Research Data Distribution Center
LDS Inpatient SNF Claim Record
Data Dictionary

Variable Name	***Label***
CLAIM_NO	*CLAIM NUMBER* The unique number used to identify a unique claim. SAS ALIAS: CLAIM_NO STANDARD ALIAS: CLAIM_NO
DSYSRTKY	*DESY SORT KEY* This field contains the key to link data for each beneficiary across all claim files. SAS ALIAS: DSYSRTKY STANDARD ALIAS: DESY_SORT_KEY
REC_LVL	*NCH Near-Line Record Version Code* The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored: DB2 ALIAS: NCH_REC_VRSN_CD SAS ALIAS: REC_LVL STANDARD ALIAS: NCH_NEAR_LINE_REC_VRSN_CD TITLE ALIAS: NCH_VERSION CODES: A = Record format as of January 1991 B = Record format as of April 1991 C = Record format as of May 1991 D = Record format as of January 1992 E = Record format as of March 1992 F = Record format as of May 1992 G = Record format as of October 1993 H = Record format as of September 1998 I = Record format as of July 2000 COMMENT: Prior to Version H this field was named: CLM_NEAR_LINE_REC_VRSN_CD SOURCE: NCH

Variable Name	*Label*
RIC_CD	*NCN Near Line Record Identification Code*

A code defining the type of claim record being processed. COMMON ALIAS: RIC

DBS ALAIS: NEAR_LINE_RIC_CD
SAS ALIAS: RIC_CD
STANDARD ALIAS: NCH_NEAR_LINE_RIC_CD
TITLE ALIAS: RIC

CODES:
REFER TO: NCH_NEAR_LINE_RIC_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
RIC_CD.

SOURCE:
NCH

CLM_TYPE	*NCH Claim Type Code*

The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was populated with data through-out history (back to service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.

DB2 ALIAS: NCH_CLM_TYPE_CD
SAS ALIAS: CLM_TYPE
STANDARD ALIAS: NCH_CLM_TYPE_CD
SYSTEM ALIAS: LTTYPE
TITLE ALIAS: CLAIM_TYPE

DERIVATION:
FFS CLAIM TYPE CODES DERIVED FROM:
NCH CLM_NEAR_LINE_RIC_CD
NCH PMT_EDIT_RIC_CD
NCH CLM_TRANS_CD
NCH PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(Pre-HDC processing -- AVAILABLE IN NCH)
CLM_MCO_PD_SW
CLM_RLT_COND_CD
MCO_CNTRCT_NUM
MCO_OPTN_CD
MCO_PRD_EFCTV_DT
MCO_PRD_TRMNTN_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(HDC processing -- AVAILABLE IN NMUD)
FI_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD)
FI_NUM
CLM_FAC_TYPE_CD
CLM_SRVC_CLSFCTN_TYPE_CD
CLM_FREQ_CD

NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.

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

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

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

DERIVATION RULES:

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

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

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

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

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

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1. FI_NUM = 80881
2. CLM_FAC_TYPE_CD = '1' OR '8';
CLM_SRVC_ CLSFCTN_TYPE_CD = '2', '3' OR '4'
& CLM_FREQ_CD = 'Z', 'Y' OR 'X'

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

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

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

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER

CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--EFFECTIVE WITH HDC PROCESSING) WHERE THE CONDITIONS ARE MET:
1. CARR_NUM = 80882 AND
2. CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

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

CODES:
REFER TO: NCH_CLM_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
NCH

STATE_CD *Beneficiary Residence SSA Standard State Code*

The SSA standard state code of a beneficiary's residence. DA3 ALIAS: SSA_STANDARD_STATE_CODE

DB2 ALIAS: BENE_SSA_STATE_CD
SAS ALIAS: STATE_CD
STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD
TITLE ALIAS: BENE_STATE_CD

EDIT-RULES:
OPTIONAL: MAY BE BLANK

CODES:
REFER TO: GEO_SSA_STATE_TB
IN THE CODES APPENDIX

COMMENT:
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.

SOURCE:
SSA/EDB

THRU_DT *Claim Through Date*

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

For the Limited Data Set Standard View of the Inpatient/SNF files, the claim through date is coded as the quarter of the calendar year when the claim through date occurred.

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

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_THRU_DT
SAS ALIAS: THRU_DT
STANDARD ALIAS: CLM_THRU_DT
TITLE ALIAS: THRU_DATE

EDIT-RULES FOR LIMITED DATA SET DATA:
YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES.
1 = FIRST QUARTER OF THE CALENDAR YEAR
2 = SECOND QUARTER OF THE CALENDAR YEAR
3 = THIRD QUARTER OF THE CALENDAR YEAR
4 = FOURTH QUARTER OF THE CALENDAR YEAR

SOURCE:
CWF

QUERY_CD *Claim Query Code*

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

DB2 ALIAS: CLM_QUERY_CD
SAS ALIAS: QUERY_CD
STANDARD ALIAS: CLM_QUERY_CD
TITLE ALIAS: QUERY_CD

CODES:
0 = Credit adjustment
1 = Interim bill
2 = Home Health Agency (HHA) benefits exhausted (obsolete 7/98)
3 = Final bill
4 = Discharge notice (obsolete 7/98)
5 = Debit adjustment

SOURCE:
CWF

PROVIDER *Provider Number*

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

DB2 ALIAS: PRVDR_NUM
SAS ALIAS: PROVIDER

STANDARD ALIAS: PRVDR_NUM
TITLE ALIAS: PROVIDER_NUMBER

CODES:
REFER TO: PRVDR_NUM_TB
IN THE CODES APPENDIX
SOURCE:
OSCAR

SGMT_CNT — *Claim Total Segment Count*

Effective with Version I, the count used to identify the total number of segments associated with a given claim. Each claim could have up to 10 segments.
2 DIGITS UNSIGNED
DB2 ALIAS: TOT_SGMT_CNT
SAS ALIAS: SGMT_CNT
STANDARD ALIAS:
CLM_TOT_SGMT_CNT TITLE ALIAS:
SEGMENT_COUNT SOURCE:
CWF

SGMT_NUM — *Claim Segment Number*

Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim.
NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). For institutional claims prior to 7/00, this number will be either 1 or 2. For non-institutional claims, the number will always be 1.
2 DIGITS UNSIGNED
DB2 ALIAS: CLM_SGMT_NUM
SAS ALIAS: SGMT_NUM
STANDARD ALIAS:
CLM_SGMT_NUM TITLE ALIAS:
SEGMENT_NUMBER SOURCE:
CWF

PE_RIC — *NCH Payment and Edit Record Identification Code*

This field is no longer populated as it is unavailable from the data source

TRANS_CD — *Claim Transaction Code*

This field is no longer populated as it is unavailable from the data source

FAC_TYPE — *Claim Facility Type Code*

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.

COMMON ALIAS: TOB1
DB2 ALIAS: CLM_FAC_TYPE_CD
SAS ALIAS: FAC_TYPE
STANDARD ALIAS: CLM_FAC_TYPE_CD
TITLE ALIAS: TOB1

CODES:

REFER TO: CLM_FAC_TYPE_TB
IN THE CODES APPENDIX

SOURCE: CWF

TYPESRVC *Claim Service Classification Type Code*

The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification ofthe type of service provided to the beneficiary.

COMMON ALIAS: TOB2
DB2 ALIAS: SRVC_CLSFCTN_CD
SAS ALIAS: TYPESRVC
STANDARD ALIAS: CLM_SRVC_CLSFCTN_TYPE_CD
TITLE ALIAS: TOB2

CODES:
REFER TO: CLM_SRVC_CLSFCTN_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
CWF

FREQ_CD *Claim Frequency Code*

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.

COMMON ALIAS: TOB3
DB2 ALIAS: CLM_FREQ_CD
SAS ALIAS: FREQ_CD
STANDARD ALIAS: CLM_FREQ_CD
SYSTEM ALIAS: LTFREQ
TITLE ALIAS: FREQUENCY_CD

CODES:
REFER TO: CLM_FREQ_TB
IN THE CODES APPENDIX

SOURCE:
CWF

CNTY_CD *Beneficiary Residence SSA Standard County Code*

The SSA standard county code of a beneficiary's residence. DA3
ALIAS: SSA_STANDARD_COUNTY_CODE
DB2 ALIAS: BENE_SSA_CNTY_CD
SAS ALIAS: CNTY_CD
STANDARD ALIAS: BENE_CNTY_CD
TITLE ALIAS: BENE_COUNTY_CD

EDIT-RULES:
OPTIONAL: MAY BE BLANK

SOURCE:
SSA/EDB

FI_NUM *FI Number*

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

DB2 ALIAS: FI_NUM
SAS ALIAS: FI_NUM
STANDARD ALIAS: FI_NUM
SYSTEM ALIAS: LTFI
TITLE ALIAS: INTERMEDIARY
CODES:
REFER TO: FI_NUM_TB
IN THE CODES APPENDIX
COMMENT:
Prior to Version H this field was named: FICARR_IDENT_NUM.

SOURCE:
CWF

GNDR_CD *Beneficiary Sex Identification Code*

The sex of a beneficiary. COMMON ALIAS: SEX_CD DA3 ALIAS: SEX_CODE
DB2 ALIAS: BENE_SEX_IDENT_CD
SAS ALIAS: GNDR_CD
STANDARD ALIAS: GNDR_CD
SYSTEM ALIAS: LTSEX
TITLE ALIAS: SEX_CD
EDIT-RULES:
REQUIRED FIELD

CODES:
1 = Male
2 = Female
0 = Unknown

SOURCE:
SSA,RRB,EDB

RACE_CD *Beneficiary Race Code*

The race of a beneficiary.
DA3 ALIAS: RACE_CODE
DB2 ALIAS: BENE_RACE_CD
SAS ALIAS: RACE
STANDARD ALIAS: BENE_RACE_CD
SYSTEM ALIAS: LTRACE
TITLE ALIAS: RACE_CD

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

SOURCE: SSA

DOB_DT — *Beneficiary Birth Date*

The beneficiary's date of birth.
For the Limited Data Set Standard View of the Inpatient/SNF files, the beneficiary's date of birth is coded as a range.

8 DIGITS UNSIGNED

DB2 ALIAS: BENE_BIRTH_DT
SAS ALIAS: DOB_DT
STANDARD ALIAS: DOB_DT
TITLE ALIAS: BENE_BIRTH_DATE

EDIT-RULES FOR LIMITED DATA SET DATA:
0000000R
WHERE R HAS ONE OF THE FOLLOWING VALUES.
0 = Unknown
1 = <65
2 = 65 Thru 69
3 = 70 Thru 74
4 = 75 Thru 79
5 = 80 Thru 84
6 = >84

SOURCE:
CWF

MS_CD — *CWF Beneficiary Medicare Status Code*

The CWF -derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM_THRU_DT).
COBOL ALIAS: MSC
COMMON ALIAS: MSC
DB2 ALIAS: BENE_MDCR_STUS_CD
SAS ALIAS: MS_CD
STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD
SYSTEM ALIAS: LTMSC
TITLE ALIAS: MSC

DERIVATION:
CWF derives MSC from the following:
1. Date of Birth
2. Claim Through Date
3. Original/Current Reasons for entitlement
4. ESRD Indicator
5. Beneficiary Claim Number

Items 1,3,4,5 come from the CWF Beneficiary Master Record; item 2 comes from the FI/Carrier claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

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

COMMENT:
Prior to Version H this field was named:

BENE_MDCR_STUS_CD. The name has been changed to distinguish this CWF-derived field from the EDB-derived MSC (BENE_MDCR_STUS_CD).

SOURCE:
CWF

PDGNS_CD — *Claim Principal Diagnosis Code*

The ICD-9-CM 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.

NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer.

DB2 ALIAS: PRNCPAL_DGNS_CD
SAS ALIAS: PDGNS_CD
STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD
TITLE ALIAS: PRINCIPAL_DIAGNOSIS

EDIT-RULES:
ICD-9-CM

SOURCE:
CWF

NOPAY_CD — *Claim Medicare Non Payment Reason Code*

The reason that no Medicare payment is made for services on an institutional claim.
NOTE: Effective with Version I, this field was put on all institutional claim types.
Prior to Version I, this field was present only on inpatient/SNF claims.

DB2 ALIAS: MDCR_NPMT_RSN_CD
SAS ALIAS: NOPAY_CD
STANDARD ALIAS: CLM_MDCR_NPMT_RSN_CD
SYSTEM ALIAS: LTNPMT
TITLE ALIAS: NON_PAYMENT_REASON

EDIT-RULES:
OPTIONAL

CODES:
REFER TO: CLM_MDCR_NPMT_RSN_TB
IN THE CODES APPENDIX

SOURCE: CWF

TRTMT_CD *Claim Excepted/Nonexcepted Medical Treatment Code*

This field is no longer populated as it is unavailable from the data source

PMT_AMT *Claim Payment Amount*

Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. **NOTE: In some situations, a negative claim payment amount may be 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 a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)

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

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

Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total payment. The Medicare payment amount takes into account the wage index adjustment and the beneficiary deductible and coinsurance amounts. NOTE: There is no CWF edit check to validate that the revenue center Medicare payment amount equals the claim level Medicare payment amount. Under Home Health PPS, beneficiaries will be classified into an appropriate case mix category known as the Home Health Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG).

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

For the final claim, PRICER calculates 100% of the amount

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

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

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

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

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

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

9.2 DIGITS SIGNED
COMMON ALIAS: REIMBURSEMENT
DB2 ALIAS: CLM_PMT_AMT
SAS ALIAS: PMT_AMT
STANDARD ALIAS: CLM_PMT_AMT
TITLE ALIAS: REIMBURSEMENT
EDIT-RULES: +9(9).99

COMMENT:
Prior to Version H the size of this field was S9(7)V99. Also the noninstitutional claim records carried this field as a line item. Effective with Version H, this element is a claim level field across all claim types (and the line item field has been renamed.)

SOURCE:
CWF

LIMITATIONS:
Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM_DISP_CD of '02', the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over or under the actual Medicare payment amount.

PRPAYAMT — *NCH Primary Payer Claim Paid Amount*

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

9.2 DIGITS SIGNED

DB2 ALIAS: PRMRY_PYR_PD_AMT
SAS ALIAS: PRPAYAMT
STANDARD ALIAS: NCH_PRMRY_PYR_CLM_PD_AMT
TITLE ALIAS: PRIMARY_PAYER_AMOUNT

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H this field was named: BENE_PRMRY_PYR_CLM_PMT_AMT and the field size was S9(7)V99.

SOURCE:
NCH

PRPAY_CD — *NCH Primary Payer Code*

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.

DB2 ALIAS: NCH_PRMRY_PYR_CD
SAS ALIAS: PRPAY_CD
STANDARD ALIAS: NCH_PRMRY_PYR_CD
TITLE ALIAS: PRIMARY_PAYER_CD

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES

SET NCH_PRMRY_PYR_CD TO 'A' WHERE THE CLM_VAL_CD = '12'

SET NCH_PRMRY_PYR_CD TO 'B' WHERE THE CLM_VAL_CD = '13'

SET NCH_PRMRY_PYR_CD TO 'C' WHERE THE CLM_VAL_CD = '16' and CLM_VAL_AMT is zeroes

SET NCH_PRMRY_PYR_CD TO 'D' WHERE THE CLM_VAL_CD = '14'

SET NCH_PRMRY_PYR_CD TO 'E' WHERE THE CLM_VAL_CD = '15'

SET NCH_PRMRY_PYR_CD TO 'F' WHERE THE CLM_VAL_CD = '16' (CLM_VAL_AMT not equal to zeroes)

SET NCH_PRMRY_PYR_CD TO 'G' WHERE THE CLM_VAL_CD = '43'

SET NCH_PRMRY_PYR_CD TO 'H' WHERE THE CLM_VAL_CD = '41'

SET NCH_PRMRY_PYR_CD TO 'I' WHERE THE CLM_VAL_CD = '42'

SET NCH_PRMRY_PYR_CD TO 'L' (or prior to 4/97 set code to 'J') WHERE THE CLM_VAL_CD = '47'

CODES:
REFER TO: BENE_PRMRY_PYR_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
BENE_PRMRY_PYR_CD.

SOURCE:
NCH

CANCELCD — *FI Requested Claim Cancel Reason Code*

This field is no longer populated as it is unavailable from the data source

ACTIONCD — *FI Claim Action Code*

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

DB2 ALIAS: FI_CLM_ACTN_CD
SAS ALIAS: ACTIONCD
STANDARD ALIAS: FI_CLM_ACTN_CD
TITLE ALIAS: ACTION_CD

CODES:
REFER TO: FI_CLM_ACTN_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
INTRMDRY_CLM_ACTN_CD.

SOURCE:
CWF

PRSTATE — *NCH Provider State Code*

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

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

DB2 ALIAS: NCH_PRVDR_STATE_CD
SAS ALIAS: PRSTATE
STANDARD ALIAS: NCH_PRVDR_STATE_CD
TITLE ALIAS: PROVIDER_STATE_CD

DERIVATION:
DERIVED FROM:
NCH PRVDR_NUM

DERIVATION RULES:

SET NCH_PRVDR_STATE_CD TO
PRVDR_NUM POS1-2.
FOR PRVDR_NUM POS1-2 EQUAL '55
SET NCH_PRVDR_STATE_CD TO '05'.
FOR PRVDR_NUM POS1-2 EQUAL '67
SET NCH_PRVDR_STATE_CD TO '45'.
FOR PRVDR_NUM POS1-2 EQUAL '68
SET NCH_PRVDR_STATE_CD TO '10'.

CODES:
REFER TO: GEO_SSA_STATE_TB
IN THE CODES APPENDIX

SOURCE:
NCH

AT_UPIN — *Claim Attending Physician UPIN Number*

On an institutional claim, the unique physician identification number (UPIN) of the physician who would normally be expected 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).

This field is ENCRYPTED for the Limited Data Set Standard View of the Inpatient/SNF files.

COMMON ALIAS: ATTENDING_PHYSICIAN_UPIN
DB2 ALIAS: ATNDG_UPIN
SAS ALIAS: AT_UPIN
STANDARD ALIAS: CLM_ATNDG_PHYSN_UPIN_NUM
TITLE ALIAS: ATTENDING_PHYSICIAN

COMMENT:
Prior to Version H this field was named: CLM_PRMRY_CARE_PHYSN_IDENT_NUM and contained 10 positions (6-position UPIN and 4-position physician surname).

SOURCE:
CWF

OP_UPIN — *Claim Operating Physician UPIN Number*

On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal element is used by the provider to identify the operating physician who performed the surgical procedure.

This field is ENCRYPTED for the Limited Data Set Standard View of the Inpatient/SNF files.

DB2 ALIAS: OPRTG_UPIN
SAS ALIAS: OP_UPIN
STANDARD ALIAS: CLM_OPRTG_PHYSN_UPIN_NUM
TITLE ALIAS: OPRTG_UPIN

COMMENT:
Prior to Version H this field was named: CLM_PRNCPAL_PRCDR_PHYSN_NUM and contained 10 positions (6-position UPIN and 4-position

physician surname.

NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces.

SOURCE:
CWF

OT_UPIN — *Claim Other Physician UPIN Number*

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

This field is ENCRYPTED for the Limited Data Set Standard View of the Inpatient/SNF files.

DB2 ALIAS: OTHR_UPIN
SAS ALIAS: OT_UPIN
STANDARD ALIAS: CLM_OTHR_PHYSN_UPIN_NUM
TITLE ALIAS: OTH_PHYSN_UPIN

COMMENT:
Prior to Version H this field was named: CLM_OTHR_PHYSN_IDENT_NUM and contained 10 positions (6-position UPIN and 4-position other physician surname).

NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces.

SOURCE:
CWF

MCOPDSW — *Claim MCO Paid Switch*

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

COBOL ALIAS: MCO_PD_IND
DB2 ALIAS: CLM_MCO_PD_SW
SAS ALIAS: MCOPDSW
STANDARD ALIAS: CLM_MCO_PD_SW
TITLE ALIAS: MCO_PAID_SW

CODES:
1 = MCO has paid the provider for a claim
Blank or 0 = MCO has not paid the provider COMMENT:
Prior to Version H this field was named: CLM_GHO_PD_SW.

SOURCE:
CWF

STUS_CD — *Patient Discharge Status Code*

The code used to identify the status of the patient as of the CLM_THRU_DT.
COMMON ALIAS: DISCHARGE_DESTINATION/PATIENT_STATUS
DB2 ALIAS: PTNT_DSCHRG_STUS
SAS ALIAS: STUS_CD
STANDARD ALIAS: PTNT_DSCHRG_STUS_CD
SYSTEM ALIAS: LTCLMST
TITLE ALIAS: PTNT_DSCHRG_STUS_CD

CODES:
REFER TO: PTNT_DSCHRG_STUS_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CLM_STUS_CD.

SOURCE:
CWF

DGNS_E — *Claim Diagnosis E Code*

This field is no longer populated as it is unavailable from the data source

PPS_IND — *Claim PPS Indicator Code*

Effective with Version H, the code indicating whether or not the (1) claim is PPS and/or (2)
the beneficiary is a deemed insured Medicare
Qualified Government Employee (MQGE).

NOTE: Beginning with NCH weekly process date 10/3/97 through 5/29/98, this field was pop-ulated with only the PPS indicator. Beginning with NCH weekly process date 6/5/98, this field was additionally populated with the deemed MQGE indicator. Claims processed prior to 10/3/97 will contain spaces.

COBOL ALIAS: PPS_IND
DB2 ALIAS: CLM_PPS_IND_CD
SAS ALIAS: PPS_IND
STANDARD ALIAS: CLM_PPS_IND_CD
TITLE ALIAS: PPS_IND

CODES:
REFER TO: CLM_PPS_IND_TB
IN THE CODES APPENDIX

SOURCE:
CWF

TOT_CHRG — *Claim Total Charge Amount*

Effective with Version G, the total charges for all services included on the institutional claim.
This field is redundant with revenue
center code 0001/total charges.

9.2 DIGITS SIGNED

DB2 ALIAS: CLM_TOT_CHRG_AMT
SAS ALIAS: TOT_CHRG
STANDARD ALIAS: CLM_TOT_CHRG_AMT
TITLE ALIAS: CLAIM_TOTAL_CHARGES

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was S9(7)V99.

SOURCE:
CWF

IPDGNCNT *Inpatient/SNF Claim Diagnosis Code Count*

The count of the number of diagnosis codes (both principal and other) reported on an inpatient/SNF claim. The purpose of this count is to indicate how many claim diagnosis trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: IP_CLM_DGNS_CD_CNT
SAS ALIAS: IPDGNCNT
STANDARD ALIAS: IP_CLM_DGNS_CD_CNT

EDIT-RULES:
RANGE: 0 TO 10

COMMENT:
Prior to Version H this field was named: CLM_OTHR_DGNS_CD_CNT and the principal was not included in the count.

SOURCE:
CWF

IPPRCNT *Inpatient/SNF Claim Procedure Code Count*

The count of the number of procedure codes (both principal and other) reported on an inpatient/SNF claim. The purpose of this count is to indicate how many claim procedure trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: IP_PRCDR_CD_CNT
SAS ALIAS: IPPRCNT
STANDARD ALIAS: IP_CLM_PRCDR_CD_CNT

EDIT-RULES:
RANGE: 0 TO 6

COMMENT:
Prior to Version H this field was named: CLM_PRCDR_CD_CNT.

SOURCE:
CWF

IPCONCNT *Inpatient/SNF Claim Related Condition Code Count*

The count of the number of condition codes reported on an inpatient/SNF claim. The purpose of this count is to indicate how many condition code trailers are present.

2 DIGITS UNSIGNED
DB2 ALIAS: IP_RLT_COND_CD_CNT
SAS ALIAS: IPCONCNT
STANDARD ALIAS: IP_CLM_RLT_COND_CD_CNT
EDIT-RULES:
RANGE: 0 TO 30
COMMENT:
Prior to Version H this field was named:
CLM_RLT_COND_CD_CNT.
SOURCE: CWF

IPOCRCNT *Inpatient/SNF Claim Related Occurrence Code Count*

The count of the number of occurrence codes reported on an inpatient/SNF claim. The purpose of this count is to indicate how many occurrence code trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: IP_OCRNC_CD_CNT
SAS ALIAS: IPOCRCNT
STANDARD ALIAS: IP_CLM_RLT_OCRNC_CD_CNT

EDIT-RULES:
RANGE: 0 TO 30

COMMENT:
Prior to Version H this field was named:
CLM_RLT_OCRNC_CD_CNT.

SOURCE:
CWF

IPVALCNT *Inpatient/SNF Claim Value Code Count*

The count of the number of value codes reported on an inpatient/SNF claim. The purpose of the count is to indicate how many value code trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: IP_VAL_CD_CNT
SAS ALIAS: IPVALCNT
STANDARD ALIAS: IP_CLM_VAL_CD_CNT

EDIT-RULES:
RANGE: 0 TO 36

COMMENT:
Prior to Version H this field was named:
CLM_VAL_CD_CNT.

SOURCE:
CWF

IPREVCNT — *Inpatient/SNF Revenue Center Code Count*

The count of the number of revenue codes reported on an inpatient/SNF claim. The purpose of the count is to indicate how many revenue center trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: IP_REV_CNTR_CD_CNT
SAS ALIAS: IPREVCNT
STANDARD ALIAS: IP_REV_CNTR_CD_I_CNT

EDIT-RULES:
RANGE: 0 TO 45

COMMENT:
Prior to Version H this field was named:
CLM_REV_CNTR_CD_CNT.

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

SOURCE:
CWF

ADMSN_DT — *Claim Admission Date*

On an institutional claim, the date the beneficiary was admitted to the hospital, skilled nursing facility, or Christian Science Sanitorium.

For the Limited Data Set Standard View of the Inpatient/SNF files, the admission date for the claim is coded as the quarter of the calendar year when the admission occurred.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_ADMSN_DT
SAS ALIAS: ADMSN_DT
STANDARD ALIAS: CLM_ADMSN_DT
TITLE ALIAS: ADMISSION_DT

EDIT-RULES FOR LIMITED DATA SET DATA:
YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES.
1 = FIRST QUARTER OF THE CALENDAR YEAR
2 = SECOND QUARTER OF THE CALENDAR YEAR
3 = THIRD QUARTER OF THE CALENDAR YEAR
4 = FOURTH QUARTER OF THE CALENDAR YEAR

SOURCE:
CWF

SRC_ADMS — *Claim Source Inpatient Admission Code*

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

DB2 ALIAS: SRC_IP_ADMSN_CD
SAS ALIAS: SRC_ADMS
STANDARD ALIAS: CLM_SRC_IP_ADMSN_CD
TITLE ALIAS: IP_ADMISSION_SOURCE

CODES:
REFER TO: CLM_SRC_IP_ADMSN_TB
IN THE CODES APPENDIX

SOURCE:
CWF

AD_DGNS — *Claim Admitting Diagnosis Code*

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

DB2 ALIAS: CLM_ADMTG_DGNS_CD
SAS ALIAS: AD_DGNS
STANDARD ALIAS: CLM_ADMTG_DGNS_CD
TITLE ALIAS: ADMITTING_DIAGNOSIS

SOURCE:
CWF

PTNTSTUS — *NCH Patient Status Indicator Code*

Effective with Version H, the code on an inpatient/SNF and Hospice claim, indicating whether the beneficiary was discharged, or still a patient (used for internal CWFMQA editing purposes.)

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

DB2 ALIAS: NCH_PTNT_STUS_IND
SAS ALIAS: PTNTSTUS
STANDARD ALIAS: NCH_PTNT_STUS_IND_CD
TITLE ALIAS: NCH_PATIENT_STUS

DERIVATION:
DERIVED FROM:
NCH PTNT_DSCHRG_STUS_CD

DERIVATION RULES:

SET NCH_PTNT_STUS_IND_CD TO 'A' WHERE THE PTNT_DSCHRG_STUS_CD NOT EQUAL TO '20'- '30' OR '40' - '42'.

SET NCH_PTNT_STUS_IND_CD TO 'B' WHERE THE PTNT_DSCHRG_STUS_CD EQUAL TO '20'- '29' OR '40' - '42'.

SET NCH_PTNT_STUS_IND_CD TO 'C' WHERE THE PTNT_DSCHRG_STUS_CD EQUAL TO '30'

CODES:
A = Discharged
B = Died
C = Still patient

SOURCE:
NCH QA Process

PER_DIEM *Claim Pass Thru Per Diem Amount*

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

9.2 DIGITS SIGNED

DB2 ALIAS: PASS_THRU_PER_DIEM
SAS ALIAS: PER_DIEM
STANDARD ALIAS: CLM_PASS_THRU_PER_DIEM_AMT
TITLE ALIAS: PER_DIEM

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the field size was:
S9(5)V99.

SOURCE:
CWF

COIN_AMT *NCH Beneficiary Part A Coinsurance Liability Amount*

The amount of money for which the intermediary has determined that the beneficiary is liable for Part A coinsurance on the

9.2 DIGITS SIGNED

DB2 ALIAS: PTA_COINSRNC_AMT
SAS ALIAS: COIN_AMT
STANDARD ALIAS: NCH_BENE_PTA_COINSRNC_AMT
TITLE ALIAS: BENE_PTA_COINSURANCE

EDIT-RULES:
+9(9).99

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to
8, 9, 10 or 11 move the corresponding value
amount to the NCH_BENE_IP_PTA_COINSRC_AMT.

COMMENT:

Prior to Version H this field was named:
BENE_PTA_COINSRNC_LBLTY_AMT and the field
size was S9(5)V99.

SOURCE:
NCH

BLDDEDAM — *NCH Beneficiary Blood Deductible Liability Amount*

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

9.2 DIGITS SIGNED

DB2 ALIAS: BLOOD_DDCTBL_AMT
SAS ALIAS: BLDDEDAM
STANDARD ALIAS: NCH_BENE_BLOOD_DDCTBL_AMT
TITLE ALIAS: BLOOD_DEDUCTIBLE

EDIT-RULES:
+9(9).99

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

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

COMMENT:
Prior to Version H, this field was named:
BENE_BLOOD_DDCTBL_LBLTY_AMT and the field
size was S9(5)V99. Also, for OP claims, this
field was stored in a blood trailer. Version
H eliminated the OP blood trailer.

SOURCE:
NCH QA PROCESS

BLDTCHRG — *NCH Blood Total Charge Amount*

This field is no longer populated as it is unavailable from the data source

BLDNCHRG — *NCH Blood Non-Covered Charge Amount*

This field is no longer populated as it is unavailable from the data source

PCCHGAMT — *NCH Professional Component Charge Amount*

Effective with Version H, for inpatient and out- patient claims,
the amount of physician and other professional charges covered
under Medicare Part B
(used for internal CWFMQA editing purposes and other
internal processes (e.g. if computing interim payment
these charges are deducted)).

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

9.2 DIGITS SIGNED

DB2 ALIAS: PROFNL_CMPNT_AMT
SAS ALIAS: PCCHGAMT
STANDARD ALIAS: NCH_PROFNL_CMPNT_CHRG_AMT
TITLE ALIAS: PROFNL_CMPNT_CHARGES

EDIT-RULES:
+9(9).99

DERIVATION:

1. IF INPATIENT - DERIVED FROM:
CLM_VAL_CD
Clm_VAL_AMT

DERIVATION RULES:
Based on the presence of value code 04 or 05 move the related value amount to the NCH_PROFNL_CMPNT_CHRG_AMT.

2. IF OUTPATIENT - DERIVED FROM: REV_CNTR_CD
REV_CNTR_TOT_CHRG_AMT

DERIVATION RULES (Effective 10/98):
Based on the presence of revenue center codes 096X, 097X & 098X move the related total charge amount to NCH_PROFNL_CMPNT_CHRG_AMT.

NOTE1: During the Version H conversion, this field was populated with data throughout history BUT the derivation rule applied to the outpatient claim was incomplete (i.e., revenue codes 0972, 0973, 0974 and 0979 were omitted from the calculation).

SOURCE:
NCH QA Process

TDEDAMT *NCH Inpatient Total Deduction Amount*

Effective with Version H, the total Part A deductions reported on the Inpatient claim (used for internal CWFMQA editing purposes).

NOTE: During the Version H conversion this field was populated with data throughout history (back to 1991), but the derivation rule applied was incomplete for claims processed prior to 10/93. Disregard any data present in this field on claims with NCH weekly process date earlier than 10/93.

9.2 DIGITS SIGNED

DB2 ALIAS: IP_TOT_DDCTN_AMT
SAS ALIAS: TDEDAMT
STANDARD ALIAS: NCH_BENE_IP_DDCTBL_AMT
TITLE ALIAS: IP_TOT_DEDUCTIONS

EDIT-RULES:
+9(9).99

DERIVATION:
DERIVED FROM:
CLM_VAL_CD

CLM_VAL_AMT

DERIVATION RULES (Effective 10/93):
Accumulate the value amounts associated with
value codes equal to 06, 08 thru 11 and A1, B1
or C1 and move to NCH_BENE_IP_DDCTBL_AMT.
NOTE: Value codes 08-11 did not exist in the NCH
prior to 2/93; values codes A1, B1, C1 did
not exist prior to 10/93.

SOURCE:
NCH QA Process

PPS_CPTL *Claim Total PPS Capital Amount*

The total amount that is payable for capital PPS for the claim.
This is the sum of the capital hospital specific portion, federal
specific portion, outlier portion,
disproportionate share portion, indirect
medical education portion, exception payments,
and hold harmless payments.

9.2 DIGITS SIGNED

DB2 ALIAS: TOT_PPS_CPTL_AMT
SAS ALIAS: PPS_CPTL
STANDARD ALIAS: CLM_TOT_PPS_CPTL_AMT
TITLE ALIAS: PPS_CAPITAL

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was:
S9(7)V99.

SOURCE:
CWF

CPTL_HSP *Claim PPS Capital HSP Amount*

This field is no longer populated as it is unavailable from the data source

CPTL_FSP *Claim PPS Capital FSP Amount*

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

DB2 ALIAS: PPS_CPTL_FSP_AMT
SAS ALIAS: CPTL_FSP
STANDARD ALIAS: CLM_PPS_CPTL_FSP_AMT
TITLE ALIAS: PPS_CAPITAL_FSP

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was:
S9(7)V99.

SOURCE:
CWF

CPTLOUTL *Claim PPS Capital Outlier Amount*

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

DB2 ALIAS: PPS_OUTLIER_AMT
SAS ALIAS: CPTLOUTL
STANDARD ALIAS: CLM_PPS_CPTL_OUTLIER_AMT
TITLE ALIAS: PPS_CPTL_OUTLIER

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was:
S9(7)V99.

SOURCE:
CWF

DISP_SHR *Claim PPS Capital Disproportionate Share Amount*

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

9.2 DIGITS SIGNED

DB2 ALIAS: PPS_DSPRPRTNT_AMT
SAS ALIAS: DISP_SHR
STANDARD ALIAS: CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT
TITLE ALIAS: PPS_DISP_SHR

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of the field was:
S9(7)V99.

SOURCE:
CWF

IME_AMT *Claim PPS Capital IME Amount*

Effective 3/2/92, the amount of the indirect medical education (IME) (reimbursable amount for teaching hospitals only; an added amount passed by Congress
to augment normal PPS payments for teaching
hospitals to compensate them for higher patient
costs resulting from medical education programs for
interns and residents) portion of the PPS payment
for capital.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS_CPTL_IME_AMT
SAS ALIAS: IME_AMT
STANDARD ALIAS: CLM_PPS_CPTL_IME_AMT
TITLE ALIAS: PPS_CPTL_IME

EDIT-RULES:
+9(9).99

COMMENT:

Prior to Version H the size of this field was:
S9(7)V99.

SOURCE:
CWF

CPTL_EXP — *Claim PPS Capital Exception Amount*

Effective 3/2/92, the capital PPS amount of exception payments provided for hospitals with inordinately high levels of capital obligations. Exception payments expire at the end of the 10-year transition period.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS_EXCPTN_AMT
SAS ALIAS: CPTL_EXP
STANDARD ALIAS: CLM_PPS_CPTL_EXCPTN_AMT
TITLE ALIAS: PPS_CPTL_EXCP

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was:
S9(7)V99.

SOURCE:
CWF

HLDHRMLS — *Claim PPS Old Capital Hold Harmless Amount*

Effective 3/2/92, this amount is the hold harmless amount payable for old capital as computed by PRICER for providers with a payment code equal to 'A'. The hold harmless amount-old capital is 100 percent of the reasonable costs of old capital for sole community sole community hospitals, or 85 percent of the reasonable costs associated with old capital for all other hospitals, plus a payment for new capital.

9.2 DIGITS SIGNED

DB2 ALIAS: PPS_CPTL_HRMLS_AMT
SAS ALIAS: HLDHRMLS
STANDARD ALIAS: CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT
TITLE ALIAS: PPS_CPTL_HOLD_HRMLS

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was:
S9(7)V99.

SOURCE:
CWF

DSCHFRCT — *Claim PPS Capital Discharge Fraction Percent*

This field is no longer populated as it is unavailable from the data source

DRGWTAMT *Claim PPS Capital DRG Weight Number*

Effective 3/2/92, the number used to determine a transfer adjusted case mix index for capital PPS. The number is determined by multiplying
the DRG weight times the discharge fraction.

3.4 DIGITS SIGNED

DB2 ALIAS: PPS_DRG_WT_NUM
SAS ALIAS: DRGWTAMT
STANDARD ALIAS: CLM_PPS_CPTL_DRG_WT_NUM
TITLE ALIAS: PPS_CAPITAL_DRG_WEIGHT_NUM

EDIT-RULES:
+999.9(4)

SOURCE:
CWF

UTIL_DAY *Claim Utilization Day Count*

On an institutional claim, the number of covered days of care that are chargeable
to Medicare facility utilization that
includes full days, coinsurance days,
and lifetime reserve days.

3 DIGITS SIGNED
DB2 ALIAS: CLM_UTLZTN_DAY_CNT
SAS ALIAS: UTIL_DAY
STANDARD ALIAS: CLM_UTLZTN_DAY_CNT
TITLE ALIAS: UTILIZATION_DAYS

EDIT -
RULES: +999

SOURCE:
CWF

COIN_DAY *Beneficiary Total Coinsurance Days Count*

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

DB2 ALIAS: COINSRNC_DAY_CNT
SAS ALIAS: COIN_DAY
STANDARD ALIAS: BENE_TOT_COINSRNC_DAY_CNT
TITLE ALIAS: COINSRNC_DAYS

EDIT -
RULES: +999

SOURCE:
CWF

LRD_USE *Beneficiary LRD Used Count*

The number of lifetime reserve days that the beneficiary has elected to use during the period covered by the institutional claim. Under Medicare, each beneficiary has a one-time reserve of sixty additional days of inpatient hospital coverage that can be used after 90 days of inpatient care have been provided in a single benefit period. This count is used to subtract from the total number of lifetime reserve days that a beneficiary has available.

3 DIGITS SIGNED

DB2 ALIAS: BENE_LRD_USE_CNT
SAS ALIAS: LRD_USE
STANDARD ALIAS: BENE_LRD_USE_CNT
TITLE ALIAS: LRD_USED

EDIT -
RULES: +999

SOURCE:
CWF

NUTILDAY *Claim Non Utilization Days Count*

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

5 DIGITS SIGNED

DB2 ALIAS: NUTLZTN_DAY_CNT
SAS ALIAS: NUTILDAY
STANDARD ALIAS: CLM_NUTLZTN_DAY_CNT
TITLE ALIAS: NUTLZTN_DAYS

EDIT- RULES:
+9(5)

SOURCE:
CWF

BLDFRNSH *NCH Blood Pints Furnished Quantity*

Number of whole pints of blood furnished to the beneficiary.
3 DIGITS SIGNED

DB2 ALIAS: NCH_BLOOD_PT_FRNSH
SAS ALIAS: BLDFRNSH
STANDARD ALIAS: NCH_BLOOD_PT_FRNSH_QTY
TITLE ALIAS: BLOOD_PINTS_FURNISHED

EDIT - RULES:
+999

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to 37 move the related value amount to the NCH_BLOOD_PT_FRNSH_QTY.

COMMENT:
Prior to Version H this field was named: CLM_BLOOD_PT_FRNSH_QTY. Also for outpatient claims this field was stored in a blood trailer. Version H eliminated the outpatient blood trailer.

SOURCE:
NCH QA Process

BLD_RPLC *NCH Blood Pints Replaced Quantity*

This field is no longer populated as it is unavailable from the data source

BLDNRPLC *NCH Blood Pints Not Replaced Quantity*

This field is no longer populated as it is unavailable from the data source

BLDDEDPT *NCH Blood Deductible Pints Quantity*

This field is no longer populated as it is unavailable from the data source

QLFYTHRU *NCH Qualify Stay Through Date*

This field is no longer populated as it is unavailable from the data source

DSCHRGDT *NCH Beneficiary Discharge Date*

Effective with Version H, on an inpatient and HHA claim, the date the beneficiary was discharged from the facility or died (used for internal CWFMQA editing purposes.)

For the Limited Data Set Standard View of the Inpatient/SNF files, the beneficiary's discharge date is coded as the quarter of the calendar year when the discharge occurred.

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

8 DIGITS UNSIGNED

DB2 ALIAS: NCH_BENE_DSCHRG_DT
SAS ALIAS: DSCHRGDT
STANDARD ALIAS: NCH_BENE_DSCHRG_DT
TITLE ALIAS: DISCHARGE_DT

EDIT-RULES FOR LIMITED DATA SET DATA:
YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES.
1 = FIRST QUARTER OF THE CALENDAR YEAR
2 = SECOND QUARTER OF THE CALENDAR YEAR
3 = THIRD QUARTER OF THE CALENDAR YEAR
4 = FOURTH QUARTER OF THE CALENDAR YEAR

DERIVATION:
DERIVED FROM:

NCH_PTNT_STUS_IND_CD
CLM_THRU_DT

DERIVATION RULES:
Based on the presence of patient discharge status code not equal to 30 (still patient), move the claim thru date to the NCH_BENE_DSCHRG_DT.

SOURCE:
NCH QA Process

DRG_CD — *Claim Diagnosis Related Group Code*

The diagnostic related group to which a hospital claim belongs for prospective payment purposes.
COMMON ALIAS: DRG DB2
ALIAS: CLM_DRG_CD SAS
ALIAS: DRG_CD
STANDARD ALIAS:
CLM_DRG_CD TITLE ALIAS: DRG

EDIT-RULES:
DRG DEFINITIONS MANUAL

COMMENT:
GROUPER is the software that determines the DRG from data elements reported by the hospital. Once determined, the DRG code is one of the elements used to determine the price upon which to base the reimbursement to the hospitals under prospective payment. Nonpayment claims (zero reimbursement) may not have a DRG present.

SOURCE:
CWF

OUTLR_CD — *Claim Diagnosis Related Group Outlier Stay Code*

On an institutional claim, the code that indicates the beneficiary stay under the prospective payment system which, although classified into a specific diagnosis related group, has an unusually long length (day outlier) or exceptionally high cost (cost outlier).

DB2 ALIAS: DRG_OUTLIER_CD
SAS ALIAS: OUTLR_CD
STANDARD ALIAS: CLM_DRG_OUTLIER_STAY_CD
TITLE ALIAS: DRG_OUTLIER_STAY_CODE

CODES:
REFER TO: DRG_OUTLIER_STAY_TB

SOURCE:
CWF

OUTLRPMT *NCH DRG Outlier Approved Payment Amount*

On an institutional claim, the additional payment amount approved by the Peer Review Organization due to an outlier situation for a beneficiary's stay under the prospective payment system, which has been classified into a specific diagnosis related group.

9.2 DIGITS SIGNED

DB2 ALIAS: DRG_OUTLIER_AMT
SAS ALIAS: OUTLRPMT
STANDARD ALIAS: NCH_DRG_OUTLIER_APRV_PMT_AMT
TITLE ALIAS: DRG_OUTLIER_PMT

EDIT-RULES:
+9(9).99

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to 17 move the related amount to NCH_DRG_OUTLIER_APRV_PMT_AMT.

COMMENT:
Prior to Version H this field was named: CLM_DRG_OUTLIER_APRV_PMT_AMT and field size was S9(7)V99.

SOURCE:
NCH QA Process

AT_NPI *Claim Attending Physician NPI Number*

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.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, NPIs, OSCAR provider numbers, etc.) on the 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.

NOTE1: CMS has determined that dual provider identifiers (legacy numbers and NPIs) must be available on the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims) so there will only be NPIs sent in to the NCH for those physicians.

SAS ALIAS: AT_NPI
STANDARD ALIAS: CLM_ATNDG_PHYSN_NPI_NUM

OP_NPI *Claim Operating Physician NPI Number*

On an institutional claim, the national provider identifier (NPI) number assigned to uniquely identify the physician with the primary responsibility for performing the surgical procedure(s).

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, NPIs, OSCAR provider numbers, etc.) on the 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.

NOTE1: CMS has determined that dual provider identifiers (legacy numbers and NPIs) must be available on the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims) so there will only be NPIs sent in to the NCH for those physicians.

SAS ALIAS: OP_NPI
STANDARD ALIAS: CLM_OPRTG_PHYSN_NPI_NUM

OT_NPI *Claim Other Physician NPI Number*

On an institutional claim, the national provider identifier (NPI) number assigned to uniquely identify the other physician associated with the institutional claim.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, NPIs, OSCAR provider numbers, etc.) on the 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.

NOTE1: CMS has determined that dual provider identifiers (legacy numbers and NPIs) must be available on the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims) so there will only be NPIs sent in to the NCH for those physicians.

SAS ALIAS: OT_NPI
STANDARD ALIAS: CLM_OTHR_PHYSN_NPI_NUM

ORGNPINM *Organization NPI Number*

On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the institutional provider certified by Medicare to provide services to the beneficiary.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, NPIs, OSCAR provider numbers, etc.) on the 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.

NOTE1: CMS has determined that dual provider identifiers (legacy numbers and NPIs) must be available on the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims) so there will only be NPIs sent in to the NCH for those physicians.
SAS ALIAS: ORGNPINM
STANDARD ALIAS: ORG_NPI_NUM

DGNSCD{x} *Claim Diagnosis Code*

where { x } ranges from 1 to 10

The ICD-9-CM based code identifying the beneficiary's principal or other diagnosis
(including E code).

NOTE:
Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM_PRNCPAL_DGNS_CD was added as the first occurrence.

DB2 ALIAS: CLM_DGNS_CD
SAS ALIAS: DGNSCD{x}
STANDARD ALIAS: CLM_DGNS_CD
TITLE ALIAS: DIAGNOSIS

EDIT-RULES:
ICD-9-CM

COMMENT:
Prior to Version H this field was named:
CLM_OTHR_DGNS_CD.

CLMPOA{x} *Claim Present on Admission Indicator Code*

Where {x} ranges from 1 to 10

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

SAS ALIAS: CLMPOA{x}
STANDARD ALIAS: CLM_POA_IND_SW{x}

PRCDRCD{x} *Claim Procedure Code*

where { x } ranges from 1 to 6

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

DB2 ALIAS: CLM_PRCDR_CD
SAS ALIAS: PRCDRCD{x}
STANDARD ALIAS: CLM_PRCDR_CD
TITLE ALIAS: PROCEDURE_CODE

EDIT-RULES:
ICD-9-CM
SOURCE: CWF

PRCDRDT{x} *Claim Procedure Performed Date*

where { x } ranges from 1 to 6

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 the quarter of the calendar year when the procedure was performed.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_PRCDR_PRFRM_DT
SAS ALIAS: PRCDRDT{x}
STANDARD ALIAS: CLM_PRCDR_PRFRM_DT
TITLE ALIAS: PROCEDURE_DATE

EDIT-RULES FOR LIMITED DATA SET DATA:
YYYYQ000 WHERE Q IS ONE OF THE
FOLLOWING VALUES.
1 = FIRST QUARTER OF THE CALENDAR YEAR
2 = SECOND QUARTER OF THE CALENDAR YEAR
3 = THIRD QUARTER OF THE CALENDAR YEAR
4 = FOURTH QUARTER OF THE CALENDAR YEAR

SOURCE:
CWF

RLTCND{x} *Claim Related Condition Code*

where { x } ranges from 1 to 30

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

DB2 ALIAS: CLM_RLT_COND_CD
SAS ALIAS: RLTCND{x}
STANDARD ALIAS: CLM_RLT_COND_CD
SYSTEM ALIAS: LTCOND
TITLE ALIAS: RELATED_CONDITION_CD

CODES:
01 THRU 16 = Insurance related
17 THRU 30 = Special condition
31 THRU 35 = Student status codes which are required when a patient is a dependent child over 18 years old
36 THRU 45 = Accommodation
46 THRU 54 = CHAMPUS information
55 THRU 59 = Skilled nursing facility
60 THRU 70 = Prospective payment
71 THRU 99 = Renal dialysis setting
A0 THRU B9 = Special program codes
C0 THRU C9 = PRO approval services
D0 THRU W0 = Change conditions

CODES:
REFER TO: CLM_RLT_COND_TB
IN THE CODES APPENDIX
SOURCE:
CWF

OCRCCD{x} *Claim Related Occurrence Code*

where { x } ranges from 1 to 30

The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date.

DB2 ALIAS: CLM_RLT_OCRNC_CD
SAS ALIAS: OCRCCD{x}
STANDARD ALIAS: CLM_RLT_OCRNC_CD

SYSTEM ALIAS: LTOCRNC
TITLE ALIAS: OCCURRENCE_CD

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

CODES:
REFER TO: CLM_RLT_OCRNC_TB
IN THE CODES APPENDIX

SOURCE:
CWF

OCRCDT{x} *Claim Related Occurrence Date*

where { x } ranges from 1 to 30

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

For the Limited Data Set Standard View of the Inpatient/SNF files, the claim procedure performed date is coded as the quarter of the calendar year when the procedure was performed.

8 DIGITS UNSIGNED
DB2 ALIAS: CLM_RLT_OCRNC_DT
SAS ALIAS: OCRCDT{x}
STANDARD ALIAS: CLM_RLT_OCRNC_DT
TITLE ALIAS: RLT_OCRNC_DT

EDIT-RULES FOR LIMITED DATA SET DATA:
YYYYQ000 WHERE Q IS ONE OF THE FOLLOWING VALUES.
1 = FIRST QUARTER OF THE CALENDAR YEAR
2 = SECOND QUARTER OF THE CALENDAR YEAR
3 = THIRD QUARTER OF THE CALENDAR YEAR
4 = FOURTH QUARTER OF THE CALENDAR YEAR
SOURCE: CWF

VAL_CD{x} *Claim Value Code*

where { x } ranges from 1 to 36

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

DB2 ALIAS: CLM_VAL_CD
SAS ALIAS: VAL_CD
STANDARD ALIAS: CLM_VAL_CD
SYSTEM ALIAS: LTVALUE
TITLE ALIAS: VALUE_CD

CODES:
REFER TO: CLM_VAL_TB
IN THE CODES APPENDIX

SOURCE:
CWF

VALAMT{x} *Claim Value Amount*

where { x } ranges from 1 to 36

The amount related to the condition identified in the CLM_VAL_CD which was used by the intermediary to process the institutional claim.

9.2 DIGITS SIGNED

DB2 ALIAS: CLM_VAL_AMT
SAS ALIAS: VALAMT{x}
STANDARD ALIAS: CLM_VAL_AMT
TITLE ALIAS: VALUE_AMOUNT

EDIT-RULES:
+9(9).99

SOURCE:
CWF

RVCNTR{x} *Revenue Center Code*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

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.

COBOL ALIAS: REV_CD
DB2 ALIAS: REV_CNTR_CD
SAS ALIAS: RVCNTR{x}
STANDARD ALIAS: REV_CNTR_CD
SYSTEM ALIAS: LTRC
TITLE ALIAS: REVENUE_CENTER_CD

CODES:
REFER TO: REV_CNTR_TB
IN THE CODES APPENDIX

SOURCE:
CWF

REV_DT{x} *Revenue Center Date*

This field is no longer populated as it is unavailable from the data source

APCPPS{x} *Revenue Center APC/HIPPS Code*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Effective with Outpatient PPS (OPPS), the Ambulatory Payment

Classification (APC) code used to identify groupings of outpatient services. APC codes are used to calculate payment for services under OPPS.

Effective with Home Health PPS (HHPPS), this field will only be populated with a HIPPS code if the HIPPS code that is stored in the HCPCS field has been downcoded and the new code will be placed in this field.

NOTE1: Under SNF PPS and HHPPS, HIPPS codes are stored in the HCPCS field. **EXCEPTION: if a HHPPS HIPPS code is downcoded the downcoded HIPPS will be stored in this field.

NOTE2: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS: REV_APC_HIPPS_CD
SAS ALIAS: APCPPS{x}
STANDARD ALIAS: REV_CNTR_APC_HIPPS_CD
SYSTEM ALIAS: LTAPC
TITLE ALIAS: APC_HIPPS

CODES:
REFER TO: REV_CNTR_APC_TB
IN THE CODES APPENDIX

SOURCE:
CWF

HCPSCD{x} — *Revenue Center HCFA Common Procedure Coding*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

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

DB2 ALIAS: REV_CNTR_HCPCS_CD
SAS ALIAS: HCPSCD{x}
STANDARD ALIAS: REV_CNTR_HCPCS_CD
SYSTEM ALIAS: LTHIPPS
TITLE ALIAS: HCPCS_CD
CODES:
REFER TO: CLM_HIPPS_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named: HCPCS_CD. With Version H, a prefix was added to denote the location of this field

on each claim type (institutional: REV_CNTR and non-institutional: LINE).

NOTE: When revenue center code = '0022' (SNF PPS) or '0023' (HH PPS), this field contains the Health Insurance PPS (HIPPS) code. The HIPPS code for SNF PPS contains the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.

The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, will be the basis of payment for each episode.

For both SNF PPS & HH PPS HIPPS values see CLM_HIPPS_TB.

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 HCFA/AMA agreement. Any other use violates the AMA copyright.

Level II
Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

Level III
Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not represented in the level I or level II codes.

MDCD1_{x} — *Revenue Center HCPCS Initial Modifier Code*

This field is no longer populated as it is unavailable from the data source

MDCD2_{x} — *Revenue Center HCPCS Second Modifier Code*

This field is no longer populated as it is unavailable from the data source

MDCD3_{x} — *Revenue Center HCPCS Third Modifier Code*

This field is no longer populated as it is unavailable from the data source

MDCD4_{x} — *Revenue Center HCPCS Fourth Modifier Code*

This field is no longer populated as it is unavailable from the data source

MDCD5_{x} — *Revenue Center HCPCS Fifth Modifier Code*

This field is no longer populated as it is unavailable from the data source

PMTTHD{x} — *Revenue Center Payment Method Indicator Code*

This field is no longer populated as it is unavailable from the data source

DSCTND{x} — *Revenue Center Discount Indicator Code*

This field is no longer populated as it is unavailable from the data source

PCKGND{x} — *Revenue Center Packaging Indicator Code*

This field is no longer populated as it is unavailable from the data source

PRICNG{x} — *Revenue Center Pricing Indicator Code*

This field is no longer populated as it is unavailable from the data source

OTAF1_{x} — *Revenue Center Obligation to Accept As Full (OTAF)*

This field is no longer populated as it is unavailable from the data source

IDENDC{x} — *Revenue Center IDE, NDC, UPC Number*

This field is no longer populated as it is unavailable from the data source

RVUNT{x} — *Revenue Center Unit Count*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

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

Depending on type of service, units are measured by number of covered days in a particular accommodation, pints of blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests.
NOTE1: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code.

7 DIGITS SIGNED

DB2 ALIAS: REV_CNTR_UNIT_CNT
SAS ALIAS: RVUNT{x}
STANDARD ALIAS: REV_CNTR_UNIT_CNT
TITLE ALIAS: UNITS

EDIT- RULES:

+9(7)

SOURCE:
CWF

RVRT{x} *Revenue Center Rate Amount*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

Charges relating to unit cost associated with the revenue center code. Exception (encounter data only): If plan (e.g. MCO) does not know the actual rate for the accommodations, $1 will be reported in the field.

NOTE1: For SNF PPS claims (when revenue center code equals '0022'), HCFA has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue center HCPCS code field).

NOTE2: For OP PPS claims, HCFA has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index.

NOTE3: Under HH PPS (when revenue center code equals '0023'), HCFA has developed a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode.

On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment. In cases of SCICs, there will be more than one '0023' revenue center line, each representing the payment made at each case-mix level.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_CNTR_RATE_AMT
SAS ALIAS: RVRT{x}
STANDARD ALIAS: REV_CNTR_RATE_AMT
TITLE ALIAS: CHARGE_PER_UNIT

EDIT-RULES:

+9(9).99

EFFECTIVE-DATE: 10/01/1993

COMMENT:
Prior to Version H the size of this field was:
S9(7)V99.

SOURCE:
CWF

RVBLD{x} — *Revenue Center Blood Deductible Amount*

This field is no longer populated as it is unavailable from the data source

RVDTBL{x} — *Revenue Center Cash Deductible Amount*

This field is no longer populated as it is unavailable from the data source

WGDJ{x} — *Revenue Center Coinsurance/Wage Adjusted*

This field is no longer populated as it is unavailable from the data source

RDCDCN{x} — *Revenue Center Reduced Coinsurance Amount*

This field is no longer populated as it is unavailable from the data source

RVMS1_{x} — *Revenue Center 1st Medicare Secondary Payer Paid*

This field is no longer populated as it is unavailable from the data source

RVMS2_{x} — *Revenue Center 2nd Medicare Secondary Payer Paid*

This field is no longer populated as it is unavailable from the data source

RPRPMT{x} — *Revenue Center Provider Payment Amount*

This field is no longer populated as it is unavailable from the data source

RBNPMT{x} — *Revenue Center Beneficiary Payment Amount*

This field is no longer populated as it is unavailable from the data source

PTNRSP{x} — *Revenue Center Patient Responsibility Payment Amount*

This field is no longer populated as it is unavailable from the data source

REVPMT{x} — *Revenue Center Payment Amount*

This field is no longer populated as it is unavailable from the data source

RVCHRG{x} — *Revenue Center Total Charge Amount*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

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:
4. 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).

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

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

7. 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').

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

9.2 DIGITS SIGNED

DB2 ALIAS: REV_TOT_CHRG_AMT
SAS ALIAS: RVCHRG{x}
STANDARD ALIAS: REV_CNTR_TOT_CHRG_AMT
TITLE ALIAS: REVENUE_CENTER_CHARGES

EDIT-RULES:
+9(9).99

COMMENT:
Prior to Version H the size of this field was:
S9(7)V99.

SOURCE:
CWF

RVNCVR{x} — *Revenue Center Non-Covered Charge Amount*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

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

NOTE: Prior to Version H the field size was S9(7)V99 and the element was only present on the Inpatient/SNF format.

As of NCH weekly process date 10/3/97 this field was added to all institutional claim types.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_NCVR_CHRG_AMT
SAS ALIAS: RVNCVR{x}
STANDARD ALIAS: REV_CNTR_NCVR_CHRG_AMT
TITLE ALIAS: REV_CENTER_NONCOVERED_CHARGES

EDIT-RULES:
+9(9).99

SOURCE:
CWF

RVDDCD{x} — *Revenue Center Deductible Coinsurance Code*

where { x } ranges from 1 to 45

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).

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

DB2 ALIAS: DDCTBL_COINSRNC_CD

SAS ALIAS: RVDDCD{x}

STANDARD ALIAS: REV_CNTR_DDCTBL_COINSRNC_CD

TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD

CODES:
REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB
IN THE CODES APPENDIX

SOURCE:
CWF