LDS DMERC Data Dictionary

No.	Field Short Name	Field Long Name	Label	Type	Length
Base Claim File					
1	DSYSRTKY	DESY_SORT_KEY	LDS Beneficiary ID	NUM	9
2	CLAIMNO	CLAIM_NO	Claim number	NUM	12
3	THRU_DT	CLM_THRU_DT	Claim Through Date (Determines Year of Claim)	DATE	8
4	RIC_CD	NCH_NEAR_LINE_REC_IDENT_CD	NCH Near Line Record Identification Code	CHAR	1
5	CLM_TYPE	NCH_CLM_TYPE_CD	NCH Claim Type Code	CHAR	2
6	DISP_CD	CLM_DISP_CD	Claim Disposition Code	CHAR	2
7	CARR_NUM	CLM_SRVC_CLSFCTN_TYPE_CD	Claim Service classification Type Code	CHAR	5
8	PMTDNLCD	CLM_FREQ_CD	Claim Frequency Code	CHAR	2
9	PMT_AMT	CLM_PMT_AMT	Claim Payment Amount	NUM	12
10	PRPAYAMT	CARR_CLM_PRMRY_PYR_PD_AMT	Carrier Claim Primary Payer Paid Amount	NUM	12
11	ASGMNTCD	CARR_CLM_PRVDR_ASGNMT_IND_SW	Carrier Claim Provider Assignment Indicator Switch	CHAR	1
12	PROV_PMT	PROV_PMT	NCH Claim Provider Payment Amount	NUM	12
13	BENE_PMT	BENE_PMT	NCH Claim Beneficiary Payment Amount	NUM	12
14	SBMTCHRG	SBMTCHRG	NCH Carrier Claim Submitted Charge Amount	NUM	12
15	ALOWCHRG	ALOWCHRG	NCH Carrier Claim Allowed Charge Amount	NUM	12
16	DEDAPPLY	DEDAPPLY	Carrier Claim Cash Deductible Applied Amount	NUM	12
17	HCPCS_YR	HCPCS_YR	Carrier Claim HCPCS Year Code	CHAR	1
18	PRNCPAL_DGNS_CD	PRNCPAL_DGNS_CD	Primary Claim Diagnosis Code	CHAR	7
19	PRNCPAL_DGNS_VRSN_CD	PRNCPAL_DGNS_VRSN_CD	Primary Claim Diagnosis Code Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
20	ICD DGNS CD1	ICD_DGNS_CD1	Claim Diagnosis Code I	CHAR	7
21	ICD DGNS VRSN CD1	ICD_DGNS_VRSN_CD1	Claim Diagnosis Code I Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
22	ICD DGNS CD2	ICD_DGNS_CD2	Claim Diagnosis Code II	CHAR	7
23	ICD DGNS VRSN CD2	ICD_DGNS_VRSN_CD2	Claim Diagnosis Code II Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
24	ICD DGNS CD3	ICD_DGNS_CD3	Claim Diagnosis Code III	CHAR	7
25	ICD DGNS VRSN CD3	ICD_DGNS_VRSN_CD3	Claim Diagnosis Code III Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
26	ICD DGNS CD4	ICD_DGNS_CD4	Claim Diagnosis Code IV	CHAR	7
27	ICD DGNS VRSN CD4	ICD_DGNS_VRSN_CD4	Claim Diagnosis Code IV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
28	ICD DGNS CD5	ICD_DGNS_CD5	Claim Diagnosis Code V	CHAR	7
29	ICD DGNS VRSN CD5	ICD_DGNS_VRSN_CD5	Claim Diagnosis Code V Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
30	ICD DGNS CD6	ICD_DGNS_CD6	Claim Diagnosis Code VI	CHAR	7
31	ICD DGNS VRSN CD6	ICD_DGNS_VRSN_CD6	Claim Diagnosis Code VI Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
32	ICD DGNS CD7	ICD_DGNS_CD7	Claim Diagnosis Code VII	CHAR	7
33	ICD DGNS VRSN CD7	ICD_DGNS_VRSN_CD7	Claim Diagnosis Code VII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
34	ICD DGNS CD8	ICD_DGNS_CD8	Claim Diagnosis Code VIII	CHAR	7
35	ICD DGNS VRSN CD8	ICD_DGNS_VRSN_CD8	Claim Diagnosis Code VIII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
36	ICD DGNS CD9	ICD_DGNS_CD9	Claim Diagnosis Code IX	CHAR	7
37	ICD DGNS VRSN CD9	ICD_DGNS_VRSN_CD9	Claim Diagnosis Code IX Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
38	ICD DGNS CD10	ICD_DGNS_CD10	Claim Diagnosis Code X	CHAR	7
39	ICD DGNS VRSN CD10	ICD_DGNS_VRSN_CD10	Claim Diagnosis Code X Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1

LDS DMERC Data Dictionary

No.	Field Short Name	Field Long Name	Label	Type	Length
40	ICD DGNS CD11	ICD_DGNS_CD11	Claim Diagnosis Code XI	CHAR	7
41	ICD DGNS VRSN CD11	ICD_DGNS_VRSN_CD11	Claim Diagnosis Code XI Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
42	ICD DGNS CD12	ICD_DGNS_CD12	Claim Diagnosis Code XII	CHAR	7
43	ICD DGNS VRSN CD12	ICD_DGNS_VRSN_CD12	Claim Diagnosis Code XII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
44	RFR_UPIN	RFR_PHYSN_UPIN	DMERC Claim Ordering Physician UPIN Number	CHAR	12
45	RFR_NPI	RFR_PHYSN_NPI	DMERC Claim Refering Physician NPI Number	CHAR	12
46	DOB_DT	DOB_DT	LDS Age Category	NUM	1
47	GNDR_CD	GNDR_CD	Gender Code from Claim	CHAR	1
48	RACE_CD	BENE_RACE_CD	Race Code from Claim	CHAR	1
49	CNTY_CD	BENE_CNTY_CD	County Code from Claim (SSA)	CHAR	3
50	STATE_CD	BENE_STATE_CD	State Code from Claim (SSA)	CHAR	2
51	CWF_BENE_MDCR_STUS_CD	CWF_BENE_MDCR_STUS_CD	CWF Beneficiary Medicare Status Code	CHAR	2

Line File					
1	DSYSRTKY	DESY_SORT_KEY	LDS Beneficiary ID	NUM	9
2	CLAIMNO	CLAIM_NO	LDS Claim Number	NUM	12
3	CLM_LN	CLM_LINE_NUM	Claim Line Number	NUM	3
4	THRU_DT	CLM_THRU_DT	Claim Through Date (Determines Year of Claim)	DATE	8
5	CLM_TYPE	NCH_CLM_TYPE_CD	NCH Claim Type Code	CHAR	2
6	HCFASPCL	PRVDR_SPCLTY	Line HCFA Provider Specialty Code	CHAR	3
7	PRTCPTG	PRTCPTNG_IND_CD	Line Provider Participating Indicator Code	CHAR	1
8	SRVC_CNT	LINE_SRVC_CNT	Line Service Count	NUM	4
9	TYPSRVCB	LINE_CMS_TYPE_SRVC_CD	Line HCFA Type Service Code	CHAR	1
10	PLCSRVC	LINE_PLACE_OF_SRVC_CD	Line Place Of Service Code	CHAR	2
11	EXPNSDT2	LINE_LAST_EXPNS_DT	Line Last Expense Date	DATE	8
12	HCPCS_CD	HCPCS_CD	Line HCFA Common Procedure Coding System	CHAR	5
13	MDFR_CD1	HCPCS_1ST_MDFR_CD	Line HCPCS Initial Modifier Code	CHAR	5
14	MDFR_CD2	HCPCS_2ND_MDFR_CD	Line HCPCS Second Modifier Code	CHAR	5
15	BETOS	BETOS_CD	Line NCH BETOS Code	CHAR	3
16	LINEPMT	LINE_NCH_PMT_AMT	Line NCH Payment Amount	NUM	12
17	LBENPMT	LINE_BENE_PMT_AMT	Line Beneficiary Payment Amount	NUM	12
18	LPRVPMT	LINE_PRVDR_PMT_AMT	Line Provider Payment Amount	NUM	12
19	LDEDAMT	LINE_BENE_PTB_DDCTBL_AMT	Line Beneficiary Part B Deductible Amount	NUM	12
20	LPRPAYCD	LINE_BENE_PRMRY_PYR_CD	Line Beneficiary Primary Payer Code	CHAR	1
21	LPRPDAMT	LINE_BENE_PRMRY_PYR_PD_AMT	Line Beneficiary Primary Payer Paid Amount	NUM	12
22	COINAMT	LINE_COINSRNC_AMT	Line Coinsurance Amount	NUM	12
23	PRPYALOW	LINE_PRMRY_ALOWD_CHRG_AMT	Line Primary Payer Allowed Charge Amount	NUM	12
24	LSBMTCHG	LINE_SBMTD_CHRG_AMT	Line Submitted Charge Amount	NUM	12
25	LALOWCHG	LINE_ALOWD_CHRG_AMT	Line Allowed Charge Amount	NUM	12
26	PRCNGIND	LINE_PRCSG_IND_CD	Line Processing Indicator Code	CHAR	2

LDS DMERC Data Dictionary

No.	Field Short Name	Field Long Name	Label	Type	Length
27	PMTINDSW	LINE_PMT_80_100_CD	Line Payment 80%/100% Code	CHAR	1
28	DED_SW	LINE_SERVICE_DEDUCTIBLE	Line Service Deductible Indicator Switch	CHAR	1
29	LINE_ICD_DGNS_CD	LINE_ICD_DGNS_CD	Line Diagnosis Code Code	CHAR	7
30	LINE_ICD_DGNS_VRSN_CD	LINE_ICD_DGNS_VRSN_CD	Line Diagnosis Code Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
31	DME_PURC	LINE_DME_PRCHS_PRICE_AMT	Line DME Purchase Price Amount	NUM	12
32	SUPLRNUM	PRVDR_NUM	DMERC Line Supplier Provider Number	CHAR	10
33	SUP_NPI	PRVDR_NPI	DMERC Line Item Supplier NPI Number	CHAR	12
34	PRCNG_ST	DMERC_LINE_PRCNG_STATE_CD	DMERC Line Pricing State Code	CHAR	2
35	PRVSTATE	PRVDR_STATE_CD	DMERC Line Provider State Code	CHAR	2
36	MDFR_CD3	HCPCS_3RD_MDFR_CD	DMERC Line HCPCS Third Modifier Code	CHAR	5
37	MDFR_CD4	HCPCS_4TH_MDFR_CD	DMERC Line HCPCS Fourth Modifier Code	CHAR	5
38	SCRNSVGS	DMERC_LINE_SCRN_SVGS_AMT	DMERC Line Screen Savings Amount	NUM	12
39	DME_UNIT	DMERC_LINE_MTUS_CNT	DMERC Line Miles/Time/Units/Services Count	NUM	7
40	UNIT_IND	DMERC_LINE_MTUS_CD	DMERC Line Miles/Time/ Units/Services Indicator Code	CHAR	1
41	HCTHGBRS	LINE_HCT_HGB_RSLT_NUM	Hematocrit/Hemoglobin Test Results	NUM	4
42	HCTHGBTP	LINE_HCT_HGB_TYPE_CD	Hematocrit/Hemoglobin Test Type code	CHAR	2
43	LNNDCCD	LINE_NDC_CD	Line National Drug Code	CHAR	11

Base Claim File

Variable	Description	Possible Values	Notes
DSYSRTKY	This field contains the key to link data for each beneficiary across all claim files.		
CLAIMNO	The unique number used to identify a unique claim.		
THRU_DT	The last day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers Thru Date').		For Part B non-institutional (Carrier and DME) services, this variable corresponds with the latest of any of the line-item level dates (i.e, in the Line File, it is the last CLM_THRU_DT for any line on the claim). It is almost always the same as the CLM_FROM_DT; exception is for DME claims - where some services are billed in advance.
RIC_CD	A code defining the type of claim record being processed.	M = Part B DMEPOS O = Part B physician/supplier U = Both Part A and B institutional HHA V = Part A institutional (IP, SNF, HOS, or HHA) W = Part B institutional claim record (HOP, HHA)	
CLM_TYPE	The code used to identify the type of claim record being processed in NCH.	10 = Home Health Agency 20 = Non swing bed SNF 30 = Swing bed SNF 40 = Hospital Outpatient 50 = Hospice 60 = Inpatient 71 = Local carrier non-DMEPOS 72 = Local carrier DMEPOS 81 = Regional carrier non-DMEPOS 82 = Regional carrier DMEPOS	Effective with Version 'J', 3 new code values have been added to include a type code for the Medicare Advantage claims (IME/GME, no-pay and paid as FFS). During the Version 'J' conversion, these type codes were populated throughout history.
DISP_CD	Code indicating the disposition or outcome of the processing of the claim record.	01 = Debit accepted	In the souce CMS National Claims History (NCH), claims are transactional records and several iterations of the claim may exist (e.g., original claim, an edited/updated version - which also cancels the original claim, etc.). The final reconciled version of the claim is contained in CCW-produced data files, unless otherwise requested. For final claims (at least those that are final at the time of the data file), this value will always be '01'.
CARR_NUM	The identification number assigned by CMS to a carrier authorized to process claims from a physician or supplier. Effective July 2006, the Medicare Administrative Contractors (MACs) began replacing the existing carriers and started processing physician or supplier claim records for states assigned to its jurisdiction.		NOTE: The 5-position MAC number will be housed in the existing CARR_NUM field. During the transition from a carrier to a MAC the CARR_NUM field could contain either a Carrier number or a MAC number. See the ARR_NUM table of codes to identify the new MAC numbers and their effective dates.
PMTDNLCD	The code on a non-institutional claim indicating to whom payment was made or if the claim was denied.		NOTE1: Effective with Version 'J', the field has been expanded on the NCH record to 2 bytes. With this expansion, the NCH will no longer use the character values to represent the official two byte values sent in by CWF since 4/2002. During the Version J conversion, all character values were converted to the two byte values. NOTE2: Effective 4/1/02, this field was expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. See table of code for the crosswalk.

PMT_AMT	The Medicare claim payment amount. For hospital services, this amount does not include the claim pass-through per diem payments made by Medicare. To obtain the total amount paid by Medicare for the claim, the pass-through amount (which is the daily per diem amount) must be multiplied by the number of Medicare-covered days (i.e., multiply the CLM_PASS_THRU_PER_DIEM_AMT by the CLM_UTLZTN_DAY_CNT), and then added to the claim payment amount (this field). For non-hospital services (SNF, home health, hospice, and hospital outpatient) and for other non-institutional services (Carrier and DME), this variable equals the total actual Medicare payment amount, and pass-through amounts do not apply. For Part B non-institutional services (Carrier and DME), this variable equals the sum of all the line item-level Medicare payments (variable called the LINE_NCH_PMT_AMT).		NOTE: In some situations, a negative claim payment amount may be pre- sent; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.) Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). After 4/1/03, the payment amount could also include a "new technology" add-on amount. It does NOT include the pass-thru amounts (i.e., capital- related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any any other payer reimbursement. Under IRFPPS, inpatient rehabilitation services are paid based on a predetermined rate per discharge, using the Case Mix Group (CMG) classification system and the PRICER program. From the CMG on the IRF PPS claim, payment is based on a standard payment amount for operating and capital cost for that facility (including routine and ancillary services). The payment is adjusted for wage, the % of low-income patients (LIP), locality, transfers, interrupted stays, short stay cases, deaths, and high cost outliers. Some or all of these adjustments could apply. The CMG payment does NOT include certain pass- through costs (i.e. bad debts, approved education activities); beneficiary-paid amounts, other payer reimbursement,and other services outside of the scope of PPS.
PRPAYAMT	The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a non-institutional claim.		
ASGMNTCD	Variable indicates whether or not the provider accepts assignment for the non-institutional claim.	CODES: A = Assigned claim N = Non-assigned claim	
PROV_PMT	The total payments made to the provider for this claim (sum of line item provider payment amounts). Variable called LINE_PRVDR_PMT_AMT		
BENE_PMT	The total payments made to the beneficiary for this claim (sum of line payment amounts to the beneficiary.) Variable called LINE_BENE_PMT_AMT		This variable is populated if, for example, a beneficiary pays for a service that should have been Medicare-covered. The beneficiary can be refunded the payment. Costs to that beneficiaries are liable for are described in detail on the Medicare.gov website. There is a CMS publication called "Your Medicare Benefits", which explains the deductibles and coinsurance amounts. Medicare payments are described in detail in a series of Medicare Payment Advisory Commission (MedPAC) documents called “Payment Basics” (see: http://www.medpac.gov/payment_basics.cfm).
SBMTCHRG	The total submitted charges on the claim (the sum of line item submitted charges). Variable called LINE_SBMTD_CHRG_AMT		
ALOWCHRG	The total allowed charges on the claim (the sum of line item allowed charges). This variable is the beneficiary's liability under the annual Part B deductible for all line items on the claim; it is the sum of all line-level deductible amounts (variable called LINE_BENE_PTB_DDCTBL_AMT). The Part B deductible applies to both institutional (e.g., HOP) and non-institutional (e.g., Carrier and DME) services.		Costs to beneficiaries are described in detail on the Medicare.gov website. There is a CMS publication called "Your Medicare Benefits", which explains the deductibles.
DEDAPPLY	The amount of the cash deductible as submitted on the claim. This variable is the beneficiary's liability under the annual Part B deductible for all line items on the claim; it is the sum of all line-level deductible amounts. (variable called LINE_BENE_PTB_DDCTBL_AMT). The Part B deductible applies to both institutional (e.g., HOP) and non-institutional (e.g., Carrier and DME) services.		Costs to beneficiaries are described in detail on the Medicare.gov website. There is a CMS publication called "Your Medicare Benefits", which explains the deductibles.
HCPCS_YR	The terminal digit of HCPCS version used to code the claim.	Blank = ICD-9 9 = ICD-9 0 = ICD-10	ICD-10 is not scheduled for implementation until 10/2015.

PRNCPAL_DGNS_CD	The diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided. This data is also reduntantly stored as the first occurrence of the diagnosis code (variable called ICD_DGNS_CD1).		Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8). Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10. ICD-10 is not scheduled for implementation until 10/2015.
PRNCPAL_DGNS_VRSN_CD	Effective with Version 'J', the code used to indicate if the diagnosis is ICD-9 or ICD-10.	Blank = ICD-9 9 = ICD-9 0 = ICD-10	With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2015.
ICD DGNS CD1 to CD12	The diagnosis code identifying the beneficiary's principal or other diagnosis (including E code).		For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros. Starting in 2011, with version J of the NCH claim layout, institutional claims can have up to 25 diagnosis codes (previously only 11 were accommodated), and the non-institutional claims can have up to 12 diagnosis codes (previously only up to 8). The lower the number, the more important the diagnosis in the patient treatment/billing (i.e., ICD_DGNS_CD1 is considered the primary diagnosis).
ICD DGNS VRSN CD1 to CD12	Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.	Blank = ICD-9 9 = ICD-9 0 = ICD-10	With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2015.
RFR_UPIN	The unique physician identification number (UPIN) of the physician who referred the beneficiary or the physician who ordered the Part B services or durable medical equipment (DME).		NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.
RFR_NPI	The national provider identifier (NPI) number of the physician who referred the beneficiary or the physician who ordered the Part B services or Durable Medical Equipment. NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.		NOTE: Effective May 2007, the NPI became the national standard identifier for covered health care providers. NPIs replaced current OSCAR provider numbers, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).
DOB_DT	The beneficiary's date of birth, coded as a range.	CODES: 0 = Unknown 1 = <65 2 = 65 Thru 69 3 = 70 Thru 74 4 = 75 Thru 79 5 = 80 Thru 84 6 = >84	For the Limited Data Set Standard View, the beneficiary's date of birth is coded as a range.
GNDR_CD	The sex of a beneficiary.	CODES: 1 = Male 2 = Female 0 = Unknown	
RACE_CD	Race code from claim.	CODES: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = North American Native	
CNTY_CD	The 3-digit SSA standard county code of a beneficiary's residence.		A listing of county codes can be found on the US Census website; also CMS has core-based statistical area (CBSA) crosswalk files available on their website, which include state and county SSA codes.
STATE_CD	The SSA standard 2-digit state code of a beneficiary's residence.		1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement. 2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish. 3. Also used for special studies.
CWF_BENE_MDCR_STUS_CD	The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM_THRU_DT).	10 = Aged without ESRD 11 = Aged with ESRD 20 = Disabled without ESRD 21 = Disabled with ESRD 31 = ESRD only	

Line File

Variable	Description	Possible Values	Notes
DSYSRTKY	This field contains the key to link data for each beneficiary across all claim files.		
CLAIMNO	The unique number used to identify a unique claim.		
CLM_LN	This variable identifies an individual line number on a claim. Each claim line has a sequential line number to distinguish distinct services that are submitted on the same claim.		
THRU_DT	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').		For Part B non-institutional (Carrier and DME) services, this variable corresponds with the latest of any of the line-item level dates, (i.e., in the Line File, it is the last CLM_THRU_DT for any line on the claim). It is almost always the same as the CLM_FROM_DT; exception is for DME claims - where some services are billed in advance.
CLM_TYPE	The code used to identify the type of claim record being processed in NCH.	10 = Home Health Agency 20 = Non swing bed SNF 30 = Swing bed SNF 40 = Hospital Outpatient 50 = Hospice 60 = Inpatient 71 = Local carrier non-DMEPOS 72 = Local carrier DMEPOS 81 = Regional carrier non-DMEPOS 82 = Regional carrier DMEPOS	Effective with Version 'J', 3 new code values have been added to include a type code for the Medicare Advantage claims (IME/GME, no-pay and paid as FFS).
HCFASPCL	CMS (previously called HCFA) specialty code used for pricing the line item service on the non-institutional claim. Assigned by the Medicare Administrative Contractor (MAC) based on the corresponding provider identification number (performing NPI or UPIN).		
PRTCPTG	Code indicating whether or not a provider is participating or accepting assignment for this line item service on the non-institutional claim.	1 = Participating 2 = All or some covered and allowed expenses applied to deductible Participating 3 = Assignment accepted / non-participating 4 = Assignment not accepted /non-participating 5 = Assignment accepted but all or some covered and allowed expenses applied to deductible Non-participating 6 = Assignment not accepted and all covered and allowed expenses applied to deductible non-participating	
SRVC_CNT	The count of the total number of services processed for the line item on the non-institutional claim.		
TYPSRVCB	Code indicating the type of service, as defined in the CMS Medicare Carrier Manual, for this line item on the non-institutional claim.	1 = Medical care 2 = Surgery 3 = Consultation 4 = Diagnostic radiology 5 = Diagnostic laboratory 6 = Therapeutic radiology 7 = Anesthesia 8 = Assistant at surgery 9 = Other medical items or services 0 = Whole blood --- A = Used DME D = Ambulance E = Enteral/parenteral nutrients/supplies F = Ambulatory surgical center (facility surgical use) G = Immunosuppressive drugs J = Diabetic shoes K = Hearing items and services L = ESRD supplies M = Monthly capitation payment for dialysis N = Kidney donor P = Lump sum purchase DME, prosthetics, orthotics Q = Vision items or services R = Rental of DME S = Surgical dressings or other medical supplies T = Outpatient mental health limitation U = Occupational therapy V = Pneumococcal/flu vaccine W = Physical therapy	EDIT RULES : The only type of service codes applicable to DMERC claims are: 1, 9, A, E, G, H, J, K, L, M, P, R, and S.
PLCSRVC	The code indicating the place of service, as defined in the Medicare Carrier Manual, for this line item on the noninstitutional claim.		

EXPNSDT2	The ending date (last expense) for the line item service on the non-institutional claim. It is almost always the same as the line-level first expense date (variable called LINE_1st_EXPNS_DT); exception is for DME claims - where some services are billed in advance.		
HCPCS_CD	The HCFA Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described in the Notes to the right.		Level I Codes and descriptors copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4). These are 5 position numeric codes representing physician and non-physician services. Note: CPT-4 codes including both long and short descriptions shall be used in accordance with the CMS/AMA agreement. Any other use violates the AMA copyright. Level II Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Fifth Edition (CDT-5). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha- numeric codes representing primarily items and non-physician services that are not represented in the level I codes. Level III Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and non-physician services that are not represented in the level I or level II codes.
MDFR_CD1	A first modifier to the HCPCS procedure code to enable a more specific procedure identification for the line item service on the non-institutional claim.		
MDFR_CD2	A second modifier to the HCPCS procedure code to make it more specific than the first modifier code to identify the line item procedures for this claim.		
BETOS	The Berenson-Eggers type of service (BETOS) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services. This field is included as a line item on the non-institutional claim.		
LINEPMT	Amount of payment made from the Medicare Trust fund (after deductible and coinsurance amounts have been paid) for the line item service on the non-institutional claim.		
LBENPMT	The payment (reimbursement) made to the beneficiary related to the line item service on the non-institutional claim.		
LPRVPMT	The payment made by Medicare to the provider for the line item service on the non-institutional claim. Additional payments may have been made to the provider - including beneficiary deductible and coinsurance amounts and/or other primary payer amounts.		
LDEDAMT	The amount of money for which the carrier has determined that the beneficiary is liable for the Part B cash deductible for the line item service on the non-institutional claim.		
LPRPAYCD	Values C, M, N and Blank indicate Medicare is primary payer.	A = Working aged bene/spouse with employer group health plan (EGHP) B = End stage renal disease (ESRD) beneficiary in the 18 month coordination period with an EGHP C = Conditional payment by Medicare; future reimbursement expected D = Automobile no-fault E = Worker's Compensation F = Public Health Service or other federal agency (other than Dept of Veterans Affairs) G = Working disabled bene (under age 65 with LGHP) H = Black Lung I = Dept of Veterans Affairs L = Any liability insurance M = Override code: EGHP services involved N = Override code: non-EGHP services involved W = Worker's Compensation Medicare Set-Aside Arrangement (WCMSA) Blank = Medicare is primary payer	Values C, M, N and Blank indicate Medicare is primary payer.
LPRPDAMT	The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges for to the line item service on the non-institutional claim.		

COINAMT	The beneficiary coinsurance liability amount for this line item service on the non-institutional claim. This variable is the beneficiary's liability for coinsurance for the service on the line item record. Beneficiaries only face coinsurance once they have satisfied Part B's annual deductible, which applies to both institutional and non-institutional services. For most Part B services, coinsurance equals 20 percent of the allowed amount.		Medicare payments are described in detail in a series called the Medicare Learning Network (MLN) "Payment System Fact Sheet Series" (see the list of MLN publications at: http://www.cms.hhs.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html).
PRPYALOW	The primary payer allowed charge amount for the line item service on the non-institutional claim. If there is a primary payer other than Medicare, there may be an allowed payment for the provider; if so, this field is populated.		
LSBMTCHG	The amount of submitted charges for the line item service on the non-institutional claim. Providers' submitted charges often differ from the amount they were eventually paid - either from Medicare, the beneficiary (through deductible or coinsurance amounts) or third party payers.		
LALOWCHG	The amount of allowed charges for the line item service on the non-institutional claim. This charge is used to compute the total claim-level payment to providers or reimbursement to beneficiaries.		NOTE1: The amount includes beneficiary-paid amounts (i.e., deductible and coinsurance). NOTE2: The allowed charge is determined by the lower of three charges: prevailing, customary or actual.
PRCNGIND	The code on a non-institutional claim indicating to whom payment was made or if the claim was denied.		NOTE1: Effective with Version 'J', the field has been expanded on the NCH record to 2 bytes. With this expansion, the NCH will no longer use the character values to represent the official two byte values sent in by CWF since 4/2002. During the Version J conversion, all character values were converted to the two byte values. NOTE2: Effective 4/1/02, this field was expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. See table of code for the crosswalk.
PMTINDSW	The code indicating that the amount shown in the payment field on the non-institutional line item represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only.	0 = 80% 1 = 100% 3 = 100% limitation of liabililty only 4 = 75% reimbursement	
DED_SW	Switch indicating whether or not the line item service on the non-institutional claim is subject to a deductible.	0 = Service subject to deductible 1 = Service not subject to deductible	
LINE_ICD_DGNS_CD	The code indicating the diagnosis supporting this line item procedure/service on the non-institutional claim.		For ICD-9 diagnosis codes, this is a 3-5 digit numeric or alpha/numeric value; it can include leading zeros.
LINE_ICD_DGNS_VRSN_CD	Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.	Blank = ICD-9 9 = ICD-9 0 = ICD-10	With 5010, the diagnosis and procedure codes have been expanded to accomodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2015.
DME_PURC	The amount representing the lower of fee schedule for purchase of new or used DME, or actual charge. In case of rental DME, this amount represents the purchase cap; rental payments can only be made until the cap is met. This line item field is applicable to non-institutional claims involving DME, prosthetic, orthotic and supply items, immunosuppressive drugs, pen, ESRD and oxygen items referred to as DMEPOS.		
SUPLRNUM	The billing number assigned to the supplier of the Part B service/DMEPOS by the National Supplier Clearinghouse, as reported on the line item for the DMERC claim.		Different types of identifiers may be used. Refer to the variable SUP_TYPE (DMERC_LINE_SUPPLR_TYPE_CD) to determine the type used for each line.
SUP_NPI	The National Provider Identifier (NPI) assigned to the supplier of the Part B service/DMEPOS line item.		NPIs replaced UPINs as the standard provider identifiers beginning in 2007. The UPIN is almost never populated after 2009.
PRCNG_ST	The 2-digit SSA State Code where the DME supplier was located; used by the MAC for pricing the service.		
PRVSTATE	The 2-digit SSA State Code where provider or facility is located.		
MDFR_CD3	A third modifier to the HCPCS procedure code to make it more specific than the first or second modifier codes to identify the line item procedures for this claim.		Available for DME line items.
MDFR_CD4	A fourth modifier to the HCPCS procedure code to make it more specific than the first, second or third modifier code to identify the line item procedures for this claim.		Available for DME line items.
SCRNSVGS	The amount of savings attributable to the coverage screen for this DMERC line item.		
DME_UNIT	The count of the total units associated with the DMERC line item service needing unit reporting, such as number of supplies, volume of oxygen or nutritional units, and drug dose. This is a line item on the DMERC claim and is used for both allowed and denied services.		Prior to Version 'J', this field was S9(3) Length: 7.3

UNIT_IND	Code indicating the units associated with services needing unit reporting on the line item for the DMERC service.	0 = Values reported as zero 3 = Number of services 4 = Oxygen volume units 6 = Drug dosage	
HCTHGBRS	This is the laboratory value for the most recent hematocrit or hemoglobin reading on the non-institutional claim.		The hematocrit/hemoglobin test result field is a redefined field. The field is being defined as X(3) and redefined as numeric (99V9). A numeric test on the alphanumeric field is needed. Whenever a user wants to use the field they must test the alphanumeric field for numerics and if it is numeric then the 99V9 definition would be used. The older data will cause an abend if trying to process numeric data with characters.
HCTHGBTP	The type of test that was performed, hematocrit or hemoglobin.	R1 = Hemoglobin test R2 = Hematocrit test	This variable became effective 9/1/2008 to comply with CR# 5699. The laboratory value for the test is indicated in the hematocrit/hemoglobin test results field (variable called LINE_HCT_HGB_RSLT_NUM or HCTHGBRS).
LNNDCCD	On the DMERC claim, the National Drug Code identifying the oral anti-cancer drugs. This line item field was added as a placeholder on the carrier claim.		