code 19 amounts - reported on the claims that comprise the stay).

COMMENTS :  
This amount is already included in the MEDPAR Medicare payment amount.

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

51. MEDPAR DRG Price Amount

4 149 152 PACK

The amount (called the 'DRG price' for purposes of MEDPAR analysis) that would have been paid if no deductibles, coinsurance, primary payers, or outliers were involved (rounded to whole dollars).

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DRGPRICE  
STANDARD ALIAS : MEDPAR\_DRG\_PRICE\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the following amounts: MEDPAR Medicare payment amount, MEDPAR beneficiary primary payer payment amount, MEDPAR beneficiary coinsurance liability amount, MEDPAR

beneficiary Inpatient deductible liability amount,  
MEDPAR beneficiary blood deductible amount; and then  
subtracting from the sum the MEDPAR DRG outlier  
approved payment amount.

SOURCE : NCH

LIMITATIONS :

REFER TO :  
MEDPAR\_DRG\_PRICE\_AMT\_LIM

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

52. MEDPAR Total Pass Through Amount  
4 153 156

PACK

The total of all claim pass through amounts (rounded to  
whole dollars) for the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PASSTHRU  
STANDARD ALIAS : MEDPAR\_PASS\_THRU\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by multiplying the  
pass thru per diem amount that is present on the last  
claim record included in the stay times the MEDPAR  
utilization day count (the sum of the utilization  
(covered) days reported on the claims that comprise the  
stay).

COMMENTS :  
Items reimbursed as pass through include capital-related costs,  
direct medical education costs, kidney acquisition costs for  
hospitals approved as rtc's, and bad debts (per provider  
reimbursement manual, part 1, section 2405.2).

The MEDPAR pass thru amount is not included in the MEDPAR  
Medicare payment amount.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

53. MEDPAR Total PPS Capital Amount

4 157 160

PACK

The total amount (rounded to whole dollars) that is payable for capital PPS (e.g., reimbursement for depreciation, rent, certain interest, real estate taxes for hospital buildings/equipment subject to PPS).

DB2 ALIAS : UNDEFINED

SAS ALIAS : PPS\_CPTL

STANDARD ALIAS : MEDPAR\_TOT\_PPS\_CPTL\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the total PPS capital amount that is present on any of the claim records included in the stay (i.e., the sum of total PPS capital amounts reported on the claims that comprise the stay).

COMMENTS :

This field is already included in the MEDPAR Medicare payment amount.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

54. FILLER

12 161 172

CHAR

DB2 ALIAS : FILLER

LENGTH : 12

55. MEDPAR Total Charge Amount

4 173 176

PACK



The total amount (rounded to whole dollars) of all charges (covered and noncovered) for all services provided to the beneficiary for the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : TOTCHRG  
STANDARD ALIAS : MEDPAR\_TOT\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the total charge amount from all claim records included in the stay (i.e., the sum of total charges reported on the claims that comprise the stay).

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

56. MEDPAR Total Covered Charge Amount  
4 177 180

PACK

The portion of the total charges amount (rounded to whole dollars) that is covered by Medicare for the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : CVRCHRG  
STANDARD ALIAS : MEDPAR\_TOT\_CVR\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by calculating the covered charges from all claim records included in the stay (i.e., subtract the revenue center noncovered charge amount from the revenue center total charge amount for revenue center code = 0001 that is reported on the claims that comprise the stay; sum the results). Exception: if there exists an erroneous condition relative to revenue center code 0001, the calculation will be made for each revenue center code included on the claims that comprise the

stay with the results summed to create the total.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

57. MEDPAR Medicare Payment Amount

4 181 184 PACK

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; and represents what was paid to the institutional provider, 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), in- direct 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.

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'.

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

DB2            ALIAS : UNDEFINED  
SAS            ALIAS : PMT\_AMT  
STANDARD ALIAS : MEDPAR\_MDCR\_PMT\_AMT

LENGTH            : 7        SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the payment amount that is present on all of the claim records included in the stay (i.e, the sum of payment (reimbursement) reported on the claims that comprise the stay).

SOURCE            : NCH

EDIT RULES :

+\$\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

58.    MEDPAR All Accommodations Total Charge Amount  
          4        185        188        PACK

The total charge amount (rounded to whole dollars) for all accommodations (routine hospital room and board charges for

general care, coronary care and/or intensive care units)  
related to a beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : ACMDTNS  
STANDARD ALIAS : MEDPAR\_ACMDTNS\_TOT\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is the sum of MEDPAR private room charge amount, MEDPAR semiprivate room charge amount, MEDPAR ward charge amount, MEDPAR intensive care charge amount, and MEDPAR coronary care charge amount (i.e., the accumulation of the revenue center total charge amount associated with revenue center codes 0100 - 0219 from all claim records included in the stay).

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

59. MEDPAR Departmental Total Charge Amount  
4 189 192 PACK

The total charge amount (rounded to whole dollars) for all ancillary departments (other than routine room and board, CCU, and ICU) related to a beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DPRTMNTL  
STANDARD ALIAS : MEDPAR\_DPRTMNTL\_TOT\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 0220 - 0999 from all claim records included in the stay (i.e, the sum of charges for all revenue centers other than accommodations 0100 - 0219).

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

60. MEDPAR Accommodations Days Group  
10 193 202 GRP

61. MEDPAR Private Room Day Count  
2 193 194 PACK

The count of the number of private room days used by the beneficiary for the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PRVTDAY  
STANDARD ALIAS : MEDPAR\_PRVT\_ROOM\_DAY\_CNT

LENGTH : 3 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center unit count associated with accommodation revenue center codes 011x and 014x from all claim records included in the stay.

Exception for SNF rugs demo eff 3/96 SNF update:  
field is derived from revenue center codes  
in the 9033-9044 series.

SOURCE : NCH

62. MEDPAR Semiprivate Room Day Count  
2 195 196 PACK

The count of the number of semi-private room days used by the beneficiary for the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : SPRVTDAY  
STANDARD ALIAS : MEDPAR\_SEMIPRVT\_ROOM\_DAY\_CNT

LENGTH : 3 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center unit count associated with accommodation revenue center codes 010X, 012X, 013X, 016X - 019X from all claim records included in the stay.

Exception for SNF rugs demo eff 3/96 SNF update:  
field is derived from revenue center codes  
in the 9019-9032 series.

SOURCE : NCH

63. MEDPAR Ward Day Count

2 197 198 PACK

The count of the number of ward days used by the beneficiary for the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : WARDDAY  
STANDARD ALIAS : MEDPAR\_WARD\_DAY\_CNT

LENGTH : 3 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center unit count associated with accommodation revenue center code 015x from all claim records included in the stay.

Exception for SNF rugs demo eff 3/96 SNF update:  
field is derived from revenue center codes  
in the 9000-9018 series.

SOURCE : NCH

64. MEDPAR Intensive Care Day Count

2 199 200 PACK

The count of the number of intensive care days used by the beneficiary for the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : ICARECNT  
STANDARD ALIAS : MEDPAR\_INTNSV\_CARE\_DAY\_CNT

LENGTH : 3 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center unit count associated with accommodation revenue center codes 020X (all 9 subcategories) from all claims included in the stay.

SOURCE : NCH

LIMITATIONS :

There is approximately a 20% error rate in the revenue center code category 0206 due to coders misunderstanding the term 'post ICU' as including any day after an ICU stay rather than just days in a step-down/lower case version of an ICU. 'Post' was removed from the revenue center code 0206 description, effective 10/1/96 (12/96 MEDPAR update). 0206 Is now defined as 'intermediate ICU'.

65. MEDPAR Coronary Care Day Count

2 201 202 PACK

The count of the number of coronary care days used by the beneficiary for the stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : CRNRYDAY

STANDARD ALIAS : MEDPAR\_CRNRY\_CARE\_DAY\_CNT

LENGTH : 3 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center unit count associated with accommodation revenue center code 021x (all six subcategories) from all claim records included in the stay.

SOURCE : NCH

LIMITATIONS :

There is approximately a 20% error rate in the revenue center code category 0214 due to coders misunderstanding the term 'post ccu' as including any day after a ccu stay rather than just days in a step-down/lower case

version of a ccu. 'Post' was removed from the revenue center code 0214 description, effective 10/1/96 (12/96 MEDPAR update). 0214 is now defined as 'intermediate ccu'.

66. MEDPAR Accommodations Charges Group  
20 203 222 GRP

67. MEDPAR Private Room Charge Amount  
4 203 206 PACK

The charge amount (rounded to whole dollars) for private room accommodations related to a beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PRVTAMT  
STANDARD ALIAS : MEDPAR\_PRVT\_ROOM\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 011x and 014x from all claim records included in the stay.

Exception for SNF rugs demo eff 3/96 SNF update:  
field is derived from revenue center codes  
in the 9033-9044 series.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

68. MEDPAR Semi-Private Room Charge Amount  
4 207 210 PACK

The charge amount (rounded to whole dollars) for semi-private room accommodations related to a beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : SPRVTAMT



STANDARD ALIAS : MEDPAR\_SEMIPRVT\_ROOM\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 010x, 012x, 013x, and 016x - 019x from all claim records included in the stay.

Exception for SNF rugs demo eff 3/96 SNF update:  
field is derived from revenue center codes  
in the 9019-9032 series.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

69. MEDPAR Ward Charge Amount

4 211 214 PACK

The charge amount (rounded to whole dollars) for ward accommodations related to a beneficiary's stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : WARDAMT

STANDARD ALIAS : MEDPAR\_WARD\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center total charge amount associated with revenue center code 015x from all claim records included in the stay.

Exception for SNF rugs demo eff 3/96 SNF update:  
field is derived from revenue center codes  
in the 9000-9018 series.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

70. MEDPAR Intensive Care Charge Amount  
4 215 218 PACK

The charge amount (rounded to whole dollars) for intensive care accommodations related to a beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : ICAREAMT  
STANDARD ALIAS : MEDPAR\_INTNSV\_CARE\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center total charge amount associated with accommodation revenue center code 020x from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

71. MEDPAR Coronary Care Charge Amount  
4 219 222 PACK

The charge amount (rounded to whole dollars) for coronary care accommodations related to a beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : CRNRYAMT  
STANDARD ALIAS : MEDPAR\_CRNRY\_CARE\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center total charge amount associated with accommodation revenue center code 021X from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

72. MEDPAR Service Charges Group  
100 223 322 GRP

73. MEDPAR Other Service Charge Amount  
4 223 226 PACK

The charge amount (rounded to whole dollars) for other services (revenue centers that do not fit into other categories) related to a beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : OTHRAMT  
STANDARD ALIAS : MEDPAR\_OTHR\_SRVC\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with the 'other' revenue center codes from all claim records included in the stay. the 'other' codes include 0002-0099, 022x, 023x, 024x, 052x, 053x, 055x - 060x, 064x - 070x, 076x - 078x, 090x - 095x, and 099x. (Some of these codes are not yet assigned.)

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

74. MEDPAR Pharmacy Charge Amount  
4 227 230 PACK

The charge amount (rounded to whole dollars) for pharmaceutical costs related to the beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PHRMCAMT

STANDARD ALIAS : MEDPAR\_PHRMCY\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 025x, 026x, and 063x from all claims records included in the stay.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

75. MEDPAR Medical/Surgical Supple Charge Amount

4 231 234 PACK

The charge amount (rounded to whole dollars) for medical/surgical supplies related to the beneficiary's stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : SUPPLYAMT

STANDARD ALIAS : MEDPAR\_MDCL\_SUPPLY\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 027x and 062x from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

76. MEDPAR DME Charge Amount

4 235 238 PACK

The charge amount (rounded to whole dollars) for DME (purchase of new DME and rentals) related to the

beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DME\_AMT  
STANDARD ALIAS : MEDPAR\_DME\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 0290, 0291, 0292, and 0294 - 0299 from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

77. MEDPAR Used DME Charge Amount  
4 239 242 PACK

The charge amount (rounded to whole dollars) for used DME (purchase of used DME) related to the beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : UDME\_AMT  
STANDARD ALIAS : MEDPAR\_USED\_DME\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with revenue center code 0293 from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

78. MEDPAR Physical Therapy Charge Amount  
4 243 246 PACK

The charge amount (rounded to whole dollars) for physical therapy services provided during the beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PHYTHAMT  
STANDARD ALIAS : MEDPAR\_PHYS\_THRPY\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with revenue center code 042x from all claims records included in the stay.

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

79. MEDPAR Occupational Therapy Charge Amount  
4 247 250

PACK

The charge amount (rounded to whole dollars) for occupational therapy services provided during the beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : OCPTLAMT  
STANDARD ALIAS : MEDPAR\_OCPTNL\_THRPY\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with revenue center code 043x from all claims records included in the stay.

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

80. MEDPAR Speech Pathology Charge Amount

4 251 254 PACK

The charge amount (rounded to whole dollars) for speech pathology services (speech, language, audiology) provided during the beneficiary's stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : SPCH\_AMT

STANDARD ALIAS : MEDPAR\_SPCH\_PTHLGY\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center total charge amount associated with revenue center code 044x and 047x from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

81. MEDPAR Inhalation Therapy Charge Amount

4 255 258 PACK

The charge amount (rounded to whole dollars) for inhalation therapy services (respiratory and pulmonary function) provided during the beneficiary's stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : INHLTAMT

STANDARD ALIAS : MEDPAR\_INHLTN\_THRPY\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 041x and 046x from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

82. MEDPAR Blood Charge Amount  
4 259 262 PACK

The charge amount (rounded to whole dollars) for blood provided during the beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : BLOODAMT  
STANDARD ALIAS : MEDPAR\_BLOOD\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with revenue center code 038x from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

83. MEDPAR Blood Administration Charge Amount  
4 263 266 PACK

The charge amount (rounded to whole dollars) for blood storage and processing related to the beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : BLDADMIN  
STANDARD ALIAS : MEDPAR\_BLOOD\_ADMIN\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with revenue center code 039x from all claim records included in the stay.



SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

84. MEDPAR Operating Room Charge Amount  
4 267 270

PACK

The charge amount (rounded to whole dollars) for the operating room, recovery room, and labor room delivery used by the beneficiary during the stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : OROOMAMT

STANDARD ALIAS : MEDPAR\_OPRTG\_ROOM\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 036X, 071X, and 072X from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

85. MEDPAR Lithotripsy Charge Amount  
4 271 274

PACK

The charge amount (rounded to whole dollars) for lithotripsy services provided during the beneficiary's stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : LTHTRPSY

STANDARD ALIAS : MEDPAR\_LTHTRPSY\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center

total charge amount associated with revenue center code  
079X from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

86. MEDPAR Cardiology Charge Amount

4 275 278 PACK

The charge amount (rounded to whole dollars) for cardiology  
services and electrocardiogram(s) provided during the  
beneficiary's stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : CRDLGY

STANDARD ALIAS : MEDPAR\_CRDLGY\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center  
total charge amount associated with revenue center codes  
048X and 073X from all claim records included in the  
stay.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

87. MEDPAR Anesthesia Charge Amount

4 279 282 PACK

The charge amount (rounded to whole dollars) for anesthesia  
services provided during the beneficiary's stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : ANSTHSA

STANDARD ALIAS : MEDPAR\_ANSTHSA\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with revenue center code 037X from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

88. MEDPAR Laboratory Charge Amount  
4 283 286 PACK

The charge amount (rounded to whole dollars) for laboratory costs related to the beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : LAB\_AMT  
STANDARD ALIAS : MEDPAR\_LAB\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 030x, 031x, 074x, and 075x from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

89. MEDPAR Radiology Charge Amount  
4 287 290 PACK

The charge amount (rounded to whole dollars) for radiology costs (including oncology, excluding MRI) related to a beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : RDLGYAMT

STANDARD ALIAS : MEDPAR\_RDLGY\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating revenue center total charge amount associated with revenue center codes 028x, 032x, 033x, 034x, 035x, and 040x from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

90. MEDPAR MRI Charge Amount

4 291 294 PACK

The charge amount (rounded to whole dollars) for MRI services provided during the beneficiary's stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : MRI\_AMT

STANDARD ALIAS : MEDPAR\_MRI\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center total charge amount associated with revenue center 061x from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$

ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

91. MEDPAR Outpatient Service Charge Amount

4 295 298 PACK

The charge amount (rounded to whole dollars) for outpatient services provided during the beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : OPSRVC  
STANDARD ALIAS : MEDPAR\_OP\_SRVC\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with revenue center code 049x and 050x from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

92. MEDPAR Emergency Room Charge Amount  
4 299 302

PACK

The charge amount (rounded to whole dollars) for emergency room services provided during the beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : ER\_AMT  
STANDARD ALIAS : MEDPAR\_ER\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with revenue center code 045X from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

93. MEDPAR Ambulance Charge Amount  
4 303 306

PACK

The charge amount (rounded to whole dollars) for ambulance

services related to a beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : AMBLNC  
STANDARD ALIAS : MEDPAR\_AMBLNC\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center total charge amount associated with revenue center code 054x from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

94. MEDPAR Professional Fees Charge Amount  
4 307 310

PACK

The charge amount (rounded to whole dollars) for professional fees related to a beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PROFFEES  
STANDARD ALIAS : MEDPAR\_PROFNL\_FEES\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 096x, 097x, and 098x from all claims records included in the stay.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

95. MEDPAR Organ Acquisition Charge Amount  
4 311 314

PACK

The charge amount (rounded to whole dollars) for organ acquisition or other donor bank services related to a beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : ORGNAMT  
STANDARD ALIAS : MEDPAR\_ORGN\_ACQSTN\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 081x and 089x from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

96. MEDPAR ESRD Revenue Setting Charge Amount  
4 315 318

PACK

The charge amount (rounded to whole dollars) for ESRD services (other than organ acquisition and other donor bank) related to a beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : ESRDSETG  
STANDARD ALIAS : MEDPAR\_ESRD\_REV\_SETG\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with revenue center codes 080x, 082x - 088x from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :

+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

97. MEDPAR Clinic Visit Charge Amount  
4 319 322 PACK

The charge amount (rounded to whole dollars) for clinic visits (e.g., visits to chronic pain or dental centers or to clinics providing psychiatric, ob-gyn, pediatric services) related to the beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : CLNC\_AMT  
STANDARD ALIAS : MEDPAR\_CLNC\_VISIT\_CHRG\_AMT

LENGTH : 7 SIGNED : Y

DERIVATIONS :  
This field is derived by accumulating the revenue center total charge amount associated with revenue center code 051x from all claim records included in the stay.

SOURCE : NCH

EDIT RULES :  
+\$\$\$\$\$\$  
ROUNDED; ON-SIZE (OVERFLOW) SITUATION = ALL NINES

98. MEDPAR Accommodations/Services Indicator Group  
23 323 345 GRP

99. MEDPAR Intensive Care Unit (ICU) Indicator Code  
1 323 323 CHAR

The code indicating that the beneficiary has spent time under intensive care during the stay. It also specifies the type of ICU.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : ICUINDCD  
STANDARD ALIAS : MEDPAR\_ICU\_IND\_CD

LENGTH : 1



DERIVATIONS :

This field is derived by checking for the presence of icu revenue center codes (listed below) on any of the claim records included in the stay. If more than one of the revenue center codes listed below are included on these claims, the code with the highest revenue center total charge amount is used.

SOURCE : NCH

LIMITATIONS :

There is approximately a 20% error rate in the revenue center code category 0206 due to coders misunderstanding the term 'post ICU' as including any day after an ICU stay rather than just days in a step-down/lower case version of an ICU. 'Post' was removed from the revenue center code 0206 description, effective 10/1/96 (12/96 MEDPAR update). 0206 Is now defined as 'intermediate ICU'.

CODE TABLE : MEDPAR\_ICU\_IND\_TB

100. MEDPAR Coronary Care Indicator Code  
1 324 324

CHAR

The code indicating that the beneficiary has spent time under coronary care during the stay. It also specifies the type of coronary care unit.

DB2 ALIAS : UNDEFINED

SAS ALIAS : CRNRY\_CD

STANDARD ALIAS : MEDPAR\_CRNRY\_CARE\_IND\_CD

LENGTH : 1

DERIVATIONS :

This field is derived by checking for the presence of coronary care revenue center codes (listed below) on any of the claim records included in the stay. If more than one of the revenue center codes listed below are included on these claims, the code with the highest revenue center total charge amount is used.

SOURCE : NCH

LIMITATIONS :

There is approximately a 20% error rate in the revenue center code category 0214 due to coders misunderstanding the term 'post CCU' as including any day after a CCU stay rather than just days in a step-down/lower case version of a CCU. 'Post' was removed from the revenue center code 0214 description, effective 10/1/96 (12/96 MEDPAR update). 0214 Is now defined as 'intermediate CCU'.

CODE TABLE : MEDPAR\_CRNRY\_CARE\_IND\_TB

101. MEDPAR Pharmacy Indicator Code

1 325 325 NUM

The code indicating whether or not the beneficiary received drugs during the stay. It also specifies the type of drugs.

DB2 ALIAS : UNDEFINED

SAS ALIAS : PHRMICYCD

STANDARD ALIAS : MEDPAR\_PHRMICY\_IND\_CD

LENGTH : 1 SIGNED : N

DERIVATIONS :

This field is derived by checking for the presence of drug-specific revenue center codes (listed below) on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_PHRMICY\_IND\_TB

102. MEDPAR Transplant Indicator Code

1 326 326 NUM

The code indicating whether or not the beneficiary received a organ transplant during the stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : TRNSPLNT

STANDARD ALIAS : MEDPAR\_TRNSPLNT\_IND\_CD

LENGTH : 1 SIGNED : N

DERIVATIONS :

This field is derived by checking for the presence of the transplant revenue center code (listed below) on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_TRNSPLNT\_IND\_TB

103. MEDPAR Radiology Indicators Group  
6 327 332 GRP

104. MEDPAR Radiology Oncology Indicator Switch  
1 327 327 NUM

The switch indicating whether or not the beneficiary received radiology oncology services during the stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : ONCLGYSW

STANDARD ALIAS : MEDPAR\_RDLGY\_ONCLGY\_IND\_SW

LENGTH : 1 SIGNED : N

DERIVATIONS :

This field is derived by checking for revenue center code 028X on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_RDLGY\_ONCLGY\_IND\_TB

105. MEDPAR Radiology Diagnostic Indicator Switch  
1 328 328 NUM

The switch indicating whether or not the beneficiary received radiology diagnostic services during the stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : DGNSTCSW

STANDARD ALIAS : MEDPAR\_RDLGY\_DGNSTC\_IND\_SW

LENGTH : 1 SIGNED : N

DERIVATIONS :  
This field is derived by checking for revenue center code  
032x on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_RDLGY\_DGNSTC\_IND\_TB

106. MEDPAR Radiology Therapeutic Indicator Switch

1 329 329 NUM

The switch indicating whether or not the beneficiary  
received radiology therapeutic services during the stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : THRPTCSW

STANDARD ALIAS : MEDPAR\_RDLGY\_THRPTC\_IND\_SW

LENGTH : 1 SIGNED : N

DERIVATIONS :  
This field is derived by checking for revenue center code  
033X on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_RDLGY\_THRPTC\_IND\_TB

107. MEDPAR Radiology Nuclear Medicine Indicator Switch

1 330 330 NUM

The switch indicating whether or not the beneficiary  
received radiology nuclear medicine services during the  
stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : NUCLR\_SW

STANDARD ALIAS : MEDPAR\_RDLGY\_NUCLR\_MDCN\_IND\_SW

LENGTH : 1 SIGNED : N

DERIVATIONS :  
This field is derived by checking for revenue center code  
034x on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_RDLGY\_NUCLR\_MDCN\_IND\_TB

108. MEDPAR Radiology CT Scan Indicator Switch

1 331 331 NUM

The switch indicating whether or not the beneficiary received radiology computed tomographic (CT) scan services during the stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : CTSCANSW

STANDARD ALIAS : MEDPAR\_RDLGY\_CT\_SCAN\_IND\_SW

LENGTH : 1 SIGNED : N

DERIVATIONS :

This field is derived by checking for revenue center code 035X on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_RDLGY\_CT\_SCAN\_IND\_TB

109. MEDPAR Radiology Other Imaging Indicator Switch

1 332 332 NUM

The switch indicating whether or not the beneficiary received radiology other imaging services during the stay.

DB2 ALIAS : UNDEFINED

SAS ALIAS : IMGNG\_SW

STANDARD ALIAS : MEDPAR\_RDLGY\_OTHR\_IMGNG\_IND\_SW

LENGTH : 1 SIGNED : N

DERIVATIONS :

This field is derived by checking for revenue center code 040X on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_RDLGY\_OTHR\_IMGNG\_IND\_TB

110. MEDPAR Outpatient Services Indicator Code  
1 333 333

NUM

The code indicating whether or not the beneficiary has received outpatient services, ambulatory surgical care, or both.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : OPSRVCCD  
STANDARD ALIAS : MEDPAR\_OP\_SRVC\_IND\_CD

LENGTH : 1 SIGNED : N

DERIVATIONS :

This field is derived by checking for the presence of the outpatient services revenue center codes listed below on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_OP\_SRVC\_IND\_TB

111. MEDPAR Organ Acquisition Indicator Code  
2 334 335

CHAR

The code indicating the type of organ acquisition received by the beneficiary during the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : ORGNCD  
STANDARD ALIAS : MEDPAR\_ORGN\_ACQSTN\_IND\_CD

LENGTH : 2

DERIVATIONS :

This field is derived by checking for the presence of the organ acquisition indicator revenue center codes listed below on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_ORGN\_ACQSTN\_IND\_TB

112. MEDPAR ESRD Setting Indicator Code  
2 336 337

CHAR

The code indicating the type of dialysis received by the beneficiary during the stay. Up to 5 2-position codes may be present.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : ESRDSETG  
STANDARD ALIAS : MEDPAR\_ESRD\_SETG\_IND\_CD

LENGTH : 2

DERIVATIONS :  
This field is derived from the presence of the dialysis revenue center codes listed below on any of the claim records included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_ESRD\_SETG\_IND\_TB

OCCURS MIN: 0 OCCURS MAX: 5

113. MEDPAR Present On Admission Diagnosis Code Group  
27 346 372 GRP

114. MEDPAR Claim Present on Admission Diagnosis Code Count  
2 346 347 NUM

Effective with Version 'J', the count of the number of Present on Admission (POA) codes reported on the Inpatient/SNF claim.  
The purpose of this count is to indicate how many claim POA diagnosis trailers are present.

DB2 ALIAS : CLM\_POA\_TRLR\_CNT  
SAS ALIAS : IPPOACNT  
STANDARD ALIAS : MEDPAR\_POA\_DGNS\_CD\_CNT

LENGTH : 2 SIGNED : N

SOURCE :

EDIT RULES :  
Range: 0 to 25

115. MEDPAR Claim Present on Admission Diagnosis Indicator Code

1 348 348 CHAR

Effective with Version 'J', the code used to identify the present on admission(POA) indicator code associated with the diagnosis codes (principal and secondary). The present on admission indicators for the diagnosis E codes are stored in the present on admission diagnosis E trailer.

DB2 ALIAS : UNDEFINED  
STANDARD ALIAS : MEDPAR\_POA\_DGNS\_IND\_CD

LENGTH : 1

OCCURS MIN: 0 OCCURS MAX: 25

116. MEDPAR Present On Admission Diagnosis E Code Group

14 373 386 GRP

117. MEDPAR Claim Present on Admission Diagnosis E Code Count

2 373 374 NUM

Effective with Version 'J', the count of the number of Present on Admission (POA) codes associated with the diagnosis E codes reported on the Inpatient/SNF claim. The purpose of this count is to indicate how many claim POA diagnosis E trailers are present.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : IPPECNT  
STANDARD ALIAS : MEDPAR\_POA\_DGNS\_E\_CD\_CNT

LENGTH : 2 SIGNED : N

SOURCE :

EDIT RULES :  
Range: 0 to 12

118. MEDPAR Claim Present on Admission Diagnosis E Indicator Code

1 375 375 CHAR



Effective with Version 'J', the code used to identify the present on admission(POA) indicator code associated with the diagnosis E codes.

DB2 ALIAS : UNDEFINED  
STANDARD ALIAS : MEDPAR\_POA\_DGNS\_E\_IND\_CD

LENGTH : 1

OCCURS MIN: 0 OCCURS MAX: 12

119. MEDPAR Diagnosis Code Group  
178 387 564 GRP

120. MEDPAR Diagnosis Code Count  
2 387 388 NUM

The count of the number of diagnosis codes included in the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DGNSCNT  
STANDARD ALIAS : MEDPAR\_DGNS\_CD\_CNT

LENGTH : 2 SIGNED : N

DERIVATIONS :  
This field is derived by adding '1' to the count of the other diagnosis codes reported on the last claim record included in the stay. The '1' represents the principal diagnosis code, which is reported separately from the other diagnosis.

SOURCE : NCH

EDIT RULES :  
RANGE: 1 through 10

121. MEDPAR Diagnosis Version Code  
1 389 389 CHAR

Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DVRSNCD  
STANDARD ALIAS : MEDPAR\_DGNS\_VRSN\_CD

LENGTH : 1

CODE TABLE : CLM\_DGNS\_VRSN\_TB

122. MEDPAR Diagnosis Code

7 390 396 CHAR

The diagnosis code identifying the beneficiary's principal or other diagnosis (including E code).

NOTE:

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

NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

NOTE2: Effective with Version 'J', the diagnosis E codes are stored in a separate trailer (CLM\_DGNS\_E\_GRP).

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DGNS\_CD

LENGTH : 7

OCCURS MIN: 0 OCCURS MAX: 25

123. MEDPAR Diagnosis Code E Group

87 565 651 GRP

124. MEDPAR Diagnosis E Code Count

2 565 566 NUM

Effective with Version 'J', the count of the number of diagnosis E codes reported on the Inpatient/SNF claim. The purpose of this count is to indicate how many diagnosis E trailers are present.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : IPDECNT

LENGTH : 2 SIGNED : N

SOURCE :

EDIT RULES :  
Range: 0 to 12

125. MEDPAR Diagnosis E Version Code

1 567 567 CHAR

Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : EVRSNCD  
STANDARD ALIAS : MEDPAR\_DGNS\_E\_VRSN\_CD

LENGTH : 1

CODE TABLE : CLM\_DGNS\_VRSN\_TB

126. MEDPAR Diagnosis E Code

7 568 574 CHAR

Effective with Version J, the code used to identify the external cause of injury, poisoning, or other adverse affect.

NOTE: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

During the Version 'J' conversion this field was populated throughout history.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : EDGNSCD  
STANDARD ALIAS : MEDPAR\_DGNS\_E\_CD

LENGTH : 7

SOURCE : CWF

EDIT RULES :  
ICD-9-CM

OCCURS MIN: 0 OCCURS MAX: 12

127. MEDPAR Surgical Procedure Indicator Switch  
1 652 652

CHAR

The switch indicating whether or not there were any surgical procedures performed during the beneficiary's stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PRCDRSW  
STANDARD ALIAS : MEDPAR\_SRGCL\_PRCDR\_IND\_SW

LENGTH : 1

DERIVATIONS :  
This field is derived by checking for the presence of procedure codes on the last claim record included in the stay.

SOURCE : NCH

CODE TABLE : MEDPAR\_SRGCL\_PRCDR\_IND\_TB

128. MEDPAR Surgical Procedure Group  
280 653 932

GRP

129. MEDPAR Surgical Procedure Code Count  
2 653 654

NUM

The count of the number of surgical procedure codes included

in the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PRCDRCNT  
STANDARD ALIAS : MEDPAR\_SRGCL\_PRCDR\_CD\_CNT

LENGTH : 2 SIGNED : N

DERIVATIONS :

This field is derived by counting the procedure codes that are reported on the last claim record included in the stay.

SOURCE : NCH

EDIT RULES :

RANGE: 0 through 6

130. MEDPAR Surgical Procedure Performed Date Count

2 655 656 NUM

The count of the number of dates associated with the surgical procedures included in the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PRCDTCNT  
STANDARD ALIAS : MEDPAR\_SRGCL\_PRCDR\_DT\_CNT

LENGTH : 2 SIGNED : N

DERIVATIONS :

This field is derived by counting the surgical procedures dates that are reported on the last claim record included in the stay.

SOURCE : NCH

EDIT RULES :

RANGE: 0 THROUGH 6

131. MEDPAR Surgical Procedure Version Code

1 657 657 CHAR

Effective with Version 'J', the code used to indicate if the surgical procedure code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PVRSNCD  
STANDARD ALIAS : MEDPAR\_SRGL\_PRCR\_VRSN\_CD

LENGTH : 1

CODE TABLE : CLM\_PRCR\_VRSN\_TB

132. MEDPAR Surgical Procedure Code  
7 658 664

CHAR

The ICD-9-CM code identifying the principal or other surgical procedure performed during the beneficiary's stay. This element is part of the MEDPAR surgical procedure group. It may occur up to 6 times.

NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PRCR\_CD  
STANDARD ALIAS : MEDPAR\_SRGL\_PRCR\_CD

LENGTH : 7

DERIVATIONS :

This field is the actual principal surgical procedure code (1st occurrence) or one of up to 5 other surgical procedure codes that may be present on the last claim record included in the stay.

SOURCE : NCH

EDIT RULES :

4 POSITION Surgical Procedure Code LEFT JUSTIFIED

OCCURS MIN: 0 OCCURS MAX: 25

133. MEDPAR Surgical Procedure Performed Date

4 833 836 PACK

The date on which the icd-9-cm surgical procedure was performed during the beneficiary's stay. This element is part of the MEDPAR surgical procedure group. It can occur up to 6 times.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PRCDR\_DT  
STANDARD ALIAS : MEDPAR\_SRGCL\_PRCDR\_PRFRM\_DT

LENGTH : 7 SIGNED : Y

DERIVATIONS :

This field is the actual date associated with the principal or one of up to 5 other surgical procedure codes that is present on the last claim record included in the stay.

SOURCE : NCH

EDIT RULES :  
+YYYYDDD

OCCURS MIN: 0 OCCURS MAX: 25

134. MEDPAR Blood Pints Furnished Quantity

2 933 934 PACK

The quantity of blood (number of whole pints) furnished to the beneficiary during the stay. Note: this includes blood pints replaced as well as not replaced.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : BLDFRNSH  
STANDARD ALIAS : MEDPAR\_BLOOD\_PT\_FRNSH\_QTY

LENGTH : 3 SIGNED : Y

DERIVATIONS :

This field is derived by accumulating the blood pints furnished quantity from all claim records included in the stay.

SOURCE : NCH

## 135. MEDPAR Beneficiary Identification Code

2 935 936 CHAR

The BIC reported on the first claim record included in the stay, representing the values existing on the CWF beneficiary master record on the date the CWF host site processed the claim.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : BIC  
STANDARD ALIAS : MEDPAR\_BENE\_IDENT\_CD

LENGTH : 2

SOURCE : NCH

CODE TABLE : BENE\_IDENT\_TB

## 136. MEDPAR DRG Code

3 937 939 NUM

The code indicating the DRG to which the claims that comprise the stay belong for payment purposes.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DRG\_CD  
STANDARD ALIAS : MEDPAR\_DRG\_CD

LENGTH : 3 SIGNED : N

## DERIVATIONS :

This field comes from the actual DRG code that is present on the last claim record included in the stay.  
exception: if the DRG code is not present (e.g., claims from Maryland and PPS-exempt hospital units do not have a DRG), a valid DRG is obtained using the grouper software and is moved to this field.

SOURCE : NCH

## 137. MEDPAR Discharge Destination Code

2 940 941 NUM

The code primarily indicating the destination of the



beneficiary upon discharge from a facility; also denotes death or SNF/still patient situations.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DSTNTNCD  
STANDARD ALIAS : MEDPAR\_DSCHRG\_DSTNTN\_CD

LENGTH : 2 SIGNED : N

DERIVATIONS :  
This field comes from the claim status code that is present on the last claim record included in the stay.

SOURCE : NCH

CODE TABLE : PTNT\_DSCHRG\_STUS\_TB

138. MEDPAR DRG/Outlier Stay Code

1 942 942 NUM

The code identifying (1) for PPS providers if the stay has an unusually long length (day outlier) or high cost (cost outlier); or (2) for non-PPS providers the source for developing the DRG.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : OUTLR\_CD  
STANDARD ALIAS : MEDPAR\_DRG\_OUTLIER\_STAY\_CD

LENGTH : 1 SIGNED : N

DERIVATIONS :  
This field is the actual DRG outlier stay code that is present on the last claim record included in the stay.  
Applicable to PPS providers:  
0 = No Outlier  
1 = Day Outlier  
2 = Cost Outlier

Applicable to Non-PPS Providers:  
6 = Valid DRG Received From Intermediary  
7 = HCFA-Developed DRG  
8 = HCFA-Developed DRG Using Claim Status Code  
9 = Not Groupable

			SOURCE	:	NCH
139. MEDPAR Beneficiary Primary Payer Code	1	943	943	CHAR	
The code indicating the type of payer who has primary responsibility for the payment of the Medicare beneficiary's claims related to the stay.					
DB2 ALIAS : UNDEFINED					
SAS ALIAS : PRPAY_CD					
STANDARD ALIAS : MEDPAR_BENE_PRMRY_PYR_CD					
LENGTH : 1					
DERIVATIONS :					
This field comes from the primary payer code that is present on the first claim record included in the stay.					
SOURCE : NCH					
CODE TABLE : MEDPAR_BENE_PRMRY_PYR_TB					
140. MEDPAR ESRD Condition Code	2	944	945	NUM	
The code indicating if the beneficiary had an ESRD condition reported during the stay.					
DB2 ALIAS : UNDEFINED					
SAS ALIAS : ESRD_CD					
STANDARD ALIAS : MEDPAR_ESRD_COND_CD					
LENGTH : 2 SIGNED : N					
DERIVATIONS :					
This field is derived by checking for condition codes 70 - 76 on any of the claim records included in the stay.					
SOURCE : NCH					
CODE TABLE : MEDPAR_ESRD_COND_TB					
141. MEDPAR Source Inpatient Admission Code	1	946	946	CHAR	

The code indicating the source of the beneficiary's admission to an Inpatient facility or, for newborn admission, the type of delivery.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : SRC\_ADMS  
STANDARD ALIAS : MEDPAR\_SRC\_IP\_ADMSN\_CD

LENGTH : 1

DERIVATIONS :

This field comes from the source Inpatient admission code that is present on the last claim record included in the stay.

SOURCE : NCH

CODE TABLE : CLM\_SRC\_IP\_ADMSN\_TB

142. MEDPAR Inpatient Admission Type Code

1 947 947 CHAR

The code indicating the type and priority of the beneficiary's admission to a facility for the Inpatient hospital stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : TYPE\_ADM  
STANDARD ALIAS : MEDPAR\_IP\_ADMSN\_TYPE\_CD

LENGTH : 1

DERIVATIONS :

This field comes from the Inpatient admission type code that is present on the last claim record included in the stay.

SOURCE : NCH

143. MEDPAR Fiscal Intermediary/Carrier Identification Number

5 948 952 CHAR

The identification of the intermediary processing the beneficiary's claims related to the stay.

NOTE: This field comes from the intermediary number that is present on the first claim record included in the stay.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : FICARR  
STANDARD ALIAS : MEDPAR\_FICARR\_IDENT\_NUM

LENGTH : 5

SOURCE : NCH

144. MEDPAR Admitting Diagnosis Code Group  
8 953 960 GRP

145. MEDPAR Admitting Diagnosis Version Code  
1 953 953 CHAR

Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010 the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : ADVRSNCD  
STANDARD ALIAS : MEDPAR\_ADMTG\_DGNS\_VRSN\_CD

LENGTH : 1

CODE TABLE : CLM\_ADMTG\_DGNS\_VRSN\_TB

146. MEDPAR Admitting Diagnosis Code  
7 954 960 CHAR

The ICD code indicating the beneficiary's initial diagnosis at the time of admission.

NOTE: This field comes from the admitting diagnosis code that is present on the last claim record included in the stay.

A diagnosis code on the institutional claim indicating the beneficiary's initial diagnosis

at admission.

NOTE1: Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, the admitting diagnosis (also known as reason for patient visit) was added to the Outpatient claim. This data was stored in positions 572-576 (FILLER) until the implementation of NCH/NMUD CR#2. Prior to 1/1/2004, this field was only present on inpatient claims.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services.

NOTE2: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : AD\_DGNS

LENGTH : 7

147. MEDPAR Admission Death Day Count  
3 961 963

PACK

The count of the number of days from the date the beneficiary was admitted to a facility to the beneficiary's date of death (DOD).

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DEATHDAY  
STANDARD ALIAS : MEDPAR\_ADMSN\_DEATH\_DAY\_CNT

LENGTH : 5 SIGNED : Y

DERIVATIONS :

This field is derived by counting the number of days between the MEDPAR admission date (the admission date present on the first claim record included in the stay) and MEDPAR beneficiary death date (the death date present on the enrollment database, which is accessed prior to creation of the quarterly MEDPAR file).

SOURCE : NCH/EDB

LIMITATIONS :

REFER TO :

MEDPAR\_ADMSN\_DEATH\_DAY\_CNT\_LIM

148. FILLER

4 964 967

CHAR

DB2 ALIAS : FILLER

LENGTH : 4

149. MEDPAR Internal Use (By IPSB) Code

3 968 970

NUM

Limited availability; for internal use only. Where not available, this field will contain zeroes.

DB2 ALIAS : UNDEFINED

SAS ALIAS : IPSBCD

STANDARD ALIAS : MEDPAR\_INTRNL\_USE\_IPSB\_CD

LENGTH : 3 SIGNED : N

150. MEDPAR Internal Use File Date Code

1 971 971

NUM

Limited availability; for internal use only to to identify fiscal year/calendar year segments. Where not available, this field will contain a zero.

DB2 ALIAS : UNDEFINED

SAS ALIAS : FILDTC

STANDARD ALIAS : MEDPAR\_INTRNL\_USE\_FIL\_DT\_CD

LENGTH : 1 SIGNED : N

151. MEDPAR Internal Use Sample Size Code

1 972 972

NUM

Limited availability; for internal use only to identify the MEDPAR sample size: 20% (HIC 9th digit = 0, 5); 20% (HIC 9th digit = 4, 8; 60% (remainder). Where not available, this field will contain a zero.

DB2 ALIAS : UNDEFINED

SAS ALIAS : SMPLSIZE  
STANDARD ALIAS : MEDPAR\_INTRNL\_USE\_SMPL\_SIZE\_CD

LENGTH : 1 SIGNED : N

152. MEDPAR Warning Indicators Code

9 973 981 PACK

The codes (commonly called warning indicators) specifying detailed billing information obtained from the claims analyzed for the stay process. The purpose of these codes is to provide additional information for the MEDPAR user; i.e., let the user know whether or not the stay included adjustments, a single claim or multiple claims, any error conditions, etc..

DB2 ALIAS : UNDEFINED  
SAS ALIAS : WRNGCD  
STANDARD ALIAS : MEDPAR\_WRNG\_IND\_CD

LENGTH : 17 SIGNED : Y

DERIVATIONS :

This field is packed. Each of the digits identify a specific item of interest to users of the MEDPAR file. Warning indicators 1 and 6, and the first two values of indicator 8, are set early in the process - while processing all claims through the final action algorithm, prior to the creation of the stay record. The other indicators are derived from the claims remaining after the final action processing, which are used to create the stay record.

SOURCE : MEDPAR

CODE TABLE : MEDPAR\_WRNG\_IND\_TB

153. FILLER

19 982 1000

CHAR

DB2 ALIAS : FILLER

LENGTH : 19

\*\*\*\*\*

H3PM.R\_RIF\_MAIN\_Q,Q1,F

1

LIMITATIONS APPENDIX FOR RECORD: MEDPAR\_1000\_REC  
AS OF: 04/04/2011

MEDPAR\_ADMSN\_DEATH\_DAY\_CNT\_LIM

FULL NAME: MEDPAR Admission Death Day Count                      Limitation

DESCRIPTION :

MEDPAR Admission Death Day Count calculated incorrectly,  
on both the 3/00 and 6/00 MEDPAR updates.

BACKGROUND :

Both the 3/00 and 6/00 MEDPAR updates incorrectly calculated the mortality days; i.e., days between the admission date and the beneficiary date of death. Users of the regular unencrypted MEDPAR file, this is not a problem, as the count can be calculated using the admission date and the date of death. The problem is with the encrypted file (the expanded modified MEDPAR) because the fields needed to calculate the mortality days are ranged.

CORRECTIVE ACTION :

The problem was corrected with the 12/00 MEDPAR update. NOTE: For users of the expanded modified MEDPAR file who needs the mortality days, the 12/00 update of the FY1999 file can be given as a replacement.

SOURCE:

CONTACT : OIS/EDG/DMUDD

MEDPAR\_BLOOD\_DDCTBL\_AMT\_LIM

FULL NAME: MEDPAR Blood Deductible Amount Limitation

DESCRIPTION :

It was discovered that the blood deductible amounts were incorrect on the old MEDPAR Files.

BACKGROUND :

Users of the MEDPAR data were comparing money amounts and counts present on the new MEDPAR file (created 6/95 using NCH Nearline File as the source) to that reported on the old MEDPAR File (created 3/95 and prior from claims from the Medicare Quality Assurance System) for Fiscal Year 1994. They discovered that the blood deductible amount on the new MEDPAR was greater than that of the old MEDPAR.



During NCH's investigation it was determined that the old 500-character MEDPAR incorrectly used a different field to report the blood deductible; specifically the noncovered charges derived from blood use Revenue Center codes 0380-0389. The new program correctly used the NCH field, BENE\_BLOOD\_DDCTBL\_LBLTY\_AMT, which is derived from a value code (CLM\_VAL\_AMT associated with CLM\_VAL\_CD = '6').

It is believed that all MEDPAR files created prior to 6/95 in the 500 character version are affected. MEDPAR 500 was first available with calendar year and fiscal year 9/91 updates for year 1987 forward.

NOTE: This anomaly also impacts the DRG Price Amount on the old MEDPAR file because it is calculated from a number of fields including the blood deductible.

SOURCE:

CONTACT : OIS/EDG/DMUDD

MEDPAR\_DOD\_LIM

FULL NAME: MEDPAR Date of Death Limitation

DESCRIPTION :

The Date of Death on the MEDPAR files were not up-to-date for four cycles.

BACKGROUND :

The MEDPAR process pulls in 10 segments of the HISKEW file, to get the date of death. The HISKEW file names were changed with no notification the change was being made. Because of this, MEDPAR kept using the HISKEW that was created in June 2000.

The incomplete MEDPAR cycles are: 12/2000, 3/2001, 6/2001 and 9/2001 (9/2000 MEDPAR was not run).

CORRECTIVE ACTION :

Since this anomaly causes no major problem to the prime user of this data, a rerun will not take place.

NOTE: The 12/01 quarterly update will access up-to-date information.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 12/01/00  
END DATE : 09/30/01  
DISCOVERY DATE : 01/16/02  
CONTACT : OIS/EDG/DMUDD

MEDPAR\_DRG\_PRICE\_AMT\_LIM

FULL NAME: MEDPAR DRG Price Amount Limitation

DESCRIPTION :

IT WAS DISCOVERED THAT THE DRG PRICE AMOUNT WAS INCORRECT ON THE OLD MEDPAR FILES.

BACKGROUND :

Users of the MEDPAR data were comparing money amounts and counts present on the new MEDPAR file (created 6/95 using NCH Nearline File as the source) to that reported on the old MEDPAR File (created 3/95 and prior from claims from the Medicare Quality Assurance System) for Fiscal Year 1994. They discovered that the DRG price amount on the new MEDPAR contained incorrect amounts.

NOTE: This anomaly occurs because the DRG price amount is calculated from a number of fields including the blood deductible amount, which was discovered to be populated incorrectly.

During NCH's investigation it was determined that the old 500-character MEDPAR incorrectly used a different field to report the blood deductible; specifically the noncovered charges derived from blood use Revenue Center codes 0380-0389. The new program correctly used the NCH field, BENE\_BLOOD\_DDCTBL\_LBLTY\_AMT, which is derived from a value code (CLM\_VAL\_AMT associated with CLM\_VAL\_CD = '6').

It is believed that all MEDPAR files created prior to 6/95 in the 500 character version were affected. MEDPAR 500 was first available with calendar year and fiscal year 9/91 updates for year 1987 forward.

SOURCE:

MEDPAR\_MAR\_QTRLY\_UPDT\_LIM

FULL NAME: MEDPAR March Quarterly Update Limitation

DESCRIPTION :

The 3/01 quarterly update of the FY00 file containing fewer records than the 12/00 version.

BACKGROUND :

The 3/01 quarterly update of the FY00 file has about 50,000 fewer records than the 12/00 update. The problem originated from modified programs required to process Version 'I' input. There was an omission of a sort step from the modified Version 'I' processing procedures.

CORRECTIVE ACTION :

The sort sequence was corrected and the 3/01 in-

correct datasets were replaced with new files on  
7/17/01.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 04/01/01  
END DATE : 07/17/01  
CONTACT : OIS/EDG/DMUDD

04/04/2011

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H3PM.R\_RIF\_LIM\_Q,F

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TABLE OF CODES APPENDIX  
FROM CA REPOSITORY RIF REPORT

MEDPAR\_1000\_REC

BENE\_IDENT\_TB

Beneficiary Identification Code (BIC) Table

Social Security Administration:

A = Primary claimant  
B = Aged wife, age 62 or over (1st  
claimant)  
B1 = Aged husband, age 62 or over (1st  
claimant)  
B2 = Young wife, with a child in her care  
(1st claimant)  
B3 = Aged wife (2nd claimant)  
B4 = Aged husband (2nd claimant)  
B5 = Young wife (2nd claimant)  
B6 = Divorced wife, age 62 or over (1st  
claimant)  
B7 = Young wife (3rd claimant)  
B8 = Aged wife (3rd claimant)  
B9 = Divorced wife (2nd claimant)  
BA = Aged wife (4th claimant)  
BD = Aged wife (5th claimant)  
BG = Aged husband (3rd claimant)

BH = Aged husband (4th claimant)  
BJ = Aged husband (5th claimant)  
BK = Young wife (4th claimant)  
BL = Young wife (5th claimant)  
BN = Divorced wife (3rd claimant)  
BP = Divorced wife (4th claimant)  
BQ = Divorced wife (5th claimant)  
BR = Divorced husband (1st claimant)  
BT = Divorced husband (2nd claimant)  
BW = Young husband (2nd claimant)  
BY = Young husband (1st claimant)  
C1-C9,CA-CZ = Child (includes minor, student  
                  or disabled child)  
D = Aged widow, 60 or over (1st claimant)  
D1 = Aged widower, age 60 or over (1st  
      claimant)  
D2 = Aged widow (2nd claimant)  
D3 = Aged widower (2nd claimant)  
D4 = Widow (remarried after attainment of  
      age 60) (1st claimant)  
D5 = Widower (remarried after attainment of  
      age 60) (1st claimant)  
D6 = Surviving divorced wife, age 60 or over  
      (1st claimant)  
D7 = Surviving divorced wife (2nd claimant)  
D8 = Aged widow (3rd claimant)  
D9 = Remarried widow (2nd claimant)  
DA = Remarried widow (3rd claimant)  
DD = Aged widow (4th claimant)  
DG = Aged widow (5th claimant)  
DH = Aged widower (3rd claimant)  
DJ = Aged widower (4th claimant)  
DK = Aged widower (5th claimant)  
DL = Remarried widow (4th claimant)  
DM = Surviving divorced husband (2nd  
      claimant)  
DN = Remarried widow (5th claimant)  
DP = Remarried widower (2nd claimant)  
DQ = Remarried widower (3rd claimant)  
DR = Remarried widower (4th claimant)  
DS = Surviving divorced husband (3rd  
      claimant)  
DT = Remarried widower (5th claimant)  
DV = Surviving divorced wife (3rd claimant)  
DW = Surviving divorced wife (4th claimant)

DX = Surviving divorced husband (4th  
claimant)  
DY = Surviving divorced wife (5th claimant)  
DZ = Surviving divorced husband (5th  
claimant)  
E = Mother (widow) (1st claimant)  
E1 = Surviving divorced mother (1st  
claimant)  
E2 = Mother (widow) (2nd claimant)  
E3 = Surviving divorced mother (2nd  
claimant)  
E4 = Father (widower) (1st claimant)  
E5 = Surviving divorced father (widower)  
(1st claimant)  
E6 = Father (widower) (2nd claimant)  
E7 = Mother (widow) (3rd claimant)  
E8 = Mother (widow) (4th claimant)  
E9 = Surviving divorced father (widower)  
(2nd claimant)  
EA = Mother (widow) (5th claimant)  
EB = Surviving divorced mother (3rd  
claimant)  
EC = Surviving divorced mother (4th  
claimant)  
ED = Surviving divorced mother (5th  
claimant)  
EF = Father (widower) (3rd claimant)  
EG = Father (widower) (4th claimant)  
EH = Father (widower) (5th claimant)  
EJ = Surviving divorced father (3rd  
claimant)  
EK = Surviving divorced father (4th  
claimant)  
EM = Surviving divorced father (5th  
claimant)  
F1 = Father  
F2 = Mother  
F3 = Stepfather  
F4 = Stepmother  
F5 = Adopting father  
F6 = Adopting mother  
F7 = Second alleged father  
F8 = Second alleged mother  
J1 = Primary prouty entitled to HIB  
(less than 3 Q.C.) (general fund)

J2 = Primary prouty entitled to HIB  
(over 2 Q.C.) (RSI trust fund)  
J3 = Primary prouty not entitled to HIB  
(less than 3 Q.C.) (general fund)  
J4 = Primary prouty not entitled to HIB  
(over 2 Q.C.) (RSI trust fund)  
K1 = Prouty wife entitled to HIB (less than  
3 Q.C.) (general fund) (1st claimant)  
K2 = Prouty wife entitled to HIB (over 2  
Q.C.) (RSI trust fund) (1st claimant)  
K3 = Prouty wife not entitled to HIB (less  
than 3 Q.C.) (general fund) (1st  
claimant)  
K4 = Prouty wife not entitled to HIB (over  
2 Q.C.) (RSI trust fund) (1st  
claimant)  
K5 = Prouty wife entitled to HIB (less than  
3 Q.C.) (general fund) (2nd claimant)  
K6 = Prouty wife entitled to HIB (over 2  
Q.C.) (RSI trust fund) (2nd claimant)  
K7 = Prouty wife not entitled to HIB (less  
than 3 Q.C.) (general fund) (2nd  
claimant)  
K8 = Prouty wife not entitled to HIB (over  
2 Q.C.) (RSI trust fund) (2nd  
claimant)  
K9 = Prouty wife entitled to HIB (less than  
3 Q.C.) (general fund) (3rd claimant)  
KA = Prouty wife entitled to HIB (over 2  
Q.C.) (RSI trust fund) (3rd claimant)  
KB = Prouty wife not entitled to HIB (less  
than 3 Q.C.) (general fund) (3rd  
claimant)  
KC = Prouty wife not entitled to HIB (over  
2 Q.C.) (RSI trust fund) (3rd  
claimant)  
KD = Prouty wife entitled to HIB (less than  
3 Q.C.) (general fund) (4th claimant)  
KE = Prouty wife entitled to HIB (over 2 Q.C.  
(4th claimant)  
KF = Prouty wife not entitled to HIB (less  
than 3 Q.C.) (4th claimant)  
KG = Prouty wife not entitled to HIB (over  
2 Q.C.) (4th claimant)  
KH = Prouty wife entitled to HIB (less than

3 Q.C.)(5th claimant)  
KJ = Prouty wife entitled to HIB (over 2  
Q.C.) (5th claimant)  
KL = Prouty wife not entitled to HIB (less  
than 3 Q.C.)(5th claimant)  
KM = Prouty wife not entitled to HIB (over  
2 Q.C.) (5th claimant)  
M = Uninsured-not qualified for deemed HIB  
M1 = Uninsured-qualified but refused HIB  
T = Uninsured-entitled to HIB under deemed  
or renal provisions  
TA = MQGE (primary claimant)  
TB = MQGE aged spouse (first claimant)  
TC = MQGE disabled adult child (first claimant)  
TD = MQGE aged widow(er) (first claimant)  
TE = MQGE young widow(er) (first claimant)  
TF = MQGE parent (male)  
TG = MQGE aged spouse (second claimant)  
TH = MQGE aged spouse (third claimant)  
TJ = MQGE aged spouse (fourth claimant)  
TK = MQGE aged spouse (fifth claimant)  
TL = MQGE aged widow(er) (second claimant)  
TM = MQGE aged widow(er) (third claimant)  
TN = MQGE aged widow(er) (fourth claimant)  
TP = MQGE aged widow(er) (fifth claimant)  
TQ = MQGE parent (female)  
TR = MQGE young widow(er) (second claimant)  
TS = MQGE young widow(er) (third claimant)  
TT = MQGE young widow(er) (fourth claimant)  
TU = MQGE young widow(er) (fifth claimant)  
TV = MQGE disabled widow(er) fifth claimant  
TW = MQGE disabled widow(er) first claimant  
TX = MQGE disabled widow(er) second claimant  
TY = MQGE disabled widow(er) third claimant  
TZ = MQGE disabled widow(er) fourth claimant  
T2-T9 = Disabled child (second to ninth  
claimant)  
W = Disabled widow, age 50 or over (1st  
claimant)  
W1 = Disabled widower, age 50 or over (1st  
claimant)  
W2 = Disabled widow (2nd claimant)  
W3 = Disabled widower (2nd claimant)  
W4 = Disabled widow (3rd claimant)  
W5 = Disabled widower (3rd claimant)

W6 = Disabled surviving divorced wife (1st claimant)  
W7 = Disabled surviving divorced wife (2nd claimant)  
W8 = Disabled surviving divorced wife (3rd claimant)  
W9 = Disabled widow (4th claimant)  
WB = Disabled widower (4th claimant)  
WC = Disabled surviving divorced wife (4th claimant)  
WF = Disabled widow (5th claimant)  
WG = Disabled widower (5th claimant)  
WJ = Disabled surviving divorced wife (5th claimant)  
WR = Disabled surviving divorced husband (1st claimant)  
WT = Disabled surviving divorced husband (2nd claimant)

Railroad Retirement Board:

NOTE:

Employee: a Medicare beneficiary who is still working or a worker who died before retirement  
Annuitant: a person who retired under the railroad retirement act on or after 03/01/37  
Pensioner: a person who retired prior to 03/01/37 and was included in the railroad retirement act

10 = Retirement - employee or annuitant  
80 = RR pensioner (age or disability)  
14 = Spouse of RR employee or annuitant (husband or wife)  
84 = Spouse of RR pensioner  
43 = Child of RR employee  
13 = Child of RR annuitant  
17 = Disabled adult child of RR annuitant  
46 = Widow/widower of RR employee  
16 = Widow/widower of RR annuitant  
86 = Widow/widower of RR pensioner  
43 = Widow of employee with a child in her care  
13 = Widow of annuitant with a child in her care



83 = Widow of pensioner with a child in her care  
45 = Parent of employee  
15 = Parent of annuitant  
85 = Parent of pensioner  
11 = Survivor joint annuitant  
(reduced benefits taken to insure benefits  
for surviving spouse)

BENE\_MDCR\_STUS\_TB

CWF Beneficiary Medicare Status Table

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

BENE\_RACE\_TB

Beneficiary Race Table

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

BENE\_SEX\_IDENT\_TB

Beneficiary Sex Identification Table

1 = Male  
2 = Female  
0 = Unknown

CLM\_ADMTG\_DGNS\_VRSN\_TB

Claim Admitting Diagnosis Version Code Table

Valid Values:

9 = ICD-9  
0 = ICD-10

CLM\_DGNS\_VRSN\_TB

Claim Diagnosis Version Code Table

Valid Values:

- 9 = ICD-9
- 0 = ICD-10

CLM\_PRCDR\_VRSN\_TB

Claim Procedure Version Code Table

Valid Values:

- 9 = ICD-9
- 0 = ICD-10

CLM\_SRC\_IP\_ADMSN\_TB

Claim Source Of Inpatient Admission Table

**\*\*For Inpatient/SNF Claims:\*\***

- 0 = ANOMALY: invalid value, if present,  
translate to '9'
- 1 = Non-Health Care Facility Point of Origin  
(Physician Referral) - The patient was  
admitted to this facility upon an order  
of a physician.
- 2 = Clinic referral - The patient was  
admitted upon the recommendation of  
this facility's clinic physician.
- 3 = HMO referral - Reserved for national  
assignment. (eff. 3/08)  
Prior to 3/08, HMO referral - The patient  
was admitted upon the recommendation of  
an health maintenance organization (HMO)  
physician.
- 4 = Transfer from hospital (Different Facility) -  
The patient was admitted to this facility  
as a hospital transfer from an acute care  
facility where he or she was an inpatient.
- 5 = Transfer from a skilled nursing  
facility (SNF) or Intermediate Care Facility

- (ICF) - The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.
- 6 = Transfer from another health care facility - The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list where he or she was an inpatient.
- 7 = Emergency room - The patient was admitted to this facility after receiving services in this facility's emergency room department. Obsolete - eff. 7/1/10
- 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. Includes transfers from incarceration facilities.
- 9 = Information not available - The means by which the patient was admitted is not known.
- A = Reserved for National Assignment. (eff. 3/08)  
Prior to 3/08 defined as: Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.
- B = Transfer from Another Home Health Agency -  
The patient was admitted to this home health agency as a transfer from another home health agency. (Discontinued July 1, 2010 - See Condition Code 47)
- C = Readmission to Same Home Health Agency -  
The patient was readmitted to this home health agency within the same home health episode period. (Discontinued July 1, 2010)
- D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer - The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.

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\*\*For Newborn Type of Admission\*\*

- 1 = Normal delivery - A baby delivered with out complications. Obsolete eff. 10/1/07
- 2 = Premature delivery - A baby delivered with time and/or weight factors qualifying it for premature status. Obsolete eff. 10/1/07
- 3 = Sick baby - A baby delivered with medical complications, other than those relating to premature status. Obsolete eff. 10/1/07
- 4 = Extramural birth - A baby delivered in a nonsterile environment. Obsolete eff. 10/1/07
- 5 = Born Inside this Hospital - eff. 10/1/07
- 6 = Born Outside of this Hospital - eff. 10/1/07
- 7-9 = Reserved for national assignment.

CTGRY\_EQTBL\_BENE\_IDENT\_TB                      Category Equatable Beneficiary Identification Code (BIC) Table

NCH BIC -----	SSA Categories -----
A	= A;J1;J2;J3;J4;M;M1;T;TA
B	= B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6; TB(F);TD(F);TE(F);TW(F)
B1	= B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M) TD(M);TE(M);TW(M)
B3	= B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2 W7;TG(F);TL(F);TR(F);TX(F)
B4	= B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG(M) TL(M);TR(M);TX(M)
B8	= B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4 W8;TH(F);TM(F);TS(F);TY(F)
BA	= BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9 WC;TJ(F);TN(F);TT(F);TZ(F)
BD	= BD;BL;BQ;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WF WJ;TK(F);TP(F);TU(F);TV(F)
BG	= BG;DH;DQ;DS;EF;EJ;W5;TH(M);TM(M);TS(M) TY(M)
BH	= BH;DJ;DR;DX;EG;EK;WB;TJ(M);TN(M);TT(M) TZ(M)
BJ	= BJ;DK;DT;DZ;EH;EM;WG;TK(M);TP(M);TU(M) TV(M)
C1	= C1;TC
C2	= C2;T2

C3 = C3;T3  
C4 = C4;T4  
C5 = C5;T5  
C6 = C6;T6  
C7 = C7;T7  
C8 = C8;T8  
C9 = C9;T9  
F1 = F1;TF  
F2 = F2;TQ  
F3-F8 = Equatable only to itself (e.g., F3 IS  
equatable to F3)  
CA-CZ = Equatable only to itself. (e.g., CA is  
only equatable to CA)

-----  
RRB Categories

10 = 10  
11 = 11  
13 = 13;17  
14 = 14;16  
15 = 15  
43 = 43  
45 = 45  
46 = 46  
80 = 80  
83 = 83  
84 = 84;86  
85 = 85

GEO\_SSA\_STATE\_TB

State Table

01 = Alabama  
02 = Alaska  
03 = Arizona  
04 = Arkansas  
05 = California  
06 = Colorado  
07 = Connecticut  
08 = Delaware  
09 = District of Columbia  
10 = Florida  
11 = Georgia

12 = Hawaii  
13 = Idaho  
14 = Illinois  
15 = Indiana  
16 = Iowa  
17 = Kansas  
18 = Kentucky  
19 = Louisiana  
20 = Maine  
21 = Maryland  
22 = Massachusetts  
23 = Michigan  
24 = Minnesota  
25 = Mississippi  
26 = Missouri  
27 = Montana  
28 = Nebraska  
29 = Nevada  
30 = New Hampshire  
31 = New Jersey  
32 = New Mexico  
33 = New York  
34 = North Carolina  
35 = North Dakota  
36 = Ohio  
37 = Oklahoma  
38 = Oregon  
39 = Pennsylvania  
40 = Puerto Rico  
41 = Rhode Island  
42 = South Carolina  
43 = South Dakota  
44 = Tennessee  
45 = Texas  
46 = Utah  
47 = Vermont  
48 = Virgin Islands  
49 = Virginia  
50 = Washington  
51 = West Virginia  
52 = Wisconsin  
53 = Wyoming  
54 = Africa  
55 = California  
56 = Canada & Islands

57 = Central America and West Indies  
 58 = Europe  
 59 = Mexico  
 60 = Oceania  
 61 = Philippines  
 62 = South America  
 63 = U.S. Possessions  
 64 = American Samoa  
 65 = Guam  
 66 = Commonwealth of the Northern Marianas Islands  
 67 = Texas  
 68 = Florida (eff. 10/2005)  
 69 = Florida (eff. 10/2005)  
 70 = Kansas (eff. 10/2005)  
 71 = Louisiana (eff. 10/2005)  
 72 = Ohio (eff. 10/2005)  
 73 = Pennsylvania (eff. 10/2005)  
 74 = Texas (eff. 10/2005)  
 80 = Maryland (eff. 8/2000)  
 97 = Northern Marianas  
 98 = Guam  
 99 = With 000 county code is American Samoa;  
      otherwise unknown

MEDPAR\_ADMSN\_DAY\_TB

MEDPAR Admission Day Code Table

1 = Sunday  
 2 = Monday  
 3 = Tuesday  
 4 = Wednesday  
 5 = Thursday  
 6 = Friday  
 7 = Saturday

MEDPAR\_BENE\_DEATH\_DT\_VRFY\_TB

MEDPAR Beneficiary Death Date Verified Code Table

V = Date of death verified (EDB received DOD from SSA's  
    MBR)  
 B = Date of death taken from claim (EDB received DOD  
    from claim)  
 N = Date of death not verified (neither V or B

applicable, but claim status code indicated death)  
Space = No date of death indicated

MEDPAR\_BENE\_DSCHRG\_STUS\_TB

MEDPAR Beneficiary Discharge Status Code Table

A = Discharged alive (claim status code other than 20 or 30)  
B = Discharged dead  
C = Still a patient

MEDPAR\_BENE\_PRMRY\_PYR\_TB

MEDPAR Beneficiary Primary Payer Code Table

A = Working aged bene/spouse with eghp  
B = ESRD bene in 18-month coordination period with eghp  
C = Conditional Medicare payment; future reimbursement expected  
D = Auto no-fault or any liability insurance  
E = Worker's compensation  
F = Phs or other federal agency (other than dept of veterans affairs)  
G = Working disabled  
H = Black lung  
I = Dept of veterans affairs  
J = Any liability insurance  
Z/BLANK = Medicare is primary payer

MEDPAR\_CRNRY\_CARE\_IND\_TB

MEDPAR Coronary Care Indicator Code Table

BLANK = No coronary care indication  
0 = General (revenue code 0210)  
1 = Myocardial (revenue code 0211)  
2 = Pulmonary care (revenue code 0212)  
3 = Heart transplant (revenue code 0213)  
4 = Intermediate CCU (revenue code 0214)

MEDPAR\_ESRD\_COND\_TB

MEDPAR ESRD Condition Code Table



00 = No ESRD Condition Codes  
70 = Self-Administered Epo  
71 = Full Care In Unit  
72 = Self-Care In Unit  
73 = Self-Care Training  
74 = Home Dialysis  
75 = Home Dialysis/100% Reimbursement  
76 = Backup-In-Facility Dialysis

MEDPAR\_ESRD\_SETG\_IND\_TB

MEDPAR ESRD Setting Indicator Code Table

00 = Ip renal dialysis-general (revenue code 0800)  
01 = Ip renal dialysis-hemodialysis (revenue code 0801)  
02 = Ip renal dialysis-peritoneal (non-capd: revenue code 0802)  
03 = Ip renal dialysis-capd (revenue code 0803)  
04 = Ip renal dialysis-ccpd (revenue code 0804)  
09 = Ip renal dialysis-other (revenue code 0809)  
20 = Hemodialysis-op-general (revenue code 0820)  
21 = Hemodialysis-op-hemodialysis/composite (revenue code 0821)  
22 = Hemodialysis-op-home supplies (revenue code 0822)  
23 = Hemodialysis-op-home equipment (revenue code 0823)  
24 = Hemodialysis-op-maintenance/100% (revenue code 0824)  
25 = Hemodialysis-op-support services (revenue code 0825)  
29 = Hemodialysis-op-other (revenue code 0829)  
30 = Peritoneal-op/home-general (revenue code 0830)  
31 = Peritoneal-op/home-peritoneal/composite (revenue code 0831)  
32 = Peritoneal-op/home-home supplies (revenue code 0832)  
33 = Peritoneal-op/home-home equipment (revenue code 0833)  
34 = Peritoneal-op/home-maintenance/100% (revenue code 0834)  
35 = Peritoneal-op/home-support services (revenue code 0835)  
39 = Peritoneal-op/home-other (revenue code 0839)  
40 = Capd-op-capd/general (revenue code 0840)  
41 = Capd-op-capd/composite (revenue code 0841)  
42 = Capd-op-home supplies (revenue code 0842)  
43 = Capd-op-home equipment (revenue code 0843)  
44 = Capd-op-maintenance/100% (revenue code 0844)  
45 = Capd-op-support services (revenue code 0845)  
49 = Capd-op-other (revenue code 0849)

50 = Ccpd-op-ccpd/general (revenue code 0850)  
51 = Ccpd-op-ccpd/composite (revenue code 0851)  
52 = Ccpd-op-home supplies (revenue code 0852)  
53 = Ccpd-op-home equipment (revenue code 0853)  
54 = Ccpd-op-maintenance/100% (revenue code 0854)  
55 = Ccpd-op-support services (revenue code 0855)  
59 = Ccpd-op-other (revenue code 0859)  
80 = Miscellaneous dialysis-general (revenue code 0880)  
81 = Miscellaneous dialysis-ultrafiltration (revenue code 0881)  
89 = Miscellaneous dialysis-other (revenue code 0889)  
BLANK = No ESRD setting indication

MEDPAR\_GHO\_PD\_TB

MEDPAR GHO Paid Code Table

1 = GHO has paid the provider  
Blank Or 0 = GHO has not paid the provider

MEDPAR\_ICU\_IND\_TB

MEDPAR Intensive Care Unit (ICU) Indicator Code

0 = General (revenue center 0200)  
1 = Surgical (revenue center 0201)  
2 = Medical (revenue center 0202)  
3 = Pediatric (revenue center 0203)  
4 = Psychiatric (revenue center 0204)

MEDPAR\_OP\_SRVC\_IND\_TB

MEDPAR Outpatient Services Indicator Codcode Table

0 = No outpatient services/ambulatory surgical care  
(revenue code other than 049X, 050X)  
1 = Outpatient services (revenue code 050X)  
2 = Ambulatory surgical care (revenue code 049X)  
3 = Outpatient services and ambulatory surgical care  
(revenue codes 049X and 050X)

MEDPAR\_ORGN\_ACQSTN\_IND\_TB

MEDPAR Organ Acquisition Indicator Code Table

K1 = General classification (revenue code 0810)  
K2 = Living donor kidney (revenue code 0811)  
K3 = Cadaver donor kidney (revenue code 0812)  
K4 = Unknown donor kidney (revenue code 0813)  
K5 = Other kidney acquisition (revenue code 0814)  
H1 = Cadaver donor heart (revenue code 0815)  
H2 = Other heart acquisition (revenue code 0816)  
L1 = Donor liver (revenue code 0817)  
O1 = Other organ acquisition (revenue code 0819)  
O2 = General acquisition (revenue code 0890)  
B1 = Bone donor bank (revenue code 0891)  
O3 = Organ donor bank other than kidney (revenue code 0892)  
S1 = Skin donor bank (revenue code 0893)  
O4 = Other donor bank (revenue code 0899)  
BLANK = No organ acquisition indication

MEDPAR\_PHRMCY\_IND\_TB

MEDPAR Pharmacy Indicator Code Table

0 = No drugs (revenue code other than those listed below)  
1 = General drugs and/pr IV therapy (revenue code 025x,  
026x)  
2 = Erythropoietin (epoetin: revenue code 0630, 0635,  
0637, 0639)  
3 = Blood clotting drugs (revenue code 0636)  
4 = General drugs and/or IV therapy; and epoetin  
(combination of values 1 and 2)  
5 = General drugs and/or IV therapy; and blood clotting  
drugs (combination of values 1 and 3)

MEDPAR\_PPS\_IND\_TB

MEDPAR PPS Indicator Code Table

0 = Non PPS  
2 = PPS

MEDPAR\_PRVDR\_NUM\_SPCL\_UNIT\_TB

MEDPAR Provider Number Special Unit Code

M = PPS-exempt psychiatric unit in CAH  
R = PPS-exempt rehabilitation unit in CAH  
S = PPS-exempt psychiatric unit

T = PPS-exempt rehabilitation unit  
U = Swing-bed short-term/acute care hospital  
W = Swing-bed long-term hospital  
Y = Swing-bed rehabilitation hospital  
Z = Swing-bed rural primary care hospital; eff  
10/97 changed to critical access hospitals  
Blanks = Not PPS-exempt or swing-bed designation

MEDPAR\_RDLGY\_CT\_SCAN\_IND\_TB                      MEDPAR Radiology CT Scan Indicator Switch Code Table

0 = No radiology CT scan (revenue code not 035X)  
1 = Yes radiology CT scan (revenue code 035X)

MEDPAR\_RDLGY\_DGNSTC\_IND\_TB                      MEDPAR Radiology Diagnostic Indicator Switch Code Table

0 = No radiology-diagnostic (revenue code not 032x)  
1 = Yes radiology-diagnostic (revenue code 032x)

MEDPAR\_RDLGY\_NUCLR\_MDCN\_IND\_TB                  MEDPAR Radiology Nuclear Medicine Indicator Switch Code Table

0 = No nuclear medicine (revenue code not 034x)  
1 = Yes nuclear medicine (revenue code 034x)

MEDPAR\_RDLGY\_ONCLGY\_IND\_TB                      MEDPAR Radiology Oncology Indicator Switch Code Table

0 = No radiology-oncology (revenue code not 028x)  
1 = Yes radiology-oncology (revenue code 028x)

MEDPAR\_RDLGY\_OTHR\_IMGNG\_IND\_TB                  MEDPAR Radiology Other Imaging Indicator Code Table

0 = No other imaging services (revenue code not 040x)  
1 = Yes other imaging services (revenue code 040x)

MEDPAR\_RDLGY\_THRPTC\_IND\_TB                      MEDPAR Radiology Therapeutic Indicator Code Table

0 = No radiology-therapeutic (revenue code not 033X)  
1 = Yes radiology-therapeutic (revenue code 033X)

MEDPAR\_SRGCL\_PRCDR\_IND\_TB MEDPAR Surgical Procedure Indicator Switch Code Table

0 = No surgery indicated  
1 = Yes surgery indicated

MEDPAR\_SS\_LS\_SNF\_IND\_TB MEDPAR Short Stay/Long Stay/SNF Indicator Code Table

N = SNF Stay (Prvdr3 = 5, 6, U, W, Y, or Z)  
S = Short-Stay (Prvdr3 = 0, M, R, S, T)  
L = Long-Stay (All Others)

MEDPAR\_TRNSPLNT\_IND\_TB MEDPAR Transplant Indicator Code Table

0 = No organ or kidney transplant  
(revenue code not 0362 or 0367)  
2 = Organ transplant other than kidney (revenue code  
0362)  
7 = Kidney transplant (revenue code 0367)

MEDPAR\_WRNG\_IND\_TB MEDPAR Warning Indicators Code Table

Warning indicator 1 ('adjustment indicator' derived  
from the presence of query code values noted below  
on any of the claim records included in the analysis):  
0 = No adjustment (no query code = 0 or 5)  
1 = Credit adjustment (query code = 0)  
2 = Debit adjustment (query code = 5)  
3 = Credit and debit adjustment (both query code = 0  
and 5)

Warning indicator 2 ('error condition' derived from  
checking the edit code trailer on the final action

claims(s) that comprise the stay):

0 = No error

1 = Error condition

Warning indicator 3 ('reimbursement/total charge indicator' derived after summing up fields on the final action claim(s) that comprise the stay; checks resulting Medicare payment amount (commonly called reimbursement), total charge amount, as well as beneficiary primary payer amount and utilization day count):

0 = Medicare payment amount and total charge amount > zeroes

1 = Medicare payment amount and total charge amount < zeroes

2 = Medicare payment amount is a credit

3 = Total charge amount is a credit

4 = Medicare payment amount, total charge amount, beneficiary primary payer claim payment amount, and utilization day count = zeroes

Warning indicator 4 ('utilization day/los day indicator' derived after summing up fields on the final action claim(s) that comprise the stay; compares resulting utilization day count and length-of-stay count):

0 = Utilization day count = los day count

1 = Utilization day count < los day count

2 = Utilization day count > los day count

warning indicator 5 ('single/multiple claim indicator' derived when the stay record is created by checking the number of final action claims that comprise the stay):

0 = Stay includes a single final action claim

1 = Stay includes multiple final action claims

2 = Stay includes multiple final action claims and beneficiary is still a patient (applicable to SNF stays only)

Warning indicator 6 ('intermediary cancel indicator' derived from the presence of the values noted below for intermediary claim action code and intermediary-

requested claim cancel reason code on any of the claims included in the analysis. If multiple claims contain these values, latest claim is used. If both specified action code and cancel reason code are present, cancel reason code takes priority.):

- 0 = No cancel action
- 1 = Cancel action by credit adjustment (action code = (2 or 6))
- 2 = Cancel action only (action code = 4)
- 3 = Coverage transfer (cancel reason code = C)
- 4 = Plan transfer (cancel reason code = P)
- 5 = Scramble (cancel reason code = S)
- 6 = Duplicate billing (cancel reason code = D)
- 7 = Other (cancel reason code = H)
- 8 = Combining 2 spells or 2 beneficiary records (cancel reason code = L)

Warning indicator 7 ('state/county numeric indicator' derived from checking the format of the beneficiary residence SSA state code and beneficiary residence county code on the final action claim(s) that comprise the stay; determine if in numeric range):

- 0 = State and county codes are valid numeric values
- 1 = State and county codes are not in numeric range
- 2 = State code is not in numeric range
- 3 = County code is not in numeric range

Warning indicator 8 ('duplicate indicator' derived from the presence of two claim records with the same claim number, admission date, provider number, claim from/thru date, HCFA process date and query code; death/admission date indicator derived by comparing the admission date on the final claim(s) that comprise the stay to the beneficiary death date):

- 0 = Do duplicate record
- 1 = Duplicate record
- 2 = Death date < admission date
- 3 = Death date < admission date and duplicate record

Warning indicator 9 ('pass-thru indicator' derived from the presence of a pass thru per diem amount on the final action claim(s) that comprise the stay):

0 = No pass thru per diem present (Non-PPS)  
1 = Pass thru per diem present on final action claim

Warning indicator 10 (eff 3/96 update) (rugs indicator applicable to 'nhcmq rugs III SNF demo' stay records derived from the presence of 9,000 series revenue center codes.)

0 = No rugs 9,000 series revenue center codes  
2 = Rugs 9,000 series revenue center code(s) with service date 1/1/96 or later  
3 = Rugs 9,000 series revenue center code(s) with service date 7/1/96 or later  
4 = Rugs 9,000 series revenue center code(s) with service date 1/1/97 or later

Warning indicators 11 - 17 (not yet assigned; zeroes will be present)

NCH\_CLM\_TYPE\_TB

NCH Claim Type Table

10 = HHA claim  
20 = Non swing bed SNF claim  
30 = Swing bed SNF claim  
40 = Outpatient claim  
50 = Hospice claim  
60 = Inpatient claim  
61 = Inpatient 'Full-Encounter' claim  
62 = Medicare Advantage IME/GME Claims  
63 = Medicare Advantage (no-pay) claims  
64 = Medicare Advantage (paid as FFS) claims  
71 = RIC O local carrier non-DMEPOS claim  
72 = RIC O local carrier DMEPOS claim  
81 = RIC M DMERC non-DMEPOS claim  
82 = RIC M DMERC DMEPOS claim

NOTE: In the data element NCH\_CLM\_TYPE\_CD (derivation rules) the numbers for these claim types need to be changed - dictionary reflects 61 for all three.

PTNT\_DSCHRG\_STUS\_TB

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) with Medicare certification in anticipation of covered skilled care -- (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 a facility that provides custodial or supportive care (includes intermediate care facilities (ICF). Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to Assisted Living Facilities.
- 05 = Discharged/transferred to a designated cancer center or children's hospital (eff. 10/09). Prior to 10/1/09, discharged/transferred to another type of institution for inpatient care (including distinct parts). NOTE: Effective 1/2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is '65'.
- 06 = Discharged/transferred to home care of organized home health service organization in anticipation of covered skilled care.
- 07 = Left against medical advice or discontinued care.
- 08 = Discharged/transferred to home under care of a home IV drug therapy provider. (discontinued effective 10/1/05)
- 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

21 = Discharged/transferred to Court/Law Enforcement.  
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)  
43 = Discharged/transferred to a federal hospital (eff. 10/1/03). Discharges and transfers to a government operated health facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not.  
50 = Hospice - home (eff. 10/96)  
51 = Hospice - medical facility (certified) providing hospice level of care  
61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/01)  
62 = Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital. (eff. 1/2002)  
63 = Discharged/transferred to a Medicare certified long term care hospitals. (eff. 1/2002)  
64 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare (eff. 10/2002)  
65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code). (eff. 1/2005).  
66 = Discharged/transferred to a Critical Access Hospital (CAH) (eff. 1/1/06)  
70 = Discharged/transferred to another type of health care institution not defined elsewhere in code list.  
71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care

(eff. 9/01) (discontinued effective 10/1/05)  
72 = Discharged/transferred/referred to this  
institution for outpatient services as  
specified by the discharge plan of care  
(eff. 9/01) (discontinued effective 10/1/05)

04/04/2011

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