LDS Skilled Nursing Facility 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	PROVIDER	PRVDR_NUM	Provider Number	CHAR	10
4	THRU_DT	CLM_THRU_DT	Claim Through Date (Determines Year of Claim)	DATE	8
5	RIC_CD	NCH_NEAR_LINE_REC_IDENT_CD	NCH Near Line Record Identification Code	CHAR	1
6	CLM_TYPE	NCH_CLM_TYPE_CD	NCH Claim Type Code	CHAR	2
7	QUERY_CD	CLAIM_QUERY_CODE	Claim Query Code	CHAR	1
8	FAC_TYPE	CLM_FAC_TYPE_CD	Claim Facility Type Code	CHAR	1
9	TYPESRVC	CLM_SRVC_CLSFCTN_TYPE_CD	Claim Service classification Type Code	CHAR	1
10	FREQ_CD	CLM_FREQ_CD	Claim Frequency Code	CHAR	1
11	FI_NUM	FI_NUM	FI Number	CHAR	5
12	NOPAY_CD	CLM_MDCR_NON_PMT_RSN_CD	Claim Medicare Non Payment Reason Code	CHAR	2
13	PMT_AMT	CLM_PMT_AMT	Claim Payment Amount	NUM	12
14	PRPAYAMT	NCH_PRMRY_PYR_CLM_PD_AMT	NCH Primary Payer Claim Paid Amount	NUM	12
15	PRPAY_CD	NCH_PRMRY_PYR_CD	NCH Primary Payer Code	CHAR	1
16	ACTIONCD	FI_CLM_ACTN_CD	FI Claim Action Code	CHAR	1
17	PRSTATE	PRVDR_STATE_CD	NCH Provider State Code	CHAR	2
18	ORGNPINM	ORG_NPI_NUM	Organization NPI Number	CHAR	10
19	AT_UPIN	AT_PHYSN_UPIN	Claim Attending Physician UPIN Number	CHAR	12
20	AT_NPI	AT_PHYSN_NPI	Claim Attending Physician NPI Number	CHAR	12
21	OP_UPIN	OP_PHYSN_UPIN	Claim Operating Physician UPIN Number	CHAR	12
22	OP_NPI	OP_PHYSN_NPI	Claim Operating Physician NPI Number	CHAR	12
23	OT_UPIN	OT_PHYSN_UPIN	Claim Other Physician UPIN Number	CHAR	12
24	OT_NPI	OT_PHYSN_NPI	Claim Other Physician NPI Number	CHAR	12
25	MCOPDSW	CLM_MCO_PD_SW	Claim MCO Paid Switch	CHAR	1
26	STUS_CD	PTNT_DSCHRG_STUS_CD	Patient Discharge Status Code	CHAR	2
27	PPS_IND	CLM_PPS_IND_CD	Claim PPS Indicator Code	CHAR	1
28	TOT_CHRG	CLM_TOT_CHRG_AMT	Claim Total Charge Amount	NUM	12
29	ADMSN_DT	CLM_ADMSN_DT	Claim Admission Date	DATE	8
30	TYPE_ADM	CLM_IP_ADMSN_TYPE_CD	Claim Inpatient Admission Type Code	CHAR	1
31	SRC_ADMS	CLM_SRC_IP_ADMSN_CD	Claim Source Inpatient Admission Code	CHAR	1
32	PTNTSTUS	NCH_PTNT_STATUS_IND_CD	NCH Patient Status Indicator Code	CHAR	1
33	DED_AMT	NCH_BENE_IP_DDCTBL_AMT	NCH Beneficiary Inpatient Deductible Amount	NUM	12
34	COIN_AMT	NCH_BENE_PTA_COINSRNC_LBLTY_AM	NCH Beneficiary Part A Coinsurance Liability Amount	NUM	12
35	BLDDEDAM	NCH_BENE_BLOOD_DDCTBL_LBLTY_AM	NCH Beneficiary Blood Deductible Liability Amount	NUM	12
36	NCCHGAMT	NCH_IP_NCVRD_CHRG_AMT	NCH Inpatient Noncovered Charge Amount	NUM	12
37	CPTL_FSP	CLM_PPS_CPTL_FSP_AMT	Claim PPS Capital FSP Amount	NUM	12
38	CPTLOUTL	CLM_PPS_CPTL_OUTLIER_AMT	Claim PPS Capital Outlier Amount	NUM	12
39	DISP_SHR	CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT	Claim PPS Capital Disproportionate Share Amount	NUM	12
40	IME_AMT	CLM_PPS_CPTL_IME_AMT	Claim PPS Capital IME Amount	NUM	12

LDS Skilled Nursing Facility Data Dictionary

No.	Field Short Name	Field Long Name	Label	Type	Length
41	CPTL_EXP	CLM_PPS_CPTL_EXCPTN_AMT	Claim PPS Capital Exception Amount	NUM	12
42	HLDHRMLS	CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT	Claim PPS Old Capital Hold Harmless Amount	NUM	12
43	UTIL_DAY	CLM_UTLZTN_DAY_CNT	Claim Utilization Day Count	NUM	3
44	COIN_DAY	BENE_TOT_COINSRNC_DAYS_CNT	Beneficiary Total Coinsurance Days Count	NUM	3
45	NUTILDAY	CLM_NON_UTLZTN_DAYS_CNT	Claim Non Utilization Days Count	NUM	5
46	BLDFRNSH	NCH_BLOOD_PNTS_FRNSHD_QTY	NCH Blood Pints Furnished Quantity	NUM	3
47	QLFYTHRU	NCH_QLFYD_STAY_THRU_DT	NCH Qualify Stay Through Date	DATE	8
48	NCOVFROM	NCH_VRFD_NCVRD_STAY_FROM_DT	NCH Verified Noncovered Stay From Date	DATE	8
49	NCOVTHRU	NCH_VRFD_NCVRD_STAY_THRU_DT	NCH Verified Noncovered Stay Through Date	DATE	8
50	EXHST_DT	NCH_BENE_MDCR_BNFTS_EXHTD_DT_I	NCH Beneficiary Medicare Benefits Exhausted Date	DATE	8
51	DSCHRGDT	NCH_BENE_DSCHRG_DT	NCH Beneficiary Discharge Date	DATE	8
52	DRG_CD	CLM_DRG_CD	Claim Diagnosis Related Group Code	CHAR	3
53	ADMTG_DGNS_CD	ADMTG_DGNS_CD	Claim Admitting Diagnosis Code	CHAR	7
54	ADMTG_DGNS_VRSN_CD	ADMTG_DGNS_VRSN_CD	Claim Admitting Diagnosis Code Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
55	PRNCPAL_DGNS_CD	PRNCPAL_DGNS_CD	Primary Claim Diagnosis Code	CHAR	7
56	PRNCPAL_DGNS_VRSN_CD	PRNCPAL_DGNS_VRSN_CD	Primary Claim Diagnosis Code Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
57	ICD DGNS CD1	ICD_DGNS_CD1	Claim Diagnosis Code I	CHAR	7
58	ICD DGNS VRSN CD1	ICD_DGNS_VRSN_CD1	Claim Diagnosis Code I Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
59	ICD DGNS CD2	ICD_DGNS_CD2	Claim Diagnosis Code II	CHAR	7
60	ICD DGNS VRSN CD2	ICD_DGNS_VRSN_CD2	Claim Diagnosis Code II Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
61	ICD DGNS CD3	ICD_DGNS_CD3	Claim Diagnosis Code III	CHAR	1
62	ICD DGNS VRSN CD3	ICD_DGNS_VRSN_CD3	Claim Diagnosis Code III Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
63	ICD DGNS CD4	ICD_DGNS_CD4	Claim Diagnosis Code IV	CHAR	1
64	ICD DGNS VRSN CD4	ICD_DGNS_VRSN_CD4	Claim Diagnosis Code IV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
65	ICD DGNS CD5	ICD_DGNS_CD5	Claim Diagnosis Code V	CHAR	1
66	ICD DGNS VRSN CD5	ICD_DGNS_VRSN_CD5	Claim Diagnosis Code V Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
67	ICD DGNS CD6	ICD_DGNS_CD6	Claim Diagnosis Code VI	CHAR	1
68	ICD DGNS VRSN CD6	ICD_DGNS_VRSN_CD6	Claim Diagnosis Code VI Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
69	ICD DGNS CD7	ICD_DGNS_CD7	Claim Diagnosis Code VII	CHAR	1
70	ICD DGNS VRSN CD7	ICD_DGNS_VRSN_CD7	Claim Diagnosis Code VII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
71	ICD DGNS CD8	ICD_DGNS_CD8	Claim Diagnosis Code VIII	CHAR	1
72	ICD DGNS VRSN CD8	ICD_DGNS_VRSN_CD8	Claim Diagnosis Code VIII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
73	ICD DGNS CD9	ICD_DGNS_CD9	Claim Diagnosis Code IX	CHAR	1
74	ICD DGNS VRSN CD9	ICD_DGNS_VRSN_CD9	Claim Diagnosis Code IX Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
75	ICD DGNS CD10	ICD_DGNS_CD10	Claim Diagnosis Code X	CHAR	1
76	ICD DGNS VRSN CD10	ICD_DGNS_VRSN_CD10	Claim Diagnosis Code X Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
77	ICD DGNS CD11	ICD_DGNS_CD11	Claim Diagnosis Code XI	CHAR	1
78	ICD DGNS VRSN CD11	ICD_DGNS_VRSN_CD11	Claim Diagnosis Code XI Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
79	ICD DGNS CD12	ICD_DGNS_CD12	Claim Diagnosis Code XII	CHAR	1
80	ICD DGNS VRSN CD12	ICD_DGNS_VRSN_CD12	Claim Diagnosis Code XII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
81	ICD DGNS CD13	ICD_DGNS_CD13	Claim Diagnosis Code XIII	CHAR	1

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No.	Field Short Name	Field Long Name	Label	Type	Length
82	ICD DGNS VRSN CD13	ICD_DGNS_VRSN_CD13	Claim Diagnosis Code XIII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
83	ICD DGNS CD14	ICD_DGNS_CD14	Claim Diagnosis Code XIV	CHAR	1
84	ICD DGNS VRSN CD14	ICD_DGNS_VRSN_CD14	Claim Diagnosis Code XIV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
85	ICD DGNS CD15	ICD_DGNS_CD15	Claim Diagnosis Code XV	CHAR	1
86	ICD DGNS VRSN CD15	ICD_DGNS_VRSN_CD15	Claim Diagnosis Code XV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
87	ICD DGNS CD16	ICD_DGNS_CD16	Claim Diagnosis Code XVI	CHAR	1
88	ICD DGNS VRSN CD16	ICD_DGNS_VRSN_CD16	Claim Diagnosis Code XVI Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
89	ICD DGNS CD17	ICD_DGNS_CD17	Claim Diagnosis Code XVII	CHAR	1
90	ICD DGNS VRSN CD17	ICD_DGNS_VRSN_CD17	Claim Diagnosis Code XVII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
91	ICD DGNS CD18	ICD_DGNS_CD18	Claim Diagnosis Code XVIII	CHAR	1
92	ICD DGNS VRSN CD18	ICD_DGNS_VRSN_CD18	Claim Diagnosis Code XVIII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
93	ICD DGNS CD19	ICD_DGNS_CD19	Claim Diagnosis Code XIV	CHAR	1
94	ICD DGNS VRSN CD19	ICD_DGNS_VRSN_CD19	Claim Diagnosis Code XIV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
95	ICD DGNS CD20	ICD_DGNS_CD20	Claim Diagnosis Code XX	CHAR	1
96	ICD DGNS VRSN CD20	ICD_DGNS_VRSN_CD20	Claim Diagnosis Code XX Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
97	ICD DGNS CD21	ICD_DGNS_CD21	Claim Diagnosis Code XXI	CHAR	1
98	ICD DGNS VRSN CD21	ICD_DGNS_VRSN_CD21	Claim Diagnosis Code XXI Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
99	ICD DGNS CD22	ICD_DGNS_CD22	Claim Diagnosis Code XXII	CHAR	1
100	ICD DGNS VRSN CD22	ICD_DGNS_VRSN_CD22	Claim Diagnosis Code XXII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
101	ICD DGNS CD23	ICD_DGNS_CD23	Claim Diagnosis Code XXIII	CHAR	1
102	ICD DGNS VRSN CD23	ICD_DGNS_VRSN_CD23	Claim Diagnosis Code XXIII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
103	ICD DGNS CD24	ICD_DGNS_CD24	Claim Diagnosis Code XXIV	CHAR	1
104	ICD DGNS VRSN CD24	ICD_DGNS_VRSN_CD24	Claim Diagnosis Code XXIV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	7
105	ICD DGNS CD25	ICD_DGNS_CD25	Claim Diagnosis Code XXV	CHAR	1
106	ICD DGNS VRSN CD25	ICD_DGNS_VRSN_CD25	Claim Diagnosis Code XXV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
107	FST_DGNS_E_CD	FST_DGNS_E_CD	First Claim Diagnosis E Code	CHAR	7
108	FST_DGNS_E_VRSN_CD	FST_DGNS_E_VRSN_CD	First Claim Diagnosis E Code Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
109	ICD DGNS E CD1	ICD_DGNS_E_CD1	Claim Diagnosis E Code I	CHAR	7
110	ICD DGNS E VRSN CD1	ICD_DGNS_E_VRSN_CD1	Claim Diagnosis E Code I Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
111	ICD DGNS E CD2	ICD_DGNS_E_CD2	Claim Diagnosis E Code II	CHAR	7
112	ICD DGNS E VRSN CD2	ICD_DGNS_E_VRSN_CD2	Claim Diagnosis E Code II Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
113	ICD DGNS E CD3	ICD_DGNS_E_CD3	Claim Diagnosis E Code III	CHAR	7
114	ICD DGNS E VRSN CD3	ICD_DGNS_E_VRSN_CD3	Claim Diagnosis E Code III Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
115	ICD DGNS E CD4	ICD_DGNS_E_CD4	Claim Diagnosis E Code IV	CHAR	7
116	ICD DGNS E VRSN CD4	ICD_DGNS_E_VRSN_CD4	Claim Diagnosis E Code IV Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
117	ICD DGNS E CD5	ICD_DGNS_E_CD5	Claim Diagnosis E Code V	CHAR	7
118	ICD DGNS E VRSN CD5	ICD_DGNS_E_VRSN_CD5	Claim Diagnosis E Code V Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
119	ICD DGNS E CD6	ICD_DGNS_E_CD6	Claim Diagnosis E Code VI	CHAR	7
120	ICD DGNS E VRSN CD6	ICD_DGNS_E_VRSN_CD6	Claim Diagnosis E Code VI Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
121	ICD DGNS E CD7	ICD_DGNS_E_CD7	Claim Diagnosis E Code VII	CHAR	7
122	ICD DGNS E VRSN CD7	ICD_DGNS_E_VRSN_CD7	Claim Diagnosis E Code VII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1

LDS Skilled Nursing Facility Data Dictionary

No.	Field Short Name	Field Long Name	Label	Type	Length
123	ICD DGNS E CD8	ICD_DGNS_E_CD8	Claim Diagnosis E Code VIII	CHAR	7
124	ICD DGNS E VRSN CD8	ICD_DGNS_E_VRSN_CD8	Claim Diagnosis E Code VIII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
125	ICD DGNS E CD9	ICD_DGNS_E_CD9	Claim Diagnosis E Code VIX	CHAR	7
126	ICD DGNS E VRSN CD9	ICD_DGNS_E_VRSN_CD9	Claim Diagnosis E Code VIX Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
127	ICD DGNS E CD10	ICD_DGNS_E_CD10	Claim Diagnosis E Code X	CHAR	7
128	ICD DGNS E VRSN CD10	ICD_DGNS_E_VRSN_CD10	Claim Diagnosis E Code X Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
129	ICD DGNS E CD11	ICD_DGNS_E_CD11	Claim Diagnosis E Code XI	CHAR	7
130	ICD DGNS E VRSN CD11	ICD_DGNS_E_VRSN_CD11	Claim Diagnosis E Code XI Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
131	ICD DGNS E CD12	ICD_DGNS_E_CD12	Claim Diagnosis E Code XII	CHAR	7
132	ICD DGNS E VRSN CD12	ICD_DGNS_E_VRSN_CD12	Claim Diagnosis E Code XII Diagnosis Version Code (ICD-9 or ICD-10)	CHAR	1
133	ICD_PRCDR_CD1	ICD_PRCDR_CD1	Claim Procedure Code I	CHAR	7
134	ICD_PRCDR_VRSN_CD1	ICD_PRCDR_VRSN_CD1	Claim Procedure Code I Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
135	PRCDR_DT1	PRCDR_DT1	Claim Procedure Code I Date	DATE	8
136	ICD_PRCDR_CD2	ICD_PRCDR_CD2	Claim Procedure Code II	CHAR	7
137	ICD_PRCDR_VRSN_CD2	ICD_PRCDR_VRSN_CD2	Claim Procedure Code II Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
138	PRCDR_DT2	PRCDR_DT2	Claim Procedure Code II Date	DATE	8
139	ICD_PRCDR_CD3	ICD_PRCDR_CD3	Claim Procedure Code III	CHAR	7
140	ICD_PRCDR_VRSN_CD3	ICD_PRCDR_VRSN_CD3	Claim Procedure Code III Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
141	PRCDR_DT3	PRCDR_DT3	Claim Procedure Code III Date	DATE	8
142	ICD_PRCDR_CD4	ICD_PRCDR_CD4	Claim Procedure Code IV	CHAR	7
143	ICD_PRCDR_VRSN_CD4	ICD_PRCDR_VRSN_CD4	Claim Procedure Code IV Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
144	PRCDR_DT4	PRCDR_DT4	Claim Procedure Code IV Date	DATE	8
145	ICD_PRCDR_CD5	ICD_PRCDR_CD5	Claim Procedure Code V	CHAR	7
146	ICD_PRCDR_VRSN_CD5	ICD_PRCDR_VRSN_CD5	Claim Procedure Code V Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
147	PRCDR_DT5	PRCDR_DT5	Claim Procedure Code V Date	DATE	8
148	ICD_PRCDR_CD6	ICD_PRCDR_CD6	Claim Procedure Code VI	CHAR	7
149	ICD_PRCDR_VRSN_CD6	ICD_PRCDR_VRSN_CD6	Claim Procedure Code VI Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
150	PRCDR_DT6	PRCDR_DT6	Claim Procedure Code VI Date	DATE	8
151	ICD_PRCDR_CD7	ICD_PRCDR_CD7	Claim Procedure Code VII	CHAR	7
152	ICD_PRCDR_VRSN_CD7	ICD_PRCDR_VRSN_CD7	Claim Procedure Code VII Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
153	PRCDR_DT7	PRCDR_DT7	Claim Procedure CodeVII Date	DATE	8
154	ICD_PRCDR_CD8	ICD_PRCDR_CD8	Claim Procedure Code VIII	CHAR	7
155	ICD_PRCDR_VRSN_CD8	ICD_PRCDR_VRSN_CD8	Claim Procedure Code VIII Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
156	PRCDR_DT8	PRCDR_DT8	Claim Procedure Code VIII Date	DATE	8
157	ICD_PRCDR_CD9	ICD_PRCDR_CD9	Claim Procedure Code IX	CHAR	7
158	ICD_PRCDR_VRSN_CD9	ICD_PRCDR_VRSN_CD9	Claim Procedure Code IX Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
159	PRCDR_DT9	PRCDR_DT9	Claim Procedure Code IX Date	DATE	8
160	ICD_PRCDR_CD10	ICD_PRCDR_CD10	Claim Procedure Code X	CHAR	7
161	ICD_PRCDR_VRSN_CD10	ICD_PRCDR_VRSN_CD10	Claim Procedure Code X Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
162	PRCDR_DT10	PRCDR_DT10	Claim Procedure Code X Date	DATE	8
163	ICD_PRCDR_CD11	ICD_PRCDR_CD11	Claim Procedure Code XI	CHAR	7

LDS Skilled Nursing Facility Data Dictionary

No.	Field Short Name	Field Long Name	Label	Type	Length
164	ICD_PRCDR_VRSN_CD11	ICD_PRCDR_VRSN_CD11	Claim Procedure Code XI Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
165	PRCDR_DT11	PRCDR_DT11	Claim Procedure Code XI Date	DATE	8
166	ICD_PRCDR_CD12	ICD_PRCDR_CD12	Claim Procedure Code XII	CHAR	7
167	ICD_PRCDR_VRSN_CD12	ICD_PRCDR_VRSN_CD12	Claim Procedure Code XII Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
168	PRCDR_DT12	PRCDR_DT12	Claim Procedure Code XII Date	DATE	8
169	ICD_PRCDR_CD13	ICD_PRCDR_CD13	Claim Procedure Code XIII	CHAR	7
170	ICD_PRCDR_VRSN_CD13	ICD_PRCDR_VRSN_CD13	Claim Procedure Code XIII Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
171	PRCDR_DT13	PRCDR_DT13	Claim Procedure Code XIII Date	DATE	8
172	ICD_PRCDR_CD14	ICD_PRCDR_CD14	Claim Procedure Code XIV	CHAR	7
173	ICD_PRCDR_VRSN_CD14	ICD_PRCDR_VRSN_CD14	Claim Procedure Code XIV Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
174	PRCDR_DT14	PRCDR_DT14	Claim Procedure Code XIV Date	DATE	8
175	ICD_PRCDR_CD15	ICD_PRCDR_CD15	Claim Procedure Code XV	CHAR	7
176	ICD_PRCDR_VRSN_CD15	ICD_PRCDR_VRSN_CD15	Claim Procedure Code XV Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
177	PRCDR_DT15	PRCDR_DT15	Claim Procedure Code XV Date	DATE	8
178	ICD_PRCDR_CD16	ICD_PRCDR_CD16	Claim Procedure Code XVI	CHAR	7
179	ICD_PRCDR_VRSN_CD16	ICD_PRCDR_VRSN_CD16	Claim Procedure Code XVI Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
180	PRCDR_DT16	PRCDR_DT16	Claim Procedure Code XVI Date	DATE	8
181	ICD_PRCDR_CD17	ICD_PRCDR_CD17	Claim Procedure Code XVII	CHAR	7
182	ICD_PRCDR_VRSN_CD17	ICD_PRCDR_VRSN_CD17	Claim Procedure Code XVII Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
183	PRCDR_DT17	PRCDR_DT17	Claim Procedure Code XVII Date	DATE	8
184	ICD_PRCDR_CD18	ICD_PRCDR_CD18	Claim Procedure Code XVIII	CHAR	7
185	ICD_PRCDR_VRSN_CD18	ICD_PRCDR_VRSN_CD18	Claim Procedure Code XVIII Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
186	PRCDR_DT18	PRCDR_DT18	Claim Procedure Code XVIII Date	DATE	8
187	ICD_PRCDR_CD19	ICD_PRCDR_CD19	Claim Procedure Code XIX	CHAR	7
188	ICD_PRCDR_VRSN_CD19	ICD_PRCDR_VRSN_CD19	Claim Procedure Code XIX Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
189	PRCDR_DT19	PRCDR_DT19	Claim Procedure Code XIX Date	DATE	8
190	ICD_PRCDR_CD20	ICD_PRCDR_CD20	Claim Procedure Code XX	CHAR	7
191	ICD_PRCDR_VRSN_CD20	ICD_PRCDR_VRSN_CD20	Claim Procedure Code XX Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
192	PRCDR_DT20	PRCDR_DT20	Claim Procedure Code XX Date	DATE	8
193	ICD_PRCDR_CD21	ICD_PRCDR_CD21	Claim Procedure Code XXI	CHAR	7
194	ICD_PRCDR_VRSN_CD21	ICD_PRCDR_VRSN_CD21	Claim Procedure Code XXI Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
195	PRCDR_DT21	PRCDR_DT21	Claim Procedure Code XXI Date	DATE	8
196	ICD_PRCDR_CD22	ICD_PRCDR_CD22	Claim Procedure Code XXII	CHAR	7
197	ICD_PRCDR_VRSN_CD22	ICD_PRCDR_VRSN_CD22	Claim Procedure Code XXII Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
198	PRCDR_DT22	PRCDR_DT22	Claim Procedure Code XXII Date	DATE	8
199	ICD_PRCDR_CD23	ICD_PRCDR_CD23	Claim Procedure Code XXIII	CHAR	7
200	ICD_PRCDR_VRSN_CD23	ICD_PRCDR_VRSN_CD23	Claim Procedure Code XXIII Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
201	PRCDR_DT23	PRCDR_DT23	Claim Procedure Code XXIII Date	DATE	8
202	ICD_PRCDR_CD24	ICD_PRCDR_CD24	Claim Procedure Code XXIV	CHAR	7
203	ICD_PRCDR_VRSN_CD24	ICD_PRCDR_VRSN_CD24	Claim Procedure Code XXIV Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
204	PRCDR_DT24	PRCDR_DT24	Claim Procedure Code XXIV Date	DATE	8

LDS Skilled Nursing Facility Data Dictionary

No.	Field Short Name	Field Long Name	Label	Type	Length
205	ICD_PRCDR_CD25	ICD_PRCDR_CD25	Claim Procedure Code XXV	CHAR	7
206	ICD_PRCDR_VRSN_CD25	ICD_PRCDR_VRSN_CD25	Claim Procedure Code XXV Claim Procedure Version Code (ICD-9 or ICD-10)	CHAR	1
207	PRCDR_DT25	PRCDR_DT25	Claim Procedure Code XXV Date	DATE	8
208	DOB_DT	DOB_DT	LDS Age Category	NUM	1
209	GNDR_CD	GNDR_CD	Gender Code from Claim	CHAR	1
210	RACE_CD	BENE_RACE_CD	Race Code from Claim	CHAR	1
211	CNTY_CD	BENE_CNTY_CD	County Code from Claim (SSA)	CHAR	3
212	STATE_CD	BENE_STATE_CD	State Code from Claim (SSA)	CHAR	2
213	CWF_BENE_MDCR_STUS_CD	CWF_BENE_MDCR_STUS_CD	CWF Beneficiary Medicare Status Code	CHAR	2

Condition Code File					
1	DSYSRTKY	DESY_SORT_KEY	LDS Beneficiary ID	NUM	9
2	CLAIMNO	CLAIM_NO	LDS Claim Number	NUM	12
3	RLTCNDSQ	RLT_COND_CD_SEQ	Claim Related Condition Code Sequence	CHAR	2
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	RLT_COND	CLM_RLT_COND_CD	Claim Related Condition Code	CHAR	2

Occurrence Code File					
1	DSYSRTKY	DESY_SORT_KEY	LDS Beneficiary ID	NUM	9
2	CLAIMNO	CLAIM_NO	LDS Claim Number	NUM	12
3	RLTOCRSQ	RLT_OCRNC_CD_SEQ	Claim Related Occurrence Code Sequence	CHAR	2
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	OCRNC_CD	CLM_RLT_OCRNC_CD	Claim Related Occurrence Code	CHAR	2
7	OCRNCDT	CLM_RLT_OCRNC_DT	Claim Related Occurrence Date	DATE	8

Value Code File					
1	DSYSRTKY	DESY_SORT_KEY	LDS Beneficiary ID	NUM	9
2	CLAIMNO	CLAIM_NO	LDS Claim Number	NUM	12
3	RLTVALSQ	RLT_VAL_CD_SEQ	Claim Related Value Code Sequence	CHAR	2
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	VAL_CD	CLM_VAL_CD	Claim Value Code	CHAR	2
7	VAL_AMT	CLM_VAL_AMT	Claim Value Amount	NUM	12

Revenue Center 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

LDS Skilled Nursing Facility Data Dictionary

No.	Field Short Name	Field Long Name	Label	Type	Length
6	REV_CNTR	REV_CNTR	Revenue Center Code	CHAR	4
7	HCPCS_CD	HCPCS_CD	Revenue Center HCFA Common Procedure Coding System	CHAR	5
8	REV_UNIT	REV_CNTR_UNIT_CNT	Revenue Center Unit Count	NUM	8
9	REV_RATE	REV_CNTR_RATE_AMT	Revenue Center Rate Amount	NUM	12
10	REV_CHRG	REV_CNTR_TOT_CHRG_AMT	Revenue Center Total Charge Amount	NUM	12
11	REV_NCVR	REV_CNTR_NCVRD_CHRG_AMT	Revenue Center Non-Covered Charge Amount	NUM	12
12	REVDEDCD	REV_CNTR_DDCTBL_COINSRNC_CD	Revenue Center Deductible Coinsurance Code	CHAR	1

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.		
PROVIDER	This variable is the provider identification number. The first two digits indicate the state where the provider is located, using the SSA state codes; the middle two characters indicate the type of provider; and the last two digits are used as a counter for the number of providers within that state and type of provider (i.e., this is a unique but not necessarily sequential number).		Refer to CCW Technical Guidance document: "Getting Started with Medicare Data" for additional information regarding setting classifications.
THRU_DT	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').		
RIC_CD	A code defining the type of claim record being processed.		
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.
QUERY_CD	Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator).	CODES: 0 - Credit adjustment 1 - Interim bill 3 - Final bill 5 - Debit adjustment	
FAC_TYPE	The first digit of the type of bill (TOB1) submitted on an institutional claim used to identify the type of facility that provided care to the beneficiary.	1 = Hospital 2 = Skilled Nursing Facility (SNF) 3 = Home Health Agency (HHA) 4 = Religious Non-medical (hospital) 6 = Intermediate Care 7 = Clinic services or hospital-based renal dialysis facility 8 = Ambulatory Surgery Center (ASC) or other special facility (e.g. Hospice)	
TYPESRVC	The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification of the type of service provided to the beneficiary.	For facility type codes 1-6: 1 = Inpatient 2 = Inpatient or Home Health (covered on Part B) 3 = Outpatient (or HHA - covered on Part A) 4 = Other (Part B) - Includes HHA medical services 5 = Intermediate Care - Level I 6 = Intermediate Care - Level II 7 = Subacute Inpatient (revenue code 019x required) 8 = Swing Bed For facility type code 7 (clinics): 1 = Rural Health Clinic 2 = Hospital based or indep renal dialysis facility 3 = Free-standing provider based FQHC 4 = Other Rehab Facility (ORF) 5 = Comprehensive Rehab Center (CORF) 6 = Community Mental Health Center (CMHC) 7 = Federally Qualified Health Center (FQHC) For facility type code 8 (special facility): 1 = Hospice (non-hospital based) 2 = Hospice (hospital based) 3 = Ambulatory Surgical Center (ASC) in hospital OPT 4 = Freestanding birthing center 5 = Critical Access Hospital - OPT services	

FREQ_CD	The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care.	0 = Non-payment / zero claim 1 = Admit thru discharge claim 2 = Interim - first claim 3 = Interim - continuing claim 4 = Interim - last claim 5 = Late charges only claim 7 = Replacement of prior claim 8 = Void / cancel prior claim 9 = Final claim (HH PPS = process as debit/credit to RAP claim) G = Common Working File (CWF) adjustment claim H = CMS generated adjustment claim I = Misc adjustment claim (from QIO, etc) J = Other adjustment request M = Medicare secondary payer (MSP) adjustment P = Adjustment required by QIO	
FI_NUM	The identification number assigned by CMS to a fiscal intermediary authorized to process institutional claim records.		Effective October 2006, the Medicare Administrative Contractors (MACs) began replacing the existing fiscal intermediaries and started processing institutional claim records for states assigned to its jurisdiction. NOTE: The 5-position MAC number will be housed in the existing FI_NUM field. During the transition from an FI to a MAC the FI_NUM field could contain either a FI number or a MAC number. See the FI_NUM table of codes to identify the new MAC numbers and their effective dates.
NOPAY_CD	The reason that no Medicare payment is made for services on an institutional claim.		NOTE: Effective with Version 'J', the field has been expanded on the NCH claim to 2 bytes. With this expansion the NCH will no longer use the character values to represent the official two byte values being sent in by CWF since 4/2002. During the Version 'J' conversion, all character values were converted to the two byte values.
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. 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 IRF PPS, 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.		

PRPAY_CD	The code on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's health insurance bills. The presence of a primary payer code indicates that some other payer besides Medicare covered at least some portion of the charges.	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.
ACTIONCD	The type of action requested by the intermediary to be taken on an institutional claim.	1 = Original debit action 5 = Force action code 3 (secondary debit adjustment) 8 = Benefits refused	
PRSTATE	The two position SSA state code where provider facility is located.		
ORGNPINM	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.		
AT_UPIN	On an institutional claim, the unique physician identification number (UPIN) of the physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the beneficiary's medical care and treatment (attending physician).		Alert: Starting April 9, 2014 CMS is no longer encrypting physician identifiers, e.g., National Provider Identifiers (NPIs), on the SAFs. All new SAF requests will include actual NPI rather than an encrypted physician identifier. Researchers who have already purchased SAFs and have an active Data Use Agreement (DUA) with CMS may request a crosswalk linking encrypted physician identifiers to NPIs/UPINs. For more information on how to request the crosswalk visit: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/DUAs_-_more_actions.html
AT_NPI	On an institutional claim, the national provider identifier (NPI) number assigned to uniquely identify the physician who has overall responsibility for the beneficiary's care and treatment.		Alert: Starting April 9, 2014 CMS is no longer encrypting physician identifiers, e.g., National Provider Identifiers (NPIs), on the SAFs. All new SAF requests will include actual NPI rather than an encrypted physician identifier. Researchers who have already purchased SAFs and have an active Data Use Agreement (DUA) with CMS may request a crosswalk linking encrypted physician identifiers to NPIs/UPINs. For more information on how to request the crosswalk visit: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/DUAs_-_more_actions.html
OP_UPIN	On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim.		Alert: Starting April 9, 2014 CMS is no longer encrypting physician identifiers, e.g., National Provider Identifiers (NPIs), on the SAFs. All new SAF requests will include actual NPI rather than an encrypted physician identifier. Researchers who have already purchased SAFs and have an active Data Use Agreement (DUA) with CMS may request a crosswalk linking encrypted physician identifiers to NPIs/UPINs. For more information on how to request the crosswalk visit: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/DUAs_-_more_actions.html
OP_NPI	On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the other physician associated with the institutional claim.		Alert: Starting April 9, 2014 CMS is no longer encrypting physician identifiers, e.g., National Provider Identifiers (NPIs), on the SAFs. All new SAF requests will include actual NPI rather than an encrypted physician identifier. Researchers who have already purchased SAFs and have an active Data Use Agreement (DUA) with CMS may request a crosswalk linking encrypted physician identifiers to NPIs/UPINs. For more information on how to request the crosswalk visit: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/DUAs_-_more_actions.html
OT_UPIN	On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim.		Alert: Starting April 9, 2014 CMS is no longer encrypting physician identifiers, e.g., National Provider Identifiers (NPIs), on the SAFs. All new SAF requests will include actual NPI rather than an encrypted physician identifier. Researchers who have already purchased SAFs and have an active Data Use Agreement (DUA) with CMS may request a crosswalk linking encrypted physician identifiers to NPIs/UPINs. For more information on how to request the crosswalk visit: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/DUAs_-_more_actions.html

OT_NPI	On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the other physician associated with the institutional claim.		Alert: Starting April 9, 2014 CMS is no longer encrypting physician identifiers, e.g., National Provider Identifiers (NPIs), on the SAFs. All new SAF requests will include actual NPI rather than an encrypted physician identifier. Researchers who have already purchased SAFs and have an active Data Use Agreement (DUA) with CMS may request a crosswalk linking encrypted physician identifiers to NPIs/UPINs. For more information on how to request the crosswalk visit: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/DUAs_-_more_actions.html
MCOPDSW	A switch indicating whether or not a Managed Care Organization (MCO) has paid the provider for an institutional claim.	Blank = MCO has not paid the provider 0 = MCO has not paid the provider 1 = MCO has paid the provider for a claim	
STUS_CD	The code used to identify the status of the patient as of the CLM_THRU_DT.	0 = Unknown value (but present in data) 01 = Discharged to home/self care 02 = Discharged / transferred to short term hospital 03 = Discharged / transferred to SNF 04 = Discharged / transferred to intermediate care 05 = Discharged / transferred to other IPT care 06 = Discharged / transferred to HHA home care 07 = Left against medical advice or discontinue care 08 = Discharged / transferred to home IV drug care 09 = Admitted as an inpatient to hospital after OPT 20 = Expired (did not recover - Christian Science) 21 = Discharged / transferred to court /law enforce 30 = Still a patient 40 = Expired at home (hospice claims only) 41 = Expired in facility (hospice claims only) 42 = Expired place unknown (hospice claims only) 43 = Discharged / transferred to federal hospital 50 = Hospice - home 51 = Hospice - medical facility 61 = Discharged / transferred to swing bed internally 62 = Discharged / transferred to IPT Rehab 63 = Discharged / transferred to to LTC 64 = Discharged / transferred to Medicaid facility 65 = Discharged / transferred to Psychiatric Hospital 66 = Discharged / transferred to CAH 70 = Discharged / transferred to other misc facility 71 = Discharged / transferred to other OPT services 72 = Discharged / transferred internally for OPT svcs	
PPS_IND	The code indicating whether or not: (1) the claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee (MQGE).	Blank = Not a PPS bill 2 = PPS bill ; claim contains PPS indicator	
TOT_CHRG	The total charges for all services included on the institutional claim. This field is redundant with revenue center code 0001/total charges.		
ADMSN_DT	On an institutional claim, the date the beneficiary was admitted to the hospital, skilled nursing facility, or religious non-medical health care institution.		For the Limited Data Set Standard View of the Inpatient/SNF files, the admission date for the claim is coded as when the admission occurred. (As opposed to preceding the claim from date for patients who have been continuously under care.)
TYPE_ADM	The code indicating the type and priority of an inpatient admission associated with the service on an intermediary submitted claim.	0 = Unknown value (but present in data) 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma Center 9 = Unknown - Information not available	

SRC_ADMS	The code indicating the source of the referral for the admission or visit.	0 = ANOMALY: invalid value, if present, translate to '9' 1 = Non-Health Care Facility Point of Origin (Physician Referral) - The patient was admitted to this facility upon an order of a physician. 2 = Clinic referral - The patient was admitted upon the recommendation of this facility's clinic physician. 3 = HMO referral - Reserved for national Prior to 3/08, HMO referral - The patient was admitted upon the recommendation of an health maintenance organization (HMO) physician. 4 = Transfer from hospital (Different Facility) - The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient. 5 = Transfer from a skilled nursing facility (SNF) or Intermediate Care Facility (ICF) - The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident. 6 = Transfer from another health care facility - The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list where he or she was an inpatient. 7 = Emergency room - The patient was admitted to this facility after receiving services in this facility's emergency room department. 8 = Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative. 9 = Information not available - The means by which the patient was admitted is not known.	ADDITIONAL CODES: A = Reserved for National Assignment. (eff. 3/08) Prior to 3/08 defined as: Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital. B = Transfer from Another Home Health Agency - The patient was admitted to this home health agency as a transfer from another home health agency.(Discontinued July 1,2010- See Condition Code 47) C = Readmission to Same Home Health Agency - The patient was readmitted to this home health agency within the same home health episode period. (Discontinued July 1,2010) D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer - The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer. *For Newborn Type of Admission* 1 = Normal delivery - A baby delivered with out complications. 2 = Premature delivery - A baby delivered with time and/or weight factors qualifying it for premature status. 3 = Sick baby - A baby delivered with medical complications, other than those relating to premature status. 4 = Extramural birth - A baby delivered in a nonsterile environment. 5-8 = Reserved for national assignment. 9 = Information not available.
PTNTSTUS	Effective with Version H, the code on an inpatient/SNF and Hospice claim, indicating whether the beneficiary was discharged, died or still a patient (used for internal CWFMQA editing purposes.)	CODES: A = Discharged B = Died C = Still patient	
DED_AMT	The amount of the deductible the beneficiary paid for inpatient services, as originally submitted on the institutional claim. Under Part A, the deductible applies only to inpatient hospital care (whether in an acute care facility, Inpatient psychiatric facility [IPF], inpatient rehabilitation facility [IRF], or long term care hospital [LTCH]) and is charged only at the beginning of each benefit period, which is similar to an episode of illness.		This variable is null/missing for skilled nursing facility (SNF), home health, and hospice claims. Costs to beneficiaries are described in detail on the Medicare.gov website.
COIN_AMT	The amount of money for which the intermediary has determined that the beneficiary is liable for Part A coinsurance on the institutional claim.		Under Part A, beneficiaries pay coinsurance starting with the 61st day of an inpatient hospital stay (one daily amount for days 61-90, and a higher daily amount for any days after that, which count towards a beneficiary's 60 lifetime reserve days) or the 21st day of a skilled nursing facility (SNF) stay (a daily amount for days 21-100, after which SNF coverage ends). This variable is null/missing for home health and hospice claims.
BLDDEDAM	The amount of money for which the intermediary determined the beneficiary is liable for the blood deductible.		A blood deductible amount applies to the first 3 pints of blood (or equivalent units; applies only to whole blood or packed red cells - not platelets, fibrinogen, plasma, etc. which are considered biologicals). However, blood processing is not subject to a deductible. Calculation of the deductible amount considers both Part A and Part B claims combined. The blood deductible does not count toward meeting the inpatient hospital deductible or any other applicable deductible and coinsurance amounts for which the patient is responsible. Costs to beneficiaries are described in detail on the Medicare.gov website. There is a CMS publication called "Your Medicare Benefits", which explains the blood deductible.
NCCHGAMT	The non-covered charges for all accommodations and services, reported on an inpatient claim (used for internal CWFMQA editing purposes).		CWFMQA = Common Working Files Medicare Quality Assurance
CPTL_FSP	The amount of the federal specific portion of the PPS payment for capital. This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.		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)
CPTLOUTL	The amount of the outlier portion of the PPS payment for capital. This is one component of the total amount that is payable for capital PPS for the claim. The total captial amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.		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)
DISP_SHR	The amount of disproportionate share (rate reflecting indigent population served) portion of the PPS payment for capital. This is one component of the total amount that is payable for capital PPS for the claim. The total captial amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.		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)

IME_AMT	The amount of the indirect medical education (IME) (reimbursable amount for teaching hospitals only; an added amount passed by Congress to augment normal PPS payments for teaching hospitals to compensate them for higher patient costs resulting from medical education programs for interns and residents) portion of the PPS payment for capital. This is one component of the total amount that is payable for capital PPS for the claim. The total captial amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.		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)
CPTL_EXP	The capital PPS amount of exception payments provided for hospitals with inordinately high levels of capital obligations. Exception payments expire at the end of the 10-year transition period. This is one component of the total amount that is payable for capital PPS for the claim. The total capital amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.		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)
HLDHRMLS	This amount is the hold harmless amount payable for old capital as computed by PRICER for providers with a payment code equal to 'A'. The hold harmless amount-old capital is 100 percent of the reasonable costs of old capital for sole community sole community hospitals, or 85 percent of the reasonable costs associated with old capital for all other hospitals, plus a payment for new capital. This is one component of the total amount that is payable for capital PPS for the claim. The total captial amount, which includes this variable, is in the variable CLM_TOT_PPS_CPTL_AMT.		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)
UTIL_DAY	On an institutional claim, the number of covered days of care that are chargeable to Medicare facility utilization that includes full days, coinsurance days, and lifetime reserve days. It excludes any days classified as non-covered, leave of absence days, and the day of discharge or death.		
COIN_DAY	The count of the total number of coinsurance days involved with the beneficiary's stay in a facility.		
NUTILDAY	On an institutional claim, the number of days of care that are not chargeable to Medicare facility utilization.		
BLDFRNSH	Number of whole pints of blood furnished to the beneficiary, as reported on the carrier claim (non-DMERC).		
QLFYTHRU	The ending date of the beneficiary's qualifying Medicare stay. For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization of benefits. For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A' (transfer from critical access hospital), or at least three days in a row if the source of admission is other than 'A'.		DERIVED FROM: CLM_OCRNC_SPAN_CD and CLM_OCRNC_SPAN_THRU_DT DERIVATION RULES: Based on the presence of the occurrence span code (variable called CLM_SPAN_CD) 70. When this code value is present the date is populated using the CLM_SPAN_THRU_DT.
NCOVFROM	The beginning date of the beneficiary's non-covered stay (used for internal CWFMQA editing purposes). Medicare places limits on the number of days of inpatient or SNF care that a beneficiary may receive. For some beneficiaries, all days in one of these settings may not be covered by Medicare.		CWFMQA = Common Working Files Medicare Quality Assurance. DERIVATION RULES: Based on the presence of the occurrence span code (variable called CLM_SPAN_CD) 74, 76, 77, or 79. When this code value is present the date is populated using the CLM_SPAN_FROM_DT.
NCOVTHRU	The ending date of the beneficiary's non-covered stay (used for internal CWFMQA editing purposes.) Medicare places limits on the number of days of inpatient or SNF care that a beneficiary may receive. For some beneficiaries, all days in one of these settings may not be covered by Medicare.		CWFMQA = Common Working Files Medicare Quality Assurance. DERIVATION RULES: Based on the presence of the occurrence span code (variable called CLM_SPAN_CD) 74, 76, 77, or 79. When this code value is present the date is populated using the CLM_SPAN_FROM_DT.
EXHST_DT	The last date for which the beneficiary has Medicare coverage. This is completed only where benefits were exhausted before the date of discharge and during the billing period covered by this institutional claim.		DERIVED FROM: CLM_RLT_OCRNC_CD and CLM_RLT_OCRNC_DT DERIVATION RULES (Eff 10/93): Based on the presence of occurrence code A3, B3 or C3 move the related occurrence date to NCH_MDCR_BNFT_EXHST_DT.
DSCHRGDT	On an inpatient or HHA claim, the date the beneficiary was discharged from the facility or died (used for internal CWFMQA editing purposes.)		CWFMQA = Common Working Files Medicare Quality Assurance. Date matches the "thru" date on the claim (CLM_THRU_DT). When there is a discharge date, the discharge status code (PTNT_DSCHRG_STUS_CD) indicates the final disposition of the patient after discharge.
DRG_CD	The diagnostic related group to which a hospital claim belongs for prospective payment purposes.		GROUPER is the software that determines the DRG from data elements reported by the hospital. Once determined, the DRG code is one of the elements used to determine the price upon which to base the reimbursement to the hospitals under prospective payment. Nonpayment claims (zero reimbursement) may not have a DRG present.

ADMTG_DGNS_CD	A diagnosis code on the institutional claim indicating the beneficiary's initial diagnosis at admission. This diagnosis code may not be confirmed after the patient is evaluated; it may be different than the eventual diagnoses (e.g., as in PRNCPAL_DGNS_CD or ICD_DGNS_CD1-25).		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.
ADMTG_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 accommodate ICD-10, even though 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.		Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.
PRNCPAL_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 accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2015.
ICD DGNS CD1 to CD25	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 acommodated), 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 CD25	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.
FST_DGNS_E_CD	The code used to identify the first external cause of injury, poisoning, or other adverse effect. This diagnosis E code is also stored as the first occurrence of the diagnosis E code trailer.		Prior to version 'J', this field was named: CLM_DGNS_E_CD. Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10, which is not scheduled for implementation until 10/2015.
FST_DGNS_E_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 accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2015.
ICD DGNS E CD1 to CD12	The code used to identify the external cause of injury, poisoning, or other adverse affect.		Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accomodate the implementation of ICD-10 in October of 2015.
ICD DGNS E 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.
ICD_PRCDR_CD1 to CD25	The code that indicates the principal or other procedure performed during the period covered by the institutional claim.		Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPAA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.
ICD_PRCDR_VRSN_CD1 to CD25	The code used to indicate if the surgical procedure 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.
PRCDR_DT1 to DT25	On an institutional claim, the date on which the principal or other procedure was performed.		For the Limited Data Set Standard View of the Inpatient/SNF files, the claim procedure performed date is coded as when the procedure was performed.
DOB_DT	The beneficiary's date of birth, coded as a range.	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 of the Inpatient/SNF files, the beneficiary's date of birth is coded as a range.
GNDR_CD	The sex of a beneficiary.	1 = Male 2 = Female 0 = Unknown	

RACE_CD	The race of a beneficiary.	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 2-digit SSA standard 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	

Condition Code 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.		
RLTCNDSQ	The sequence number of the claim related condition code (variable called CLM_RLT_COND_CD).		
THRU_DT	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').		
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.
RLT_COND	The code that indicates a condition relating to an institutional claim that may affect payer processing.	01 THRU 16 = Insurance related 17 THRU 30 = Special condition 31 THRU 35 = Student status codes which are required when a patient is a dependent child over 18 years old 36 THRU 45 = Accommodation 46 THRU 54 = CHAMPUS information 55 THRU 59 = Skilled nursing facility 60 THRU 70 = Prospective payment 71 THRU 99 = Renal dialysis setting A0 THRU B9 = Special program codes C0 THRU C9 = PRO approval services D0 THRU W0 = Change conditions	

Occurrence Code 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.		
RLTOCRSQ	The sequence number of the claim related occurrence code (variable called CLM_RLT_OCRNC_CD).		
THRU_DT	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').		

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.
OCRNC_CD	The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are associated with a specific date (the claim related occurrence date).	01 THRU 09 = Accident 10 THRU 19 = Medical condition 20 THRU 39 = Insurance related 40 THRU 69 = Service related A1-A3 = Miscellaneous	
OCRNCDT	The date associated with a significant event related to an institutional claim that may affect payer processing. The date for the event that appears in the claim related occurrence code field.		For the Limited Data Set Standard View of the Inpatient/SNF files, the claim procedure performed date is coded as when the procedure was performed.

Value Code 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.		
RLTVALSQ	The sequence number of the claim related condition code (variable called CLM_RLT_COND_CD).		
THRU_DT	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').		
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.
VAL_CD	The code indicating the value of a monetary condition which was used by the intermediary to process an institutional claim. The associated monetary value is in the claim value amount field (CLM_VAL_AMT).		
VAL_AMT	The amount related to the condition identified in the CLM_VAL_CD field which was used by the intermediary to process the institutional claim.		

Revenue Center 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	The claim line number for detail revenue or part B line.		
THRU_DT	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').		
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.

REV_CNTR	The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.		
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. In the Institutional Claim Revenue Center Files, this variable can indicate the specific case-mix grouping that Medicare used to pay for skilled nursing facility (SNF), home health, or inpatient rehabilitation facility (IRF) services. These groupings are sometimes known as Health Insurance Prospective Payment System (HIPPS) codes. This field will contain a HIPPS code if the revenue center code (REV_CNTR) equals 0022 for SNF care, 0023 for home health, or 0024 for IRF care. For home health claims, please also see the revenue center APC/HIPPS code variable (REV_CNTR_APC_HIPPS_CD).		Level I Codes and descriptors copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4). These are 5 position numeric codes representing physician and nonphysician services. Note: CPT-4 codes including both long and short descriptions shall be used in accordance with the 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 nonphysician services that are not represented in the level I codes. Level III Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not represented in the level I or level II codes.
REV_UNIT	A quantitative measure (unit) of the number of times the service or procedure being reported was performed according to the revenue center/HCPCS code definition as described on an institutional claim. Depending on type of service, units are measured by number of covered days in a particular accommodation, pints of blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests.		When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code.
REV_RATE	Charges relating to unit cost associated with the revenue center code. Exception (encounter data only): If plan (e.g. MCO) does not know the actual rate for the accommodations, $1 will be reported in the field.		NOTE1: For SNF PPS claims (when revenue center code equals '0022'), CMS has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue center HCPCS code field). NOTE2: For OP PPS claims, CMS has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index. NOTE3: Under HH PPS (when revenue center code equals '0023'), CMS has developed a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode. On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment. In cases of SCICs, there will be more than one '0023' revenue center line, each representing the payment made at each case-mix level. NOTE4: For IRF PPS claims (when revenue center code equals '0024'), CMS has developed a PRICER to compute the rate based on the HIPPS/CMG (HIPPS code, stored in revenue center HCPCS code field).

REV_CHRG	The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided. NOTE: For accommodation revenue center total charges must equal the rate times units (days).		EXCEPTIONS: (1) For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo). (2) For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero. (3) For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line. (4) For Home Health PPS (final claim), when revenue center code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023'). (5) For Inpatient Rehabilitation Facility (IFR) PPS, when the revenue center code = '0024', the total charges will be zero. For accommodation revenue codes (010X - 021X), total charges must equal the rate times the units. (6) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be $1 (rate) times units (days).
REV_NCVR	The charge amount related to a revenue center code for services that are not covered by Medicare.		
REVDEDCD	Code indicating whether the revenue center charges are subject to deductible and/or coinsurance.	0 = Charges subject to deductible and coinsurance 1 = Charges not subject to deductible 2 = Charges not subject to coinsurance 3 = Charges not subject to deductible or coinsurance 4 = No charge or units associated with this revenue center code. (For multiple HCPCS per single revenue center code) For revenue center code 0001, the following MSP override values may be present: M = Override code; EGHP (employer group health plan) services involved N = Override code; non-EGHP services involved X = Override code: MSP (Medicare is secondary payer) cost avoided	