## Research Data Distribution Center
### Outpatient Claim Record -- Data Dictionary For SAS and CSV Datasets

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BID</td>
<td>Beneficiary Identification Number</td>
<td>Beneficiary Identification Number for this data request</td>
</tr>
<tr>
<td>REC_LEN</td>
<td>Record Length Count</td>
<td>Effective with Version H, the count (in bytes) of the length of the claim record. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). 5 DIGITS SIGNED</td>
</tr>
<tr>
<td>REC_LVL</td>
<td>NCH Near-Line Record Version Code</td>
<td>The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored.</td>
</tr>
<tr>
<td>RIC_CD</td>
<td>NCH Near Line Record Identification Code</td>
<td>A code defining the type of claim record being processed.</td>
</tr>
</tbody>
</table>

DB2 ALIAS: REC_LENGTH_CNT
SAS ALIAS: REC_LEN
STANDARD ALIAS: REC_LENGTH_CNT
SOURCE: NCH

DB2 ALIAS: 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

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
--- | ---
**IN THE CODES APPENDIX**
**COMMENT:**
Prior to Version H this field was named:
RIC_CD.
**SOURCE:**
NCH

**MQA_RIC** | **NCH MQA RIC Code**
--- | ---
Effective with Version H, the code used (for internal editing purposes) to identify the record being processed through HCFA's CWFMQA system.
**NOTE:** Beginning with NCH weekly process date 10/3/97 field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.
**DB2 ALIAS:** NCH_MQA_RIC_CD
**SAS ALIAS:** MQA_RIC
**STANDARD ALIAS:** NCH_MQA_RIC_CD
**TITLE ALIAS:** MQA_RIC
**CODES:**
1 = Inpatient
2 = SNF
3 = Hospice
4 = Outpatient
5 = Home Health Agency
6 = Physician/Supplier
7 = Durable Medical Equipment
**SOURCE:**
NCH QA PROCESS

**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
Variable Name        Label

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')
**Variable Name** | **Label**

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 ENCODING 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 = '2', '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_CNRCT_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 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 = '2'

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

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

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

CODES:
REFER TO: NCH_CLM_TYPE_TB
IN THE CODES APPENDIX
SOURCE: NCH

**CAN**

**Beneficiary Claim Account Number (BLANKED)**

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

COMMON ALIAS: CAN
DA3 ALIAS: CLAIM_ACCOUNT_NUMBER
DB2 ALIAS: BENE_CLM_ACNT_NUM
SAS ALIAS: CAN
STANDARD ALIAS: BENE_CLM_ACNT_NUM
TITLE ALIAS: CAN
SOURCE: SSA, RRB

LIMITATIONS:
RRB-issued numbers contain an overpunch in the first position that may appear as a plus zero or A-G. RRB-formatted numbers may cause matching problems on non-IBM machines.

**EQ_BIC**

**NCH Category Equatable Beneficiary Identification Code**

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

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

COMMON ALIAS: NCH_BASE_CATEGORY_BIC
DB2 ALIAS: CTGRY_EQTBL_BIC
SAS ALIAS: EQ_BIC
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST.Standard Alias: NCH_CTGRY_EQTBL_BIC_CD</td>
<td>STANDARD ALIAS: NCH_CTGRY_EQTBL_BIC_CD</td>
</tr>
<tr>
<td>TITLE ALIAS: EQUATED_BIC</td>
<td>TITLE ALIAS: EQUATED_BIC</td>
</tr>
<tr>
<td>CODES:</td>
<td>CODES:</td>
</tr>
<tr>
<td>REFER TO: CTGRY_EQTBL_BENE_IDENT_TB</td>
<td>REFER TO: CTGRY_EQTBL_BENE_IDENT_TB</td>
</tr>
<tr>
<td>IN THE CODES APPENDIX</td>
<td>IN THE CODES APPENDIX</td>
</tr>
<tr>
<td>COMMENT:</td>
<td>COMMENT:</td>
</tr>
<tr>
<td>Prior to Version H this field was named:</td>
<td>Prior to Version H this field was named:</td>
</tr>
<tr>
<td>CTGRY_EQTBL_BENE_IDENT_CD.</td>
<td>CTGRY_EQTBL_BENE_IDENT_CD.</td>
</tr>
<tr>
<td>SOURCE:</td>
<td>SOURCE:</td>
</tr>
<tr>
<td>BIC EQUATE MODULE</td>
<td>BIC EQUATE MODULE</td>
</tr>
</tbody>
</table>

**BIC**

Beneficiary Identification Code

The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary.

**COMMON ALIAS:** BIC

**DA3 ALIAS:** BENE_IDENT_CODE

**DB2 ALIAS:** BENE_IDENT_CD

**SAS ALIAS:** BIC

**STANDARD ALIAS:** BENE_IDENT_CD

**TITLE ALIAS:** BIC

**EDIT-RULES:**

**EDB REQUIRED FIELD**

**CODES:**

**REFER TO:** BENE_IDENT_TB

**IN THE CODES APPENDIX**

**SOURCE:**

SSA/RRB

**ST.STANDARD ALIAS: NCH_STATE_SGMT_CD**

**STANDARD ALIAS: NCH_STATE_SGMT_CD**

**TITLE ALIAS: NEAR_LINE_SEGMENT**

**CODES:**

**REFER TO:** NCH_STATE_SGMT_TB

**IN THE CODES APPENDIX**

**COMMENT:**

Prior to Version H this field was named:

**BENE_STATE_SGMT_NEAR_LINE_CD.**

**SOURCE:**

NCH

**STATE_STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD**

**STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD**

**TITLE ALIAS:** BENE_RSDNC_SSA_STD_STATE_CD

**EDIT-RULES:**

**SOURCE:**

NCH
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FROM_DT</strong></td>
<td>Claim From Date</td>
</tr>
<tr>
<td><strong>THRU_DT</strong></td>
<td>Claim Through Date</td>
</tr>
<tr>
<td><strong>WKLY_DT</strong></td>
<td>NCH Weekly Claim Processing Date</td>
</tr>
</tbody>
</table>

**FROM_DT**

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

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

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_FROM_DT
SAS ALIAS: FROM_DT
STANDARD ALIAS: CLM_FROM_DT
TITLE ALIAS: FROM_DATE
EDIT-RULES: YYYYMMDD
SOURCE: CWF

**THRU_DT**

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

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

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_THRU_DT
SAS ALIAS: THRU_DT
STANDARD ALIAS: CLM_THRU_DT
TITLE ALIAS: THRU_DATE
EDIT-RULES: YYYYMMDD
SOURCE: CWF

**WKLY_DT**

The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file.

This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date.

8 DIGITS UNSIGNED
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
</table>
| NCH_WKLY_PROC_DT | DB2 ALIAS: NCH_WKLY_PROC_DT  
SAS ALIAS: WKLY_DT  
STANDARD ALIAS: NCH_WKLY_PROC_DT  
TITLE ALIAS: NCH_PROCESS_DT  
EDIT-RULES: YYYYMMDD  
COMMENT: Prior to Version H this field was named: HCFA_CLM_PROC_DT.  
SOURCE: NCH |
| CWF_CLM_ACRTN_DT | ACRTN_DT  
CWF Claim Accretion Date  
The date the claim record is accreted (posted/processed) to the beneficiary master record at the CWF host site and authorization for payment is returned to the fiscal intermediary or carrier.  
8 DIGITS UNSIGNED  
DB2 ALIAS: CWF_CLM_ACRTN_DT  
SAS ALIAS: ACRTN_DT  
STANDARD ALIAS: CWF_CLM_ACRTN_DT  
TITLE ALIAS: ACCRETION_DT  
EDIT-RULES: YYYYMMDD  
SOURCE: CWF |
| CWF_CLM_ACRTN_NUM | ACRTN_NM  
CWF Claim Accretion Number  
The sequence number assigned to the claim record when accreted (posted/processed) to the beneficiary master record at the CWF host site on a given date. This element indicates the position of the claim within that day's processing at the CWF host. **(Exception: If the claim record is missing the accretion date HCFA's CWFMQA system places a zero in the accretion number.**  
3 DIGITS SIGNED  
DB2 ALIAS: CWF_CLM_ACRTN_NUM  
SAS ALIAS: ACRTN_NM  
STANDARD ALIAS: CWF_CLM_ACRTN_NUM  
TITLE ALIAS: ACCRETION_NUMBER  
SOURCE: CWF |
| FI_DOC_CLM_CNTL_NUM | CLM_CNTL  
FI Document Claim Control Number  
Unique control number assigned by an intermediary to an institutional claim.  
COMMON ALIAS: ICN  
DB2 ALIAS: DOC_CLM_CNTL_NUM  
SAS ALIAS: CLM_CNTL  
STANDARD ALIAS: FI_DOC_CLM_CNTL_NUM  
TITLE ALIAS: ICN  
SOURCE: CWF |
| FI_DOC_CLM_CNTL_NUM | ORIGCNTL  
FI Original Claim Control Number  

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Variable Name</strong></td>
<td><strong>Label</strong></td>
</tr>
</tbody>
</table>
| Effective with Version G, the original intermediary control number (ICN) which is present on adjustment claims, representing the ICN of the original transaction now being adjusted. | COMMON ALIAS: ORIGINAL_ICN  
DB2 ALIAS: ORIG_CLM_CNTL_NUM  
SAS ALIAS: ORIGCNTL  
STANDARD ALIAS: FI_ORIG_CLM_CNTL_NUM  
TITLE ALIAS: ORIGINAL_ICN  
SOURCE: CWF |

<table>
<thead>
<tr>
<th>QUERY_CD</th>
<th>Claim Query Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator).</td>
<td></td>
</tr>
</tbody>
</table>
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 |

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>Provider Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.</td>
<td></td>
</tr>
</tbody>
</table>
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 |

<table>
<thead>
<tr>
<th>DAILY_DT</th>
<th>NCH Daily Process Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective with Version H, the date the claim record was processed by HCFA's CWFMQA system (used for internal editing purposes). Effective with Version I, this date is used in conjunction with the NCH Segment Link Number to keep claims with multiple records/segments together.</td>
<td></td>
</tr>
</tbody>
</table>
NOTE1: With Version 'H' this field was populated with data beginning with NCH weekly process date 10/3/97. Under Version 'I' claims prior to 10/3/97, that were blank under Version 'H', were populated with a date.  
8 DIGITS UNSIGNED |
**Variable Name** | **Label**
---|---
DB2 ALIAS: NCH_DAILY_PROC_DT  
SAS ALIAS: DAILY_DT  
STANDARD ALIAS: NCH_DAILY_PROC_DT  
TITLE ALIAS: DAILY_PROCESS_DT  
EDIT-RULES: YYYYMMDD  
SOURCE: NCH

**LINK_NUM** | **NCH Segment Link Number**
Effective with Version I, the system generated number used in conjunction with the NCH daily process date to keep records/segments belonging to a specific claim together. This field was added to ensure that records/segments that come in on the same batch with the same identifying information in the link group are not mixed with each other.  
NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991).  
9 DIGITS SIGNED  
DB2 ALIAS: NCH_SGMT_LINK_NUM  
SAS ALIAS: LINK_NUM  
STANDARD ALIAS: NCH_SGMT_LINK_NUM  
TITLE ALIAS: LINK_NUM  
SOURCE: NCH

**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.  
NOTE: During the Version I conversion, this field was populated with data throughout history (back to service year 1991).  
For institutional claims, the count for claims prior to 7/00 will be 1 or 2  
(1 if 45 or less revenue center lines on a claim and 2 if more than 45 revenue center lines on a claim). For noninstitutional claims, the count will always be 1.  
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).
Variable Name | Label
--- | ---
CLM_SGMT_NUM | 2 DIGITS UNSIGNED
DB2 ALIAS: CLM_SGMT_NUM
SAS ALIAS: SGMT_NUM
STANDARD ALIAS: CLM_SGMT_NUM
TITLE ALIAS: SEGMENT_NUMBER
SOURCE: CWF

LINECNT | Claim Total Line Count
--- | ---
Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim.
NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991).
Prior to Version 'I', the maximum line count will be no more than 58. Effective with Version 'I', the maximum line count could be 450.
3 DIGITS UNSIGNED
DB2 ALIAS: TOT_LINE_CNT
SAS ALIAS: LINECNT
STANDARD ALIAS: CLM_TOT_LINE_CNT
TITLE ALIAS: TOTAL_LINE_COUNT
SOURCE: CWF

SGMTLINE | Claim Segment Line Count
--- | ---
Effective with Version I, the count used to identify the number of revenue center lines on a record/segment.
NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991).
The maximum line count per record/segment is 45.
2 DIGITS UNSIGNED
DB2 ALIAS: SGMT_LINE_CNT
SAS ALIAS: SGMTLINE
STANDARD ALIAS: CLM_SGMT_LINE_CNT
TITLE ALIAS: SEGMENT_LINE_COUNT
SOURCE: CWF

PE_RIC | NCH Payment and Edit Record Identification Code
--- | ---
The code used for payment and editing purposes that indicates the type of institutional claim record.
DB2 ALIAS: PMT_EDIT_RIC_CD
SAS ALIAS: PE_RIC
STANDARD ALIAS: NCH_PMT_EDIT_RIC_CD
TITLE ALIAS: NCH_PAYMENT_EDIT_RIC
CODES:
C = Inpatient hospital, SNF
D = Outpatient
E = Religious Nonmedical Health Care Institutions (eff.
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
</table>
| Christian Science, prior to 7/00  
F = Home Health Agency (HHA)  
G = Discharge notice  
(obsoleted 7/98)  
I = Hospice | COMMENT:  
Prior to Version H this field was named:  
PMT_EDIT_RIC_CD.  
SOURCE:  
NCH QA Process |

### TRANS_CD  
Claim Transaction Code

The code derived by CWF to indicate the type of claim submitted by an institutional provider.

DB2 ALIAS: CLM_TRANS_CD  
SAS ALIAS: TRANS_CD  
STANDARD ALIAS: CLM_TRANS_CD  
SYSTEM ALIAS: LTCLTRAN  
TITLE ALIAS: TRANSACTION_CODE  
CODES:  
REFER TO: CLM_TRANS_TB  
IN THE CODES APPENDIX  
SOURCE:  
CWF

### 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 of the 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
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Variable Name</strong></td>
<td><strong>Label</strong></td>
</tr>
<tr>
<td><strong>MQAQUERY</strong></td>
<td><strong>NCH MQA Query Patch Code</strong></td>
</tr>
<tr>
<td>Effective with Version H, a code used (for internal editing purposes) to indicate that the CWFMQA process changed the query code submitted on the claim record.</td>
<td>NOTE: Beginning with NCH weekly process date 10/3/97 field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: MQA_QUERY_PATCH_CD SAS ALIAS: MQAQUERY STANDARD ALIAS: NCH_MQA_QUERY_PATCH_CD TITLE ALIAS: MQA_QUERY_PATCH_IND CODES: Y = MQA changed bill query code on a action code 6 (force action code 2) bill to a zero. (Eff. 10/12/93) Z = MQA changed bill query code on a action code 4 (cancel only adjustment) bill to zero. (Eff. 5/16/94) SOURCE: NCH QA Process</td>
</tr>
<tr>
<td><strong>DISP_CD</strong></td>
<td><strong>Claim Disposition Code</strong></td>
</tr>
<tr>
<td>Code indicating the disposition or outcome of the processing of the claim record.</td>
<td>DB2 ALIAS: CLM_DISP_CD SAS ALIAS: DISP_CD STANDARD ALIAS: CLM_DISP_CD TITLE ALIAS: DISPOSITION_CD CODES: REFER TO: CLM_DISP_TB IN THE CODES APPENDIX SOURCE: CWF</td>
</tr>
<tr>
<td><strong>EDITDISP</strong></td>
<td><strong>NCH Edit Disposition Code</strong></td>
</tr>
<tr>
<td>Effective with Version H, a code used (for internal editing purposes) to indicate the disposition of the claim after editing in the CWFMQA process.</td>
<td>NOTE: Beginning with NCH weekly process date 10/3/97 field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: NCH_EDIT_DISP_CD SAS ALIAS: EDITDISP STANDARD ALIAS: NCH_EDIT_DISP_CD TITLE ALIAS: NCH_EDIT_DISP</td>
</tr>
<tr>
<td>Variable Name</td>
<td>Label</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td><strong>BIC_MDFY</strong></td>
<td>NCH Claim BIC Modify H Code</td>
</tr>
<tr>
<td><strong>CNTY_CD</strong></td>
<td>Beneficiary Residence SSA Standard County Code</td>
</tr>
<tr>
<td><strong>RCPT_DT</strong></td>
<td>FI Claim Receipt Date</td>
</tr>
<tr>
<td><strong>SCHLD_DT</strong></td>
<td>FI Claim Scheduled Payment Date</td>
</tr>
</tbody>
</table>

**CODES:**
- 00 = No MQA errors
- 10 = Possible duplicate
- 20 = Utilization error
- 30 = Consistency error
- 40 = Entitlement error
- 50 = Identification error
- 60 = Logical duplicate
- 70 = Systems duplicate

**SOURCE:**
- NCH QA Process

**BIC_MDFY**

Effective with Version H, the code used (for internal editing purposes) to identify a claim record that was submitted with an incorrect HA, HB, or HC BIC.

**NOTE:** Beginning with NCH weekly process date 10/3/97 field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

**SOURCE:**
- NCH QA Process

**CNTY_CD**

The SSA standard county code of a beneficiary’s residence.

**SOURCE:**
- SSA/EDB

**RCPT_DT**

The date the fiscal intermediary received the institutional claim from the provider.

**SOURCE:**
- CWF

**SCHLD_DT**

**SOURCE:**
- CWF
<table>
<thead>
<tr>
<th><strong>Variable Name</strong></th>
<th><strong>Label</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SCHLD_DT</strong></td>
<td>The scheduled date of payment to the institutional provider, as reflected on the claim record transmitted to the CWF host. Note: This date is considered to be the date paid since no additional information as to the actual payment date is available. 8 DIGITS UNSIGNED DB2 ALIAS: FI_SCHLD_PMT_DT SAS ALIAS: SCHLD_DT STANDARD ALIAS: FI_CLM_SCHLD_PMT_DT TITLE ALIAS: SCHEDULED_PMT_DT EDIT-RULES: YYYYMMDD COMMENT: Prior to Version H this field was named: FICARR_CLM_PMT_DT. SOURCE: CWF</td>
</tr>
<tr>
<td><strong>FRWRD_DT</strong></td>
<td>Effective with Version H, the date CWF forwarded the claim record to HCFA (used for internal editing purposes). NOTE: Beginning with NCH weekly process date 10/3/97 field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 8 DIGITS UNSIGNED DB2 ALIAS: CWF_FRWRD_DT SAS ALIAS: FRWRD_DT STANDARD ALIAS: CWF_FRWRD_DT TITLE ALIAS: FORWARD_DT EDIT-RULES: YYYYMMDD SOURCE: CWF</td>
</tr>
<tr>
<td><strong>FI_NUM</strong></td>
<td>The identification number assigned by HCFA 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</td>
</tr>
<tr>
<td><strong>ASGN_NUM</strong></td>
<td>Effective with Version H, the number assigned to an institutional claim record by CWF (used for internal editing purposes). NOTE: Beginning with NCH weekly process date</td>
</tr>
</tbody>
</table>
Variable Name | Label
--- | ---
| 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: CWF_CLM_ASGN_NUM SAS ALIAS: ASGN_NUM STANDARD ALIAS: CWF_CLM_ASGN_NUM TITLE ALIAS: ASSIGNED_NUM SOURCE: CWF | FIBATCH | CWF Transmission Batch Number
Effective with Version H, the number assigned to each batch of claims transactions sent from CWF (used for internal editing purposes). NOTE: Beginning 11/98, this field will be populated with data. Claims processed prior to 11/98 will contain spaces in this field. DB2 ALIAS: TRNSMSN_BATCH_NUM SAS ALIAS: FIBATCH STANDARD ALIAS: CWF_TRNSMSN_BATCH_NUM TITLE ALIAS: BATCH_NUM SOURCE: CWF | BENE_ZIP | Beneficiary Mailing Contact ZIP Code
The ZIP code of the mailing address where the beneficiary may be contacted. DB2 ALIAS: BENE_MLG_ZIP_CD SAS ALIAS: BENE_ZIP STANDARD ALIAS: BENE_MLG_CNTCT_ZIP_CD TITLE ALIAS: BENE_ZIP SOURCE: EDB | SEX | Beneficiary Sex Identification Code
The race of a beneficiary. DA3 ALIAS: RACE_CODE DB2 ALIAS: BENE_RACE_CD SAS ALIAS: RACE STANDARD ALIAS: BENE_RACE_CD
Variable Name | Label
--- | ---
**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

**BENE DOB** | **Beneficiary Birth Date**
--- | ---
The beneficiary's date of birth.  
**8 DIGITS UNSIGNED**  
**DB2 ALIAS: BENE_BIRTH_DT**  
**SAS ALIAS: BENE DOB**  
**STANDARD ALIAS: BENE_BIRTH_DT**  
**TITLE ALIAS: BENE_BIRTH_DATE**  
**EDIT-RULES:**  
YYYYMMDDD  
**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:

<table>
<thead>
<tr>
<th>MSC</th>
<th>OASI</th>
<th>DI B</th>
<th>ESRD</th>
<th>AGE</th>
<th>BIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>YES</td>
<td>N/A</td>
<td>N/A</td>
<td>65 and over</td>
<td>N/A</td>
</tr>
<tr>
<td>11</td>
<td>YES</td>
<td>N/A</td>
<td>YES</td>
<td>65 and over</td>
<td>N/A</td>
</tr>
<tr>
<td>20</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>under 65</td>
<td>N/A</td>
</tr>
<tr>
<td>21</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>under 65</td>
<td>N/A</td>
</tr>
<tr>
<td>31</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>any age</td>
<td>T.</td>
</tr>
</tbody>
</table>

**CODES:**  
10 = Aged without ESRD  
11 = Aged with ESRD  
20 = Disabled without ESRD  
21 = Disabled with ESRD
Variable Name | Label
---|---
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

SURNAME | Claim Patient 6 Position Surname
The first 6 positions of the Medicare patient's surname (last
name) as reported by the provider on the claim.
NOTE1: Prior to Version H, this field was only
present on the IP/SNF claim record.
Effective with Version H, this field is
present on all claim types.
NOTE2: For OP, HHA, Hospice and all Carrier
claims, data was populated beginning
with NCH weekly process 10/3/97. Claims
processed prior to 10/3/97 will contain
spaces in this field.
COMMON ALIAS: PATIENT_SURNAME
DB2 ALIAS: PTNT_6_PSTN_SRNM
SAS ALIAS: SURNAME
STANDARD ALIAS: CLM_PTNT_6_PSTN_SRNM_NAME
TITLE ALIAS: PATIENT_SURNAME
SOURCE:
CWF

FRSTINIT | Claim Patient 1st Initial Given Name
The first initial of the Medicare patient's given name (first
name) as reported by the provider on the claim.
NOTE1: Prior to Version H, this field was only
present on the IP/SNF claim record.
Effective with Version H, this field is
present on all claim types.
NOTE2: For OP, HHA, Hospice and all Carrier claims,
data was populated beginning with NCH
weekly process date 10/3/97. Claims
processed prior to 10/3/97 will contain
spaces in this field.
COMMON ALIAS: PATIENT_GIVEN_NAME
DB2 ALIAS: 1ST_INITL_GVN_NAME
SAS ALIAS: FRSTINIT
STANDARD ALIAS: CLM_PTNT_1ST_INITL_GVN_NAME
TITLE ALIAS: PATIENT_FIRST_INITIAL
SOURCE:
CWF

MDL_INIT | Claim Patient First Initial Middle Name
The first initial of the Medicare patient's middle name as
reported by the provider on
the claim.
NOTE1: Prior to Version H, this field was only
present on the IP/SNF claim record.
Effective with Version H, this field is
present on all claim types.
NOTE2: For OP, HHA, Hospice and all Carrier claims,
**Variable Name** | **Label**
--- | ---
data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.
COMMON ALIAS: PATIENT_MIDDLE_NAME
DB2 ALIAS: 1ST_INI_MDL_NAME
SAS ALIAS: MDL_INIT
STANDARD ALIAS: CLM_PTNT_1ST_INI_MDL_NAME
TITLE ALIAS: PATIENT_MIDDLE_INITIAL
SOURCE: CWF

**CWFLOCCD** | **Beneficiary CWF Location Code**
The code that identifies the Common Working File (CWF) location (the host site) where a beneficiary's Medicare utilization records are maintained.
COMMON ALIAS: CWF_HOST
DB2 ALIAS: BENE_CWF_LOC_CD
SAS ALIAS: CWFLOCCD
STANDARD ALIAS: BENE_CWF_LOC_CD
SYSTEM ALIAS: LTCWFLOC
TITLE ALIAS: CWF_HOST
CODES:
B = Mid-Atlantic
C = Southwest
D = Northeast
E = Great Lakes
F = Great Western
G = Keystone
H = Southeast
I = South
J = Pacific
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 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.
**Variable Name**  
**Label**

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

Effective with Version I, the code used to identify whether or not the medical care or treatment received by a beneficiary, who has elected care from a Religious Nonmedical Health Care Institution (RNHCI), is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is required under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted.  
DB2 ALIAS: EXCPTD_NEXCPTD_CD  
SAS ALIAS: TRTMT_CD

STANDARD ALIAS:  
TITLE ALIAS: EXCPTD_NEXCPTD_CD  
CODES:  
0 = No Entry  
1 = Excepted  
2 = Nonexcepted  
SOURCE:  
CWF

**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 present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)  
Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). It does NOT include the pass thru amounts (i.e., capital-related costs, direct medical
Variable Name | Label
--- | ---
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 adjustment and the beneficiary deductible and coinsurance amounts. NOTE: There is no CWF edit check to validate 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 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. 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 actually receive the 40% or 50% payment.
Exceptions: For claims involving demos and BBA 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
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
</table>
| **Variable Name**<br>STANDARD ALIAS: CLM_PMT_AMT<br>TITLE ALIAS: REIMBURSEMENT<br>EDIT-RULES: $$$$$$$CCC<br>COMMENT: Prior to Version H the size of this field was S9(7)V99. Also the noninstitutional claim records carried this field as a line item. Effective with Version H, this element is a claim level field across all claim types (and the line item field has been renamed.)<br>SOURCE: CWF<br>LIMITATIONS: Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM_DISP_CD of ‘02’, the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over or under the actual Medicare payment amount.<br>**SOURCE:**<br><br>**PRPAYAMT**<br>NCH Primary Payer Claim Paid Amount<br>The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on an institutional, carrier, or DMERC claim.<br>9.2 DIGITS SIGNED<br>DB2 ALIAS: PRMRY_PYR_PD_AMT<br>SAS ALIAS: PRPAYAMT<br>STANDARD ALIAS: NCH_PRMRY_PYR_CLM_PD_AMT<br>TITLE ALIAS: PRIMARY_PAYER_AMOUNT<br>EDIT-RULES: $$$$$$$CCC<br>COMMENT: Prior to Version H this field was named: BENE_PRMRY_PYR_CLM_PMT_AMT and the field size was S9(7)V99.<br>SOURCE: NCH<br><br>**PRPAY_CD**<br>NCH Primary Payer Code<br>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.<br>DB2 ALIAS: NCH_PRMRY_PYR_CD<br>SAS ALIAS: PRPAY_CD<br>STANDARD ALIAS: NCH_PRMRY_PYR_CD<br>TITLE ALIAS: PRIMARY_PAYER_CD<br>DERIVATION:<br>DERIVED FROM:<br>CLM_VAL_CD<br>CLM_VAL_AMT<br>DERIVATION RULES<br>SET NCH_PRMRY_PYR_CD TO ‘A’ WHERE THE CLM_VAL_CD = ‘12’
Variable Name | Label
--- | ---
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
The reason that an intermediary requested cancelling a previously submitted institutional claim.
DB2 ALIAS: RQST_CNL_RSN_CD
SAS ALIAS: CANCELCD
STANDARD ALIAS: FI_RQST_CLM_CNCL_RSN_CD
TITLE ALIAS: CANCEL_CD
CODES:
REFER TO: FI_RQST_CLM_CNCL_RSN_TB IN THE CODES APPENDIX
COMMENT:
Prior to Version H this field was named:
INTRMDRY_RQST_CLM_CNCL_RSN_CD.
SOURCE:
CWF

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:
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>APRVL_DT</td>
<td>F1 Claim Process Date</td>
<td>The date the fiscal intermediary completes processing and releases the institutional claim to the CWF host. 8 DIGITS UNSIGNED. DB2 ALIAS: FI_CLM_PROC_DT, SAS ALIAS: APRVL_DT, STANDARD ALIAS: FI_CLM_PROC_DT, TITLE ALIAS: FI_PROCESS_DT, EDIT-RULES: YYYYMMDD, SOURCE: CWF.</td>
</tr>
<tr>
<td>PRSTATE</td>
<td>NCH Provider State Code</td>
<td>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: 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.</td>
</tr>
<tr>
<td>ORGNPINM</td>
<td>Organization NPI Number</td>
<td>A placeholder field (effective with Version H) for storing the NPI assigned to the institutional provider. DB2 ALIAS: ORG_NPI_NUM, SAS ALIAS: ORGNPINM, STANDARD ALIAS: ORG_NPI_NUM, TITLE ALIAS: ORG_NPI, SOURCE: CWF.</td>
</tr>
<tr>
<td>AT_UPIN</td>
<td>Claim Attending Physician UPIN Number</td>
<td>On an institutional claim, the unique physician identification number (UPIN) of the physician who would normally be expected to certify and...</td>
</tr>
</tbody>
</table>

Page 24 of 71
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>recertify the medical necessity of the services rendered and/or who has primary responsibility for the beneficiary's medical care and treatment (attending physician).</td>
<td></td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>AT_NPI</th>
<th>Claim Attending Physician NPI Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A placeholder field (effective with Version H) for storing the NPI assigned to the attending physician.</td>
<td></td>
</tr>
</tbody>
</table>
**COMMON ALIAS:** ATTENDING_PHYSICIAN_NPI  
**DB2 ALIAS:** ATNDG_NPI  
**SAS ALIAS:** AT_NPI  
**STANDARD ALIAS:** CLM_ATNDG_PHYSN_NPI_NUM  
**TITLE ALIAS:** ATNDG_NPI  
**SOURCE:**  
CWF

<table>
<thead>
<tr>
<th>AT_SRNM</th>
<th>Claim Attending Physician Surname</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective with Version H, the last name of the attending physician (used for internal editing purpose in HCFA's CWFMQA system.)</td>
<td></td>
</tr>
</tbody>
</table>
**NOTE:** Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.  
**DB2 ALIAS:** ATNDG_SRNM  
**SAS ALIAS:** AT_SRNM  
**STANDARD ALIAS:** CLM_ATNDG_PHYSN_SRNM_NAME  
**TITLE ALIAS:** ATNDG_PHYSN_SURNAME  
**SOURCE:**  
CWF

<table>
<thead>
<tr>
<th>AT_GVNNM</th>
<th>Claim Attending Physician Given Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective with Version H, the first name of the attending physician (used for internal editing purposes in HCFA's CWFMQA system).</td>
<td></td>
</tr>
</tbody>
</table>
**NOTE:** Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.  
**DB2 ALIAS:** ATNDG_GVN_NAME  
**SAS ALIAS:** AT_GVNNM  
**STANDARD ALIAS:** CLM_ATNDG_PHYSN_GVN_NAME  
**TITLE ALIAS:** ATNDG_PHYSN_FIRSTNAME  
**SOURCE:**  
CWF

Page 25 of 71
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT_MDL</td>
<td>Claim Attending Physician Middle Initial Name</td>
</tr>
<tr>
<td></td>
<td>Effective with Version H, the middle initial of the attending physician (used for internal editing purposes in HCFA's CWFMQA system.)</td>
</tr>
<tr>
<td></td>
<td>NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: ATNDG_MI_NAME</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: AT_MDL</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: CLM_ATNDG_PHYSN_MDL_INITL_NAME</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: ATNDG_PHYSN_MI</td>
</tr>
<tr>
<td></td>
<td>SOURCE: CWF</td>
</tr>
<tr>
<td>OP_UPIN</td>
<td>Claim Operating Physician UPIN Number</td>
</tr>
<tr>
<td></td>
<td>On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgical procedure.</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: OPRTG_UPIN</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: OP_UPIN</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: CLM_OPRTG_PHYSN_UPIN_NUM</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: OPRTG_UPIN</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>SOURCE: CWF</td>
</tr>
<tr>
<td>OP_NPI</td>
<td>Claim Operating Physician NPI Number</td>
</tr>
<tr>
<td></td>
<td>A placeholder field (effective with Version H) for storing the NPI assigned to the operating physician.</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: OPRTG_NPI</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: OP_NPI</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: CLM_OPRTG_PHYSN_NPI_NUM</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: OPRTG_NPI</td>
</tr>
<tr>
<td></td>
<td>SOURCE: CWF</td>
</tr>
<tr>
<td>OP_SRNM</td>
<td>Claim Operating Physician Surname</td>
</tr>
<tr>
<td></td>
<td>Effective with Version H, the last name of the operating physician (used for internal editing purposes in HCFA's CWFMQA system.)</td>
</tr>
<tr>
<td></td>
<td>NOTE: Beginning with the NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.</td>
</tr>
<tr>
<td>Variable Name</td>
<td>Label</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td><strong>DB2 ALIAS: OPRTG_SRNM</strong>&lt;br&gt;SAS ALIAS: OP_SRNM&lt;br&gt;STANDARD ALIAS: CLM_OPRTG_PHYSN_SRNM_NAME&lt;br&gt;TITLE ALIAS: OPRTG_PHYSN_SURNAME&lt;br&gt;SOURCE: CWF</td>
<td><strong>Claim Operating Physician Given Name</strong>&lt;br&gt;Effective with Version H, the first name of the operating physician (used for internal editing purposes in HCFA's CWFMQA system.)&lt;br&gt;NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.&lt;br&gt;<strong>DB2 ALIAS: OPRTG_GVN_NAME</strong>&lt;br&gt;SAS ALIAS: OP_GVN&lt;br&gt;STANDARD ALIAS: CLM_OPRTG_PHYSN_GVN_NAME&lt;br&gt;TITLE ALIAS: OPRTG_PHYSN_FIRSTNAME&lt;br&gt;SOURCE: CWF</td>
</tr>
<tr>
<td><strong>DB2 ALIAS: OPRTG_MI_NAME</strong>&lt;br&gt;SAS ALIAS: OP_MDL&lt;br&gt;STANDARD ALIAS: CLM_OPRTG_PHYSN_MDL_INITL_NAME&lt;br&gt;TITLE ALIAS: OPRTG_PHYSN_MI&lt;br&gt;SOURCE: CWF</td>
<td><strong>Claim Operating Physician Middle Initial Name</strong>&lt;br&gt;Effective with Version H, the middle initial of the operating physician (used for internal editing purposes in HCFA's CWFMQA system.)&lt;br&gt;NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.</td>
</tr>
<tr>
<td><strong>DB2 ALIAS: OTHR_UPIN</strong>&lt;br&gt;SAS ALIAS: OT_UPIN&lt;br&gt;STANDARD ALIAS: CLM_OTHR_PHYSN_UPIN_NUM&lt;br&gt;TITLE ALIAS: OTH_PHYSN_UPIN&lt;br&gt;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).&lt;br&gt;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.&lt;br&gt;SOURCE: CWF</td>
<td><strong>Claim Other Physician UPIN Number</strong>&lt;br&gt;On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim.</td>
</tr>
<tr>
<td>Variable Name</td>
<td>Label</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>OT_NPI</td>
<td>Claim Other Physician NPI Number</td>
</tr>
<tr>
<td>OT_SRNM</td>
<td>Claim Other Physician Surname</td>
</tr>
<tr>
<td>OT_GVN</td>
<td>Claim Other Physician Given Name</td>
</tr>
<tr>
<td>OT_MDL</td>
<td>Claim Other Physician Middle Initial Name</td>
</tr>
<tr>
<td>MDCD_PRV</td>
<td>Medicaid Provider Identification Number</td>
</tr>
<tr>
<td><strong>Variable Name</strong></td>
<td><strong>Label</strong></td>
</tr>
<tr>
<td>------------------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>Variable Name</strong></td>
<td><strong>Label</strong></td>
</tr>
<tr>
<td>A unique identification number assigned to each provider by the state Medicaid agency. This unique provider number is used to ensure proper payment of providers and claims history on individual providers for surveillance and utilization review.</td>
<td></td>
</tr>
<tr>
<td>DB2 ALIAS: MDCD_PRVDR_NUM</td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: MDCD_PRV</td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: MDCD_PRVDR_IDENT_NUM</td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: MEDICAID_PROVIDER</td>
<td></td>
</tr>
<tr>
<td>COMMENT: Prior to Version H the field size was X(12).</td>
<td></td>
</tr>
<tr>
<td>SOURCE: CWF</td>
<td></td>
</tr>
</tbody>
</table>

**MDCDINFO**  
Claim Medicaid Information Code

Effective with Version G, code identifying Medicaid information supplied by the contractor to Medicaid.

| DB2 ALIAS: CLM_MDCD_INFO_CD |
| SAS ALIAS: MDCDINFO |
| STANDARD ALIAS: CLM_MDCDINFO |
| TITLE ALIAS: MEDICAID_INFO |
| 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 for a claim |
| COMMENT: Prior to Version H this field was named: CLM_GHO_PD_SW. |
| SOURCE: CWF |

**AUTHRZTN**  
Claim Treatment Authorization Number

The number assigned by the medical reviewer and reported by the provider to identify the medical review (treatment authorization) action taken after review of the beneficiary's case. It designates that treatment covered by the bill has been authorized by the payer. This number is used by the intermediary and the Peer Review Organization.

| NOTE: Under HH PPS this field will be used to link claims to the OASIS assessment used as the basis of payment. This eighteen character string consists of the start of care date, the OASIS assessment date and the two digit reason for assessment code. |

Page 29 of 71
<table>
<thead>
<tr>
<th><strong>Variable Name</strong></th>
<th><strong>Label</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTNTCNTL</strong></td>
<td><strong>Patient Control Number</strong></td>
</tr>
<tr>
<td></td>
<td>The unique alphanumeric identifier assigned by the provider to the institutional claim to facilitate retrieval of individual case records and posting of payments. DB2 ALIAS: PTNT_CNTL_NUM SAS ALIAS: PTNTCNTL STANDARD ALIAS: PTNT_CNTL_NUM TITLE ALIAS: PATIENT_CONTROL_NUM SOURCE: CWF</td>
</tr>
<tr>
<td><strong>MDCL_REC</strong></td>
<td><strong>Claim Medical Record Number</strong></td>
</tr>
<tr>
<td></td>
<td>The number assigned by the provider to the beneficiary's medical record to assist in record retrieval. DB2 ALIAS: CLM_MDCL_REC_NUM SAS ALIAS: MDCL_REC STANDARD ALIAS: CLM_MDCL_REC_NUM TITLE ALIAS: MEDICAL_RECORD_NUM SOURCE: CWF</td>
</tr>
<tr>
<td><strong>PRO_CNTL</strong></td>
<td><strong>Claim PRO Control Number</strong></td>
</tr>
<tr>
<td></td>
<td>Effective with Version G, the unique identifier assigned by the Peer Review Organization (PRO) for control purposes. DB2 ALIAS: CLM_PRO_CNTL_NUM SAS ALIAS: PRO_CNTL STANDARD ALIAS: CLM_PRO_CNTL_NUM TITLE ALIAS: PRO_CONTROL_NUM SOURCE: CWF</td>
</tr>
<tr>
<td><strong>PRO_DT</strong></td>
<td><strong>Claim PRO Process Date</strong></td>
</tr>
<tr>
<td></td>
<td>Effective with Version H, the date the claim was used in the PRO review process. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 8 DIGITS UNSIGNED DB2 ALIAS: CLM_PRO_PROC_DT SAS ALIAS: PRO_DT STANDARD ALIAS: CLM_PRO_PROC_DT TITLE ALIAS: PRO_PROC_DT EDIT-RULES: YYYYMMDD SOURCE: CWF</td>
</tr>
</tbody>
</table>
### Variable Name  | Label  
--- | ---
**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

Effective with Version H, the ICD-9-CM code used to identify the external cause of injury, poisoning, or other adverse affect. Redundantly this field is also stored as the last occurrence of the diagnosis trailer.

**NOTE:** During the Version H conversion, the data in the last occurrence of the diagnosis trailer was used to populate history.

**DB2 ALIAS:** CLM_DGNS_E_CD  
**SAS ALIAS:** DGNS_E  
**STANDARD ALIAS:** CLM_DGNS_E_CD  
**TITLE ALIAS:** DGNS_E_CD  
**SOURCE:** CWF

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

**DB2 ALIAS:** CLM_PPS_IND_CD  
**SAS ALIAS:** PPS_IND  
**STANDARD ALIAS:** CLM_PPS_IND_CD  
**TITLE ALIAS:** PPS_IND  
**SOURCE:** CWF
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
<th>Description</th>
</tr>
</thead>
</table>
| **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
COMMENT: Prior to Version H the size of this field was S9(7)V99.
SOURCE: CWF |
| **OPEDCNT**   | **Outpatient NCH Edit Code Count** | The count of how many claim edit trailers present on an outpatient claim during the quality assurance process. The purpose of this count is to indicate how many claim edit trailers are present. 2 DIGITS UNSIGNED

DB2 ALIAS: OP_NCH_EDIT_CD_CNT
SAS ALIAS: OPEDCNT
STANDARD ALIAS: OP_NCH_EDIT_CD_CNT
SOURCE: NCH |
| **OPPATCNT**  | **Outpatient NCH Patch Code Count** | Effective with Version H, the count of the number of HCFA patch codes annotated to the outpatient claim during the Nearline maintenance process. The purpose of this count is to indicate how many NCH patch trailers are present. NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991).
NOTE2: Effective with Version 'I' the number of possible occurrences was reduced to 30. Prior to Version 'I' the number of possible occurrences was 99. 2 DIGITS UNSIGNED

DB2 ALIAS: OP_PATCH_CD_CNT
SAS ALIAS: OPPATCNT
STANDARD ALIAS: OP_NCH_PATCH_CD_CNT
SOURCE: NCH |
| **OPMCOCNT**  | **Outpatient MCO Period Count** | Effective with Version H, the count of the number of Managed Care Organization (MCO) periods reported on an outpatient claim. The purpose of this count is to indicate how many MCO period trailers are present. NOTE: Beginning with NCH weekly process date |

*Page 32 of 71*
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPPLNCNT</td>
<td>Outpatient Claim Health PlanID Count</td>
</tr>
<tr>
<td>OPDEMCNT</td>
<td>Outpatient Claim Demonstration Id Count</td>
</tr>
<tr>
<td>OPDGNCNT</td>
<td>Outpatient Claim Diagnosis Code Count</td>
</tr>
</tbody>
</table>

**OPPLNCNT**

Outpatient Claim Health PlanID Count

A placeholder field (effective with Version H) for storing the count of the number of Health PlanIDs reported on the outpatient claim. The purpose of this count is to indicate how many Health PlanID trailers are present. NOTE: Prior to Version 'I' this field was named: OP_CLM_PAYERID_CNT.

1 DIGIT UNSIGNED
DB2 ALIAS: OP_CLM_PLANID_CNT
SAS ALIAS: OPPLNCNT
STANDARD ALIAS: OP_CLM_HLTH_PLANID_CNT
EDIT-RULES:
RANGE: 0 TO 3
SOURCE: NCH

**OPDEMCNT**

Outpatient Claim Demonstration Id Count

Effective with Version H, the count of the number of claim demonstration IDs reported on an outpatient claim. The purpose of this count is to indicate how many claim demonstration trailers are present. NOTE: During the Version H conversion this field was populated with data where a demo was identifiable.

1 DIGIT UNSIGNED
DB2 ALIAS: OP_CLM_DEMO_ID_CNT
SAS ALIAS: OPDEMCNT
STANDARD ALIAS: OP_CLM_DEMO_ID_CNT
EDIT-RULES:
RANGE: 0 TO 5
SOURCE: NCH

**OPDGNCNT**

Outpatient Claim Diagnosis Code Count

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

2 DIGITS UNSIGNED
DB2 ALIAS: OP_CLM_DGNS_CD_CNT
SAS ALIAS: OPDGNCNT
STANDARD ALIAS: OP_CLM_DGNS_CD_CNT
EDIT-RULES:
RANGE: 0 TO 10
Variable Name | Label
---|---
OPPRCCNT | Outpatient Claim Procedure Code Count

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

2 DIGITS UNSIGNED

DB2 ALIAS: OP_PRCDR_CD_CNT
SAS ALIAS: OPPRCCNT
STANDARD ALIAS: OP_CLM_PRCDR_CD_CNT
EDIT-RULES:
RANGE: 0 TO 6

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

OPCONCNT | Outpatient Claim Related Condition Code Count

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

2 DIGITS UNSIGNED

DB2 ALIAS: OP_RLT_COND_CD_CNT
SAS ALIAS: OPCONCNT
STANDARD ALIAS: OP_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

OPOCRCNT | Outpatient Claim Related Occurrence Code Count

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

2 DIGITS UNSIGNED

DB2 ALIAS: OP_OCRNC_CD_CNT
SAS ALIAS: OPOCRCNT
STANDARD ALIAS: OP_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: NCH

OPSPNCNT | Outpatient Claim Occurrence Span Code Count
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPVALCNT</td>
<td>Outpatient Claim Value Code Count</td>
</tr>
<tr>
<td>OPREVCNT</td>
<td>Outpatient Revenue Center Code Count</td>
</tr>
<tr>
<td>OPSRVTYP</td>
<td>Claim Outpatient Service Type Code</td>
</tr>
</tbody>
</table>

**OPVALCNT**

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

- **Variable Name**: OPVALCNT
- **DB2 Alias**: OP_CLM_VAL_CD_CNT
- **SAS Alias**: OPVALCNT
- **Standard Alias**: OP_CLM_VAL_CD_CNT
- **Edit-Rules**: Range: 0 TO 36
- **Comment**: Prior to Version H this field was named: CLM_VAL_CD_CNT.
- **Source**: NCH

**OPREVCNT**

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.

- **Variable Name**: OPREVCNT
- **DB2 Alias**: OP_REV_CNTR_CD_CNT
- **SAS Alias**: OPREVCNT
- **Standard Alias**: OP_REV_CNTR_CD_CNT
- **Edit-Rules**: Range: 0 TO 45
- **Comment**: Prior to Version H this field was named: CLM_REV_CNTR_CD_CNT.

**OPSRVTYP**

Code indicating type and priority of outpatient service.

- **DB2 Alias**: OP_SRVC_TYPE_CD
- **SAS Alias**: OPSRVTYP
- **Standard Alias**: CLM_OP_SRVC_TYPE_CD
- **Title Alias**: OP_SERVICE_TYPE_CODE
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OP_RFRL</strong></td>
<td>Claim Outpatient Referral Code</td>
</tr>
<tr>
<td></td>
<td>The code indicating the means by which the beneficiary was referred for outpatient services.</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: CLM_OP_RFRL_CD</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: OP_RFRL</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: CLM_OP_RFRL_CD</td>
</tr>
<tr>
<td></td>
<td>SYSTEM ALIAS: LTORFRL</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: OP_REFERRAL_CODE</td>
</tr>
<tr>
<td></td>
<td>CODES: REFER TO: CLM_OP_RFRL_TB IN THE CODES APPENDIX</td>
</tr>
<tr>
<td><strong>BLDDEDAM</strong></td>
<td>NCH Beneficiary Blood Deductible Liability Amount</td>
</tr>
<tr>
<td></td>
<td>The amount of money for which the intermediary determined the beneficiary is liable for the blood</td>
</tr>
<tr>
<td></td>
<td>9.2 DIGITS SIGNED</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: BLOOD_DDCTBL_AMT</td>
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<tr>
<td></td>
<td>SAS ALIAS: BLDDEDAM</td>
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<tr>
<td></td>
<td>STANDARD ALIAS: NCH_BENE_BLOOD_DDCTBL_AMT</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: BLOOD_DEDUCTIBLE</td>
</tr>
<tr>
<td></td>
<td>DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT</td>
</tr>
<tr>
<td></td>
<td>DERIVATION RULES: Based on the presence of value code equal to '06' move the corresponding value amount to NCH_BENE_BLOOD_DDCTBL_AMT.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>SOURCE: NCH QA PROCESS</td>
</tr>
<tr>
<td><strong>PTB_DED</strong></td>
<td>NCH Beneficiary Part B Deductible Amount</td>
</tr>
<tr>
<td></td>
<td>The amount of money for which the intermediary or carrier has determined that the beneficiary is liable for the Part B cash deductible on the claim.</td>
</tr>
<tr>
<td></td>
<td>9.2 DIGITS SIGNED</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: NCH_PTB_DDCTBL_AMT</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: PTB_DED</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: NCH_BENE_PTB_DDCTBL_AMT</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: PTB_DDCTBL</td>
</tr>
<tr>
<td></td>
<td>EDIT-RULES: $$$$$$$$$CC</td>
</tr>
<tr>
<td></td>
<td>DERIVATION: DERIVED FROM: CLM_VAL_CD CLM_VAL_AMT</td>
</tr>
<tr>
<td>Variable Name</td>
<td>Label</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>PTB_COIN</td>
<td>NCH Beneficiary Part B Coinsurance Amount</td>
</tr>
<tr>
<td>PCCHGAMT</td>
<td>NCH Professional Component Charge Amount</td>
</tr>
</tbody>
</table>

**DERIVATION RULES (Effective 10/93):**
Based on the presence of value codes A1, B1 or C1 move the related value amount to the NCH_BENE_PTB_DDCTBL_AMT. *NOTE: Prior to 10/93, this field was present on the claim transmitted by CWF.

**COMMENT:**
Prior to Version H this field was named: BENE_PTB_DDCTBL_LBLTY_AMT and field size was S9(5)V99.

**SOURCE:**
NCH QA PROCESS

**PTB_COIN**
The amount of money for which the intermediary has determined that the beneficiary is liable for Part B coinsurance on the institutional claim.

- 9.2 DIGITS SIGNED
- DB2 ALIAS: PTB_COINSRNC_AMT
- SAS ALIAS: PTB_COIN
- STANDARD ALIAS: NCH_BENE_PTB_COINSRNC_AMT
- TITLE ALIAS: BENE_PTB_COINSURANCE_AMT

**DERIVATION:**
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

**DERIVATION RULES (Effective 10/93):**
Based on the presence of value codes A2, B2 or C2 move the related value amount to the NCH_BENE_PTB_COINSRNC_AMT. *NOTE: Prior to 10/93, this field was present on the claim transmitted by CWF.

**COMMENT:**
Prior to Version H this field was named: BENE_PTB_COINSRNC_LBLTY_AMT and field size was S9(5)V99.

**SOURCE:**
NCH QA PROCESS

**PCCHGAMT**
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

**DERIVATION:**
1. IF INPATIENT - DERIVED FROM:
**Variable Name** | **Label**
--- | ---
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

**INTRMDED** | Claim Outpatient Beneficiary Interim Deductible Amount
--- | ---
Effective with Version H, the amount paid by the beneficiary that is being applied to the deductible, as reported on the outpatient claim.
NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.
9.2 DIGITS SIGNED
DB2 ALIAS: INTRM_DDCTBL_AMT
SAS ALIAS: INTRMDED
STANDARD ALIAS: CLM_OP_BENE_INTRM_DDCTBL_AMT
TITLE ALIAS: INTRM_DDCTBL
SOURCE: CWF

**PRVDRPMT** | Claim Outpatient Provider Payment Amount
--- | ---
Effective with Version H, the amount paid to the provider for the services reported on the outpatient claim.
NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.
9.2 DIGITS SIGNED
DB2 ALIAS: OP_PRVDR_PMT_AMT
SAS ALIAS: PRVDRPMT
STANDARD ALIAS: CLM_OP_PRVDR_PMT_AMT
TITLE ALIAS: OP_PRVDR_PMT
SOURCE: NCH

**BENEPMT** | Claim Outpatient Beneficiary Payment Amount
--- | ---
Effective with Version H, the amount paid to the beneficiary for the services reported on the outpatient claim.
NOTE: Beginning with NCH weekly process date
Variable Name | Label
--- | ---

10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

9.2 DIGITS SIGNED
DB2 ALIAS: OP_BENE_PMT_AMT
SAS ALIAS: BENEPMT
STANDARD ALIAS: CLM_OP_BENE_PMT_AMT
TITLE ALIAS: OP_BENE_PMT
SOURCE: CWF

BLDFRNSH | NCH Blood Pints Furnished Quantity

Number of whole pints of blood furnished to the
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:
NUMERIC
DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT
DERIVATION RULES:
Based on the presence of value code equal to 37 move the related value amount to the
NCH_BLOOD_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

Number of whole pints of blood replaced. 3 DIGITS SIGNED
DB2 ALIAS: BLOOD_PT_RPLC_QTY
SAS ALIAS: BLD_RPLC
STANDARD ALIAS: NCH_BLOOD_PT_RPLC_QTY
TITLE ALIAS: BLOOD_PINTS_REPLACED
EDIT-RULES:
NUMERIC
DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT
DERIVATION RULES:
Based on the presence of value code equal to 39 move the related value amount to the
NCH_BLOOD_PT_RPLC_QTY.
COMMENT:
Prior to Version H this field was named: CLM_BLOOD_PT_RPLC_QTY. Also for outpatient claims this field was stored in a blood trailer. Version H eliminated the outpatient blood trailer.
SOURCE: NCH QA Process
**Variable Name**  |  **Label**  
--- | ---  
**BLDNRPLC** | *NCH Blood Pints Not Replaced Quantity*  
Number of whole pints of blood not replaced. 3 DIGITS SIGNED  
DB2 ALIAS: BLOOD_PT_NRPLC_QTY  
SAS ALIAS: BLDNRPLC  
STANDARD ALIAS: NCH_BLOOD_PT_NRPLC_QTY  
TITLE ALIAS: BLOOD_PINTS_NOT_REPLACED  
EDIT-RULES: NUMERIC  
DERIVATION:  
DERIVED FROM: CLM_VAL_CD  
CLM_VAL_AMT  
DERIVATION RULES:  
Subtract value code 39 amount from value code 37 amount and move the result to NCH_BLOOD_PT_NRPLC_QTY.  
COMMENT: Prior to Version H this field was named: CLM_BLOOD_PT_NRPLC_QTY. Also for outpatient claims this field was stored in a blood trailer. Version H eliminated the outpatient blood trailer.  
SOURCE: NCH QA Process  

**BLDDEDPT** | *NCH Blood Deductible Pints Quantity*  
The quantity of blood pints applied (blood deductible).  
3 DIGITS SIGNED  
DB2 ALIAS: BLOOD_DDCTBL_QTY  
SAS ALIAS: BLDDEDPT  
STANDARD ALIAS: NCH_BLOOD_DDCTBL_PT_QTY  
TITLE ALIAS: BLOOD_PINTS_DEDUCTIBLE  
EDIT-RULES: NUMERIC  
DERIVATION:  
DERIVED FROM: CLM_VAL_CD  
CLM_VAL_AMT  
DERIVATION RULES:  
Based on the presence of value code equal to 38 move the related value amount to the NCH_BLOOD_DDCTBL_PT_QTY.  
COMMENT: Prior to Version H this field was named: CLM_BLOOD_DDCTBL_PT_QTY. Also for outpatient claims this field was stored in a blood trailer. Version H eliminated the outpatient blood trailer.  
SOURCE: NCH QA Process
**Variable Name** | **Label** | **Description**
--- | --- | ---
**TRANTYPE** | Claim Outpatient Transaction Type Code | Effective with Version H, the code derived at CWF based on type of bill and provider number to identify the outpatient transaction type. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: OP_TRANS_TYPE_CD SAS ALIAS: TRANTYPE STANDARD ALIAS: CLM_OP_TRANS_TYPE_CD TITLE ALIAS: OP_TRANS_TYPE CODES: REFER TO: CLM_OP_TRANS_TYPE_TB IN THE CODES APPENDIX
SOURCE: CWF

**ESRDMTHD** | Claim Outpatient ESRD Method of Reimbursement Code | Effective with Version H, the code denoting the method of reimbursement selected by the ESRD bene for home dialysis (i.e. whether home supplies are purchased through a facility or from a supplier.) NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: ESRD_REIMBRSMT_CD SAS ALIAS: ESRDMTHD STANDARD ALIAS: CLM_OP_ESRD_MTHD_REIMBRSMT_CD TITLE ALIAS: ESRD_REIMBRSMT_MTHD CODES: 0 = Not ESRD 1 = Method 1 - Home supplies purchased through a facility 2 = Method 2 - Home supplies purchased from a supplier. SOURCE: CWF

**EDTND{x}** | NCH Edit Trailer Indicator Code | Effective with Version H, the code indicating the presence of an NCH edit trailer. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991.) DB2 ALIAS: EDIT_TRLR_IND_CD SAS ALIAS: EDITIND STANDARD ALIAS: NCH_EDIT_TRLR_IND_CD CODES: E = Edit code trailer present SOURCE: NCH QA Process
### Variable Name | Label
--- | ---
EDITCD[x] | NCH Edit Code

where \( x \) ranges from 1 to 13

The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.

NOTE: Prior to Version H only the highest priority code was stored. Beginning 11/98 up to 13 edit codes may be present.

COMMON ALIAS: QA_ERROR_CODE
DB2 ALIAS: NCH_EDIT_CD
SAS ALIAS: EDIT_CD
STANDARD ALIAS: NCH_EDIT_CD
TITLE ALIAS: QA_ERROR_CD

CODES:
REFER TO: NCH_EDIT_TB
IN THE CODES APPENDIX
SOURCE:
NCH QA EDIT PROCESS

PTCHND[x] | NCH Patch Trailer Indicator Code

where \( x \) ranges from 1 to 30

Effective with Version H, the code indicating the presence of an NCH patch trailer.

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

DB2 ALIAS: PATCH_TRLR_IND_CD
SAS ALIAS: PATCHIND
STANDARD ALIAS: NCH_PATCH_TRLR_IND_CD

CODES:
P = Patch code trailer present

SOURCE:
NCH

PTCHCD[x] | NCH Patch Code

where \( x \) ranges from 1 to 30

Effective with Version H, the code annotated to the claim indicating a patch was applied to the record during an NCH Nearline record conversion and/or during current processing.

NOTE: Prior to Version H this field was located in the third and fourth occurrence of the CLM_EDIT_CD.

DB2 ALIAS: NCH_PATCH_CD
SAS ALIAS: PATCHCD
STANDARD ALIAS: NCH_PATCH_CD
TITLE ALIAS: NCH_PATCH

CODES:
REFER TO: NCH_PATCH_TB
IN THE CODES APPENDIX
SOURCE:
NCH

PTCHDT[x] | NCH Patch Applied Date

where \( x \) ranges from 1 to 30

Effective with Version H, the code annotated to the claim indicating a patch was applied to the record during an NCH Nearline record conversion and/or during current processing.

NOTE: Prior to Version H this field was located in the third and fourth occurrence of the CLM_EDIT_CD.

DB2 ALIAS: NCH_PATCH_CD
SAS ALIAS: PATCHCD
STANDARD ALIAS: NCH_PATCH_CD
TITLE ALIAS: NCH_PATCH

CODES:
REFER TO: NCH_PATCH_TB
IN THE CODES APPENDIX
SOURCE:
NCH
**Variable Name** | **Label**
--- | ---
*Variable Name* | **Label**

Effective with Version H, the date the NCH patch was applied to the claim.

8 DIGITS UNSIGNED
DB2 ALIAS: NCH_PATCH_APPLY_DT
SAS ALIAS: PATCHDT
STANDARD ALIAS: NCH_PATCH_APPLY_DT
TITLE ALIAS: NCH_PATCH_DT
EDIT-RULES:
YYYYMMDD
SOURCE:
NCH

**MCOIND{x}** | **NCH MCO Trailer Indicator Code**
--- | ---
where {x} ranges from 1 to 2

Effective with Version H, the code indicating the presence of a Managed Care Organization (MCO) trailer.
NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 will contain spaces in this field.
COBOL ALIAS: MCO_IND
DB2 ALIAS: MCO_TRLR_IND_CD
SAS ALIAS: MCOIND
STANDARD ALIAS: NCH_MCO_TRLR_IND_CD
TITLE ALIAS: MCO_INDICATOR

**CODES:**
M = MCO trailer present
SOURCE:
NCH QA Process

**MCONUM{x}** | **MCO Contract Number**
--- | ---
where {x} ranges from 1 to 2

Effective with Version H, this field represents the plan contract number of the Managed Care Organization (MCO).
NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 will contain spaces in this field.
DB2 ALIAS: MCO_CNTRCT_NUM
SAS ALIAS: MCONUM
STANDARD ALIAS: MCO_CNTRCT_NUM
TITLE ALIAS: MCO_NUM
SOURCE:
CWF

**MCOOPTN{x}** | **MCO Option Code**
--- | ---
where {x} ranges from 1 to 2

Effective with Version H, the code indicating Managed Care Organization (MCO) lock-in enrollment status of the beneficiary.
NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 will contain spaces in this field.
DB2 ALIAS: MCO_OPTN_CD
SAS ALIAS: MCOOPTN
Variable Name | Label
---|---
STANDARD ALIAS: MCO_OPTN_CD | TITe ALIAS: MCO_OPTION_CD
CODES:
*****For lock-in beneficiaries****
A = HCFA to process all provider bills
B = MCO to process only in-plan
C = MCO to process all Part A and Part B bills
***** For non-lock-in beneficiaries*****
1 = HCFA to process all provider bills
2 = MCO to process only in-plan Part A and Part B bills
SOURCE:
CWF

MCFFDT{x} | MCO Period Effective Date
where { x } ranges from 1 to 2

Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) became effective.
NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 will contain zeroes in this field.
8 DIGITS UNSIGNED
DB2 ALIAS: MCO_PRD_EFCTV_DT
SAS ALIAS: MCOEFFDT
STANDARD ALIAS: MCO_PRD_EFCTV_DT
TITLE ALIAS: MCO_PERIOD_EFF_DT
EDIT-RULES:
YYYYMMDD
SOURCE:
CWF

MCTRMDT{x} | MCO Period Termination Date
where { x } ranges from 1 to 2

Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) was terminated.
NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 will contain zeroes in this field.
8 DIGITS UNSIGNED
DB2 ALIAS: MCO_PRD_TRMNTN_DT
SAS ALIAS: MCOTRMDT
STANDARD ALIAS: MCO_PRD_TRMNTN_DT
TITLE ALIAS: MCO_PERIOD_TERM_DT
EDIT-RULES:
YYYYMMDD
SOURCE:
CWF

MCPLND{x} | MCO Health PLANID Number
where { x } ranges from 1 to 2

A placeholder field (effective with Version H) for storing the Health PlanID associated with the Managed Care Organization (MCO). Prior to
Variable Name | Label
---|---

**PLNDND{x}** | NCH Health PlanID Trailer Indicator Code

where \{ x \} ranges from 1 to 3

A placeholder field (effective with Version H) for storing the code that indicates the presence of a Health PlanID trailer.

NOTE: Prior to Version 'I' this field was named:
NCH_PAYERID_TRLR_IND_CD.

DB2 ALIAS: PLANID_TRLR_CD
SAS ALIAS: PLANIDIN
STANDARD ALIAS: NCH_HLTH_PLANID_TRLR_IND_CD
CODES:
I = Health PlanID trailer present

COMMENT:
Prior to Version I this field was named:
NCH_PAYERID_TRLR_IND_CD.

SOURCE:
NCH

**PLNDCD{x}** | Claim Health PlanID Code

where \{ x \} ranges from 1 to 3

A placeholder field (effective with Version H) for storing the code identifying the type of Health PlanID. Prior to Version 'I' this field was named: CLM_PAYERID-CD

DB2 ALIAS: CLM_PLANID_CD
SAS ALIAS: PLANIDCD
STANDARD ALIAS: CLM_HLTH_PLANID_CD
TITLE ALIAS: PLANID_TYPE
CODES:
1 = Medicare Secondary Payer
2 = Medicaid
3 = Medigap
4 = Supplemental Insurer
5 = Managed Care Organization

COMMENT:
Prior to Version I this field was named:
CLM_PAYERID_CD.

SOURCE:
CWF

**PLANID{x}** | Claim Health PlanID Number

where \{ x \} ranges from 1 to 3

A placeholder field (effective with Version H) for storing the Health PlanID number. Prior to Version 'I' this field was named:
CLM_PAYERID_NUM.
**Variable Name** | **Label**
---|---
DB2 ALIAS: CLM_PLANID_NUM | **SAS ALIAS:** PLANID  
STANDARD ALIAS: CLM_HLTH_PLANID_NUM | **TITLE ALIAS:** PLANID
COMMENT: Prior to Version I this field was named: CLM_PAYERID_NUM.
SOURCE: CWF

**DEMOIND{x}** | **NCH Demonstration Trailer Indicator Code**
where {x} ranges from 1 to 5

Effective with Version H, the code indicating the presence of a demo trailer.
NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).
COBOL ALIAS: DEMO IND  
DB2 ALIAS: DEMO_TRLR_IND_CD  
SAS ALIAS: DEMOIND
STANDARD ALIAS: NCH_DEMO_TRLR_IND_CD
TITLE ALIAS: DEMO_INDICATOR
CODES:
D = Demo trailer present
SOURCE: NCH

**DEMONUM{x}** | **Claim Demonstration Identification Number**
where {x} ranges from 1 to 5

Effective with Version H, the number assigned to identify a demo. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).
NOTE: Prior to Version H, Demo ID was stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4. During the H conversion, this field was populated with data throughout history (as appropriate either by moving ID on Version G or by deriving from specific demo criteria).
01 = Nursing Home Case-Mix and Quality: NHCMQ (RUGS) Demo -- testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a RUGS indicator and one or more revenue center codes in the 9,000 series.
NOTE1: Effective for SNF claims with NCH weekly process date after 2/8/96 (and service date after 12/31/95) -- beginning 4/97, Demo ID '01' was derived in NCH based on presence of RUGS phase # '2', '3' or '4' on incoming claim; since 7/97, CWF has been adding ID to claim.
NOTE2: During the Version H conversion, Demo ID '01' was populated back to NCH weekly process date 2/9/96 based on the RUGS phase indicator (stored in Claim Edit Group, 3rd occurrence, 4th position, in Version G).
02 = National HHA Prospective Payment Demo --
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 = PPS for HHAs in 5 states</td>
<td>using two alternate methods of paying HHAs: per visit by type of HHA visit and per episode of HH care.</td>
</tr>
<tr>
<td>NOTE1: Effective for HHA claims with NCH weekly process date after 5/31/95</td>
<td>Demo ID '02' was derived in NCH based on HCFA/CHPP-supplied listing of provider # and start/stop dates of participants.</td>
</tr>
<tr>
<td>NOTE2: During the Version H conversion, Demo ID '02' was populated back to NCH weekly process date 6/95 based on the CHPP criteria.</td>
<td></td>
</tr>
<tr>
<td>03 = Telemedicine Demo</td>
<td>testing covering traditionally noncovered physician services for medical consultation furnished via two-way, interactive video systems (i.e. teleconsultation) in 4 states. The claims contain line items with 'QQ' HCPCS code.</td>
</tr>
<tr>
<td>NOTE1: Effective for physician/supplier (nonDMERC) claims with NCH weekly process date after 12/31/96 (and service date after 9/30/96)</td>
<td>since 7/97, CWF has been adding Demo ID '03' to claim.</td>
</tr>
<tr>
<td>NOTE2: During Version H conversion, Demo ID '03' was populated back to NCH weekly process date 1/97 based on the presence of 'QQ' HCPCS on one or more line items.</td>
<td></td>
</tr>
<tr>
<td>04 = United Mine Workers of America (UMWA) Managed Care Demo</td>
<td>testing risk sharing for Part A services, paying special capitation rates for all UMWA beneficiaries residing in 13 designated counties in 3 states. Under the demo, UMWA will waive the 3-day qualifying hospital stay for a SNF admission. The claims contain TOB '18X','21X','28X' and '51X'; condition code = W0; claim MCO paid switch = not '0'; and MCO contract # = '90091'.</td>
</tr>
<tr>
<td>NOTE: Initially scheduled to be implemented for all SNF claims for admission or services on 1/1/97 or later, CWF did not transmit any Demo ID '04' annotated claims until on or about 2/98.</td>
<td></td>
</tr>
<tr>
<td>05 = Medicare Choices (MCO encounter data) demo</td>
<td>testing expanding the type of Managed Care plans available and different payment methods at 16 MCOs in 9 states. The claims contain one of the specific MCO Plan Contract # assigned to the Choices Demo site.</td>
</tr>
<tr>
<td>NOTE1: Effective for all claim types with NCH weekly process date after 7/31/97</td>
<td>CWF adds Demo ID '05' to claim based on the presences of the MCO Plan Contract #.</td>
</tr>
<tr>
<td>NOTE2: During the Version H conversion, Demo ID '05' was populated back to NCH weekly process date 8/97 based on the presence of the Choices indicator (stored as an alpha character cross-walked from MCO plan contract # in the Claim Edit Group, 4th occurrence, 2nd position, in Version 'G').</td>
<td></td>
</tr>
</tbody>
</table>
| 06 = Coronary Artery Bypass Graft (CABG) Demo | --
Variable Name  Label

testing bundled payment (all-inclusive global pricing) for hospital + physician services related to CABG surgery in 7 hospitals in 7 states. The inpatient claims contain a DRG '106' or '107'.

NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit Date no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID '06' on the claim. The FI adds the ID to the claim based on the presence of DRG '106' or '107' from specific providers for specified time periods; the carrier adds the ID to the claim based on receiving "Daily Census List" from participating hospitals. Demo ID '06' will end once Demo ID '07' is implemented.

NOTE2: During the Version H conversion, any claims where Medicare is the primary payer that were not already identified as Demo ID '06' (stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4, Version G) were annotated based on the following criteria: Inpatient - presence of DRG '106' or '107' and a provider number=220897, 150897, 380897,450897,110082,230156 or 360085 for specified service dates; noninstitutional - presence of HCPCS modifier (initial and/or second) = 'Q2' and a carrier number =00700/31143 00630,01380,00900,01040/00511,00710,00623, or 13630 for specified service dates.

07 = Participating Centers of Excellence (PCOE) Demo -- testing a negotiated all-inclusive pricing arrangement (bundled rates) for high-cost acute care cardiovascular and orthopedic procedures performed in 60-100 premier facilities in the Chicago and San Francisco Regions or by current CABG providers. The inpatient claims will contain a DRG '104','105', '106', '107', '112', '124', '125', '209', or '471'; the related physician/supplier claims will contain the claim payment denial reason code = 'D'.

NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '07' to claim.

08 = Provider Partnership Demo -- testing per-case payment approaches for acute inpatient hospitalizations, making a lump-sum payment (combining the normal Part A PPS payment with the Part B allowed charges into a single fee schedule) to a Physician/Hospital Organization for all Part A and Part B services associated with a hospital admission. From 3 to 6 hospitals in the Northeast and Mid-Atlantic regions may participate in the demo.

NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '08' to claim.

15 = ESRD Managed Care (MCO encounter data) -- testing open enrollment of ESRD beneficiaries
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>and capitation rates adjusted for patient treatment needs at 3 MCOs in 3 States. The claims contain one of the specific MCO Plan Contract # assigned to the ESRD demo site. NOTE: Effective 10/1/97 (but not actually implemented at a site until 1/1/98) for all claim types -- the FI and carrier add Demo ID ‘15’ to claim based on the presence of the MCO plan contract #.</td>
<td></td>
</tr>
<tr>
<td>30 = Lung Volume Reduction Surgery (LVRS) or National Emphysema Treatment Trial (NETT) Clinical Study -- evaluating the effectiveness of LVRS and maximum medical therapy (including pulmonary rehab) for Medicare beneficiaries in last stages of emphysema at 18 hospitals nationally, in collaboration with NIH. NOTE: Effective for all claim types (except DMERC) with NCH weekly process date after 2/27/98 (and service date after 10/31/97) -- the FI adds Demo ID ‘30’ based on the presence of a condition code = EY; the participating physician (not the carrier) adds ID to the noninstitutional claim. DUE TO THE SENSITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO HCFA BUT NOT STORED IN THE NEARLINE FILE (access is restricted to study evaluators only).</td>
<td></td>
</tr>
<tr>
<td>31 = VA Pricing Special Processing (SPN) -- not really a demo but special request from VA due to court settlement; not Medicare services but VA inpatient and physician services submitted to FI 00400 and Carrier 00900 to obtain Medicare pricing -- CWF WILL PROCESS VA CLAIMS ANNOTATED WITH DEMO ID ‘31’, BUT WILL NOT TRANSMIT TO HCFA (not in Nearline File).</td>
<td></td>
</tr>
<tr>
<td>37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries improve outcomes of care and reduce Medicare expenditures under Part A and Part B. There will be at least 9 Coordinated Care Entities (CCEs). The selected entities will be assigned a provider number specifically for the demonstration services. NOTE: The demo is on HOLD. The FI and carrier will add Demo ID ‘37’ to claim.</td>
<td></td>
</tr>
<tr>
<td>38 = Physician Encounter Claims - the purpose of this demo id is to identify the physician encounter claims being processed at the HCFA Data Center (HDC). This number will help EDS in making the claim go through the appropriate processing logic, which differs from that for fee-for-service. <strong>NOT IN NCH -- AVAILABLE IN NMUD.</strong> NOTE: Effective October, 2000. Demo ids will not be assigned to Inpatient and Outpatient encounter claims.</td>
<td></td>
</tr>
<tr>
<td><strong>Variable Name</strong></td>
<td><strong>Label</strong></td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>39 = Centralized Billing of Flu and PPV Claims – The purpose of this demo is to facilitate the processing carrier, Trailblazers, paying flu and PPV claims based on payment localities. Providers will be giving the shots throughout the country and transmitting the claims to Trailblazers for processing. NOTE: Effective October, 2000 for carrier claims.</td>
<td></td>
</tr>
<tr>
<td>DB2 ALIAS: CLM_DEMO_ID_NUM</td>
<td>SAS ALIAS: DEMONUM</td>
</tr>
<tr>
<td>STANDARD ALIAS: CLM_DEMO_ID_NUM</td>
<td>TITLE ALIAS: DEMO_ID</td>
</tr>
<tr>
<td>SOURCE: CWF</td>
<td></td>
</tr>
</tbody>
</table>

**DEMOTXT** \{x\}  **Claim Demonstration Information Text**

\[\text{where} \{x\} \text{ ranges from } 1 \text{ to } 5\]

Effective with Version H, the text field that contains related demo information. For example, a claim involving a CHOICES demo id ‘05’ would contain the MCO plan contract number in the first five positions of this text field. NOTE: During the Version H conversion this field was populated with data throughout history.

**DB2 ALIAS: CLM_DEMO_INFO_TXT**

**SAS ALIAS: DEMOTXT**

**STANDARD ALIAS: CLM_DEMO_INFO_TXT**

**TITLE ALIAS: DEMO_INFO**

**DERIVATION:**

**DERIVATION RULES:**

- Demo ID = 01 (RUGS) -- the text field will contain a 2, 3 or 4 to denote the RUGS phase. If RUGS phase is blank or not one of the above the text field will reflect ‘INVALID’. NOTE: In Version ‘G’, RUGS phase was stored in redefined Claim Edit Group, 3rd occurrence, 4th position.

- Demo ID = 02 (Home Health demo) -- the text field will contain PROV#. When demo number not equal to 02 then text will reflect ‘INVALID’.

- Demo ID = 03 (Telemedicine demo) -- text field will contain the HCPCS code. If the required HCPCS is not shown then the text field will reflect ‘INVALID’.

- Demo ID = 04 (UMWA) -- text field will contain W0 denoting that condition code W0 was present. If condition code W0 not present then the text field will reflect ‘INVALID’.

- Demo ID = 05 (CHOICES) -- the text field will contain the CHOICES plan number, if both of the following conditions are met: (1) CHOICES plan number present and PPS or Inpatient claim shows that 1st 3 positions of provider number as ‘210’ and the admission date is within HMO effective/termination date; or non-PPS claim and the from date is within HMO effective/termination date and (2) CHOICES plan number matches the HMO plan number. If either condition is not met the text field will reflect ‘INVALID CHOICES PLAN NUMBER’. When

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*Page 50 of 71*
Variable Name       Label

CHOICES plan number not present, text will reflect 'INVALID'.
NOTE: In Version 'G', a valid CHOICES plan ID is stored as alpha character in redefined Claim Edit Group, 4th occurrence, 2nd position. If invalid, CHOICES indicator 'ZZ' displayed.
Demo ID = 15 (ESRD Managed Care) -- text field will contain the ESRD/MCO plan number. If ESRD/MCO plan number not present the field will reflect 'INVALID'.
Demo ID = 38 (Physician Encounter Claims) -- text field will contain the MCO plan number. When MCO plan number not present the field will reflect 'INVALID'.
SOURCE: CWF

DGNSND\{x\}     NCH Diagnosis Trailer Indicator Code
                  where \{ x \} ranges from 1 to 10

Effective with Version H, the code indicating the presence of a diagnosis trailer.
NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).
DB2 ALIAS: DGNS_TRLR_IND_CD
SAS ALIAS: DGNSIND
STANDARD ALIAS: NCH_DGNS_TRLR_IND_CD
CODES:
Y = Diagnosis code trailer present
SOURCE: NCH

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: DGNS_CD
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.

PRCDRND\{x\}     NCH Procedure Trailer Indicator Code
                  where \{ x \} ranges from 1 to 6

Effective with Version H, the code indicating the presence of a procedure trailer.
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).</td>
<td></td>
</tr>
<tr>
<td>DB2 ALIAS: PRCDR_TRLR_IND_CD</td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: PRCDRIND</td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: NCH_PRCDR_TRLR_IND_CD</td>
<td></td>
</tr>
<tr>
<td>CODES:</td>
<td></td>
</tr>
<tr>
<td>Z = Procedure code trailer present</td>
<td></td>
</tr>
<tr>
<td>SOURCE: NCH</td>
<td></td>
</tr>
<tr>
<td><strong>PRCDRCD{y}</strong></td>
<td><em>Claim Procedure Code</em></td>
</tr>
<tr>
<td>where {y} ranges from 1 to 6</td>
<td>The ICD-9-CM code that indicates the principal or other procedure performed during the period covered by the institutional claim.</td>
</tr>
<tr>
<td>DB2 ALIAS: CLM_PRCDR_CD</td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: PRCDR_CD</td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: CLM_PRCDR_CD</td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: PROCEDURE_CODE</td>
<td></td>
</tr>
<tr>
<td>EDIT-RULES:</td>
<td></td>
</tr>
<tr>
<td>ICD-9-CM</td>
<td></td>
</tr>
<tr>
<td>SOURCE: CWF</td>
<td></td>
</tr>
<tr>
<td><strong>PRCDRDT{y}</strong></td>
<td><em>Claim Procedure Performed Date</em></td>
</tr>
<tr>
<td>where {y} ranges from 1 to 6</td>
<td>On an institutional claim, the date on which the principal or other procedure was performed.</td>
</tr>
<tr>
<td>8 DIGITS UNSIGNED</td>
<td></td>
</tr>
<tr>
<td>DB2 ALIAS: CLM_PRCDR_PRFRM_DT</td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: PRCDR_DT</td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: CLM_PRCDR_PRFRM_DT</td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: PROCEDURE_DATE</td>
<td></td>
</tr>
<tr>
<td>EDIT-RULES:</td>
<td></td>
</tr>
<tr>
<td>YYYYMMDD</td>
<td></td>
</tr>
<tr>
<td>SOURCE: CWF</td>
<td></td>
</tr>
<tr>
<td><strong>CNDND{y}</strong></td>
<td><em>NCH Condition Trailer Indicator Code</em></td>
</tr>
<tr>
<td>where {y} ranges from 1 to 30</td>
<td>Effective with Version H, the code indicating the presence of a condition code trailer.</td>
</tr>
<tr>
<td>NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).</td>
<td></td>
</tr>
<tr>
<td>DB2 ALIAS: COND_TRLR_IND_CD</td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: CONDIND</td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: NCH_COND_TRLR_IND_CD</td>
<td></td>
</tr>
<tr>
<td>CODES:</td>
<td></td>
</tr>
<tr>
<td>C = Condition code trailer present</td>
<td></td>
</tr>
<tr>
<td>SOURCE: NCH</td>
<td></td>
</tr>
<tr>
<td><strong>RLTCND{y}</strong></td>
<td><em>Claim Related Condition Code</em></td>
</tr>
<tr>
<td>where {y} ranges from 1 to 30</td>
<td>The code that indicates a condition relating to an institutional claim that may affect payer processing.</td>
</tr>
</tbody>
</table>
### Variable Name

<table>
<thead>
<tr>
<th>Label</th>
<th>DB2 ALIAS: CLM_RLT_COND_CD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SAS ALIAS: RLT_COND</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: CLM_RLT_COND_CD</td>
</tr>
<tr>
<td></td>
<td>SYSTEM ALIAS: LTCOND</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: RELATEDCONDITION_CD</td>
</tr>
<tr>
<td>CODES:</td>
<td>01 THRU 16 = Insurance related</td>
</tr>
<tr>
<td></td>
<td>17 THRU 30 = Special condition</td>
</tr>
<tr>
<td></td>
<td>31 THRU 35 = Student status codes which are required when a patient is a dependent child over 18 years old</td>
</tr>
<tr>
<td></td>
<td>36 THRU 45 = Accommodation</td>
</tr>
<tr>
<td></td>
<td>46 THRU 54 = CHAMPUS information</td>
</tr>
<tr>
<td></td>
<td>55 THRU 59 = Skilled nursing facility</td>
</tr>
<tr>
<td></td>
<td>60 THRU 70 = Prospective payment</td>
</tr>
<tr>
<td></td>
<td>71 THRU 99 = Renal dialysis setting</td>
</tr>
<tr>
<td></td>
<td>A0 THRU B9 = Special program codes</td>
</tr>
<tr>
<td></td>
<td>C0 THRU C9 = PRO approval services</td>
</tr>
<tr>
<td></td>
<td>D0 THRU W0 = Change conditions</td>
</tr>
<tr>
<td>CODES:</td>
<td>REFER TO: CLM_RLT_COND_TB IN THE CODES APPENDIX</td>
</tr>
<tr>
<td>SOURCE:</td>
<td>CWF</td>
</tr>
</tbody>
</table>

### OCRCND[x]

**NCH Occurrence Trailer Indicator Code**

*where \( x \) ranges from 1 to 30*

Effective with Version H, the code indicating the presence of a occurrence code trailer.

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

<table>
<thead>
<tr>
<th>DB2 ALIAS: OCR_NC_TRLR_IND_CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAS ALIAS: OCRNCIND</td>
</tr>
<tr>
<td>STANDARD ALIAS: NCH_OCRNC_TRLR_IND_CD</td>
</tr>
<tr>
<td>CODES: ( O ) = Occurrence code trailer present</td>
</tr>
<tr>
<td>SOURCE: NCH</td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>DB2 ALIAS: CLM_RLT_OCRNC_CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAS ALIAS: OCRNC_CD</td>
</tr>
<tr>
<td>STANDARD ALIAS: CLM_RLT_OCRNC_CD</td>
</tr>
<tr>
<td>SYSTEM ALIAS: LTOCRNC</td>
</tr>
<tr>
<td>TITLE ALIAS: OCCURRENCE_CD</td>
</tr>
<tr>
<td>CODES: ( 01 ) THRU 09 = Accident</td>
</tr>
<tr>
<td>( 10 ) THRU 19 = Medical condition</td>
</tr>
<tr>
<td>( 20 ) THRU 39 = Insurance related</td>
</tr>
<tr>
<td>( 40 ) THRU 69 = Service related</td>
</tr>
<tr>
<td>A1-A3 = Miscellaneous</td>
</tr>
</tbody>
</table>

"Page 53 of 71"
**Variable Name** | **Label**
--- | ---

**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.  
8 DIGITS UNSIGNED  
DB2 ALIAS: CLM_RLT_OCRNC_DT  
SAS ALIAS: OCRNCDT  
STANDARD ALIAS: CLM_RLT_OCRNC_DT  
TITLE ALIAS: RLT_OCRNC_DT  
EDIT-RULES: YYYYMMDD  
SOURCE: CWF

**SPNND{\(x\)}**: NCH Span Trailer Indicator Code  
*where \(x\) ranges from 1 to 10*

Effective with Version H, the code indicating the presence of a span code trailer.  
NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).  
DB2 ALIAS: SPAN_TRLR_IND_CD  
SAS ALIAS: SPANIND  
STANDARD ALIAS: NCH_SPAN_TRLR_IND_CD  
CODES:  
S = Span code trailer present  
SOURCE: CWF

**SPANCD{\(x\)}**: Claim Occurrence Span Code  
*where \(x\) ranges from 1 to 10*

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 time period (span of dates).  
DB2 ALIAS: CLM_OCRNC_SPAN_CD  
SAS ALIAS: SPAN_CD  
STANDARD ALIAS: CLM_OCRNC_SPAN_CD  
SYSTEM ALIAS: LTSPAN  
TITLE ALIAS: SPAN_CD  
CODES:  
REFER TO: CLM_OCRNC_SPAN_TB  
IN THE CODES APPENDIX  
SOURCE: CWF

**SPNFRM{\(x\)}**: Claim Occurrence Span From Date  
*where \(x\) ranges from 1 to 10*
Variable Name | Label
--- | ---
SPNTHR\{x\} | Claim Occurrence Span Through Date
where \( x \) ranges from 1 to 10

The thru date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.

8 DIGITS UNSIGNED
DB2 ALIAS: OCRNCSPAN_THRU_DT
SAS ALIAS: SPANTHRU
STANDARD ALIAS: CLM_OCRNCSPAN_THRU_DT
TITLE ALIAS: SPAN_THRU_DT
EDIT-RULES: YYYYMMDD
SOURCE: CWF

VALIND\{x\} | NCH Value Trailer Indicator Code
where \( x \) ranges from 1 to 36

Effective with Version H, the code indicating the presence of a value code trailer.

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

DB2 ALIAS: VAL_TRLR_IND_CD
SAS ALIAS: VALIND
STANDARD ALIAS: NCH_VAL_TRLR_IND_CD
CODES:
\( V = \) Value code trailer present
SOURCE: NCH

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
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VALAMT{x}</strong></td>
<td>Claim Value Amount</td>
</tr>
</tbody>
</table>

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: VAL_AMT
STANDARD ALIAS: CLM_VAL_AMT
TITLE ALIAS: VALUE_AMOUNT
EDIRULES: $$$$$$$$$$CC
SOURCE: CWF

| REVIND{x} | NCH Revenue Center Trailer Indicator Code |

where \{ x \} ranges from 1 to 58

Effective with Version H, the code identifying the revenue center trailer.

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

DB2 ALIAS: REV_CNTR_TRLR_CD
SAS ALIAS: REVIND
STANDARD ALIAS: NCH_REV_CNTR_TRLR_IND_CD
CODES:
R = Revenue code trailer present
SOURCE: NCH

| RVCNTR{x} | Revenue Center Code |

where \{ x \} ranges from 1 to 58

The provider-assigned revenue code for each cost center for which a separate charge is billed (type of 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: REV_CNTR
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 |

where \{ x \} ranges from 1 to 58
Variable Name       Label

Effective with Version H, the date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS.

NOTE1: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

NOTE2: When revenue center code equals '0022' (SNF PPS) and revenue center HCPCS code not equal to 'AAA00' (default for no assessment), date represents the MDS RAI assessment reference date.

NOTE3: When revenue center code equals '0023' (HHPPS), the date on the initial claim (RAP) must represent the first date of service in the episode. The final claim will match the '0023' information submitted on the initial claim. The SCIC (significant change in condition) claims may show additional '0023' revenue lines in which the date represents the date of the first service under the revised plan of treatment.

8 DIGITS UNSIGNED
DB2 ALIAS: REV_CNTR_DT
SAS ALIAS: REV_DT
STANDARD ALIAS: REV_CNTR_DT
TITLE ALIAS: REV_CNTR_DATE
EDIT-RULES:
YYYYMMDD
SOURCE:
CWF

RVNS1{x}           Revenue Center 1st ANSI Code
where { x } ranges from 1 to 58

The first code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS: REV_CNTR_ANSI1_CD
SAS ALIAS: REVANSI1
STANDARD ALIAS: REV_CNTR_ANSI_1_CD
SYSTEM ALIAS: LTANSI
TITLE ALIAS: ANSI_CD
CODES:
REFER TO: REV_CNTR_ANSI_TB
IN THE CODES APPENDIX
SOURCE:
CWF

RVNS2{x}           Revenue Center 2nd ANSI Code
where { x } ranges from 1 to 58

Page 57 of 71
### Variable Name | Label
--- | ---
The second code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).<br>Note: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.<br>DB2 ALIAS: REV_CNTR_ANSI2_CD<br>SAS ALIAS: REVANSI2<br>STANDARD ALIAS: REV_CNTR_ANSI_2_CD<br>TITLE ALIAS: ANSI_CD<br>SOURCE: CWF<br>RVNS3{\text{x}} | Revenue Center 3rd ANSI Code<br>where \{ x \} ranges from 1 to 58
The third code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).<br>Note: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.<br>DB2 ALIAS: REV_CNTR_ANSI3_CD<br>SAS ALIAS: REVANSI3<br>STANDARD ALIAS: REV_CNTR_ANSI_3_CD<br>TITLE ALIAS: ANSI_CD<br>SOURCE: CWF<br>RVNS4{\text{x}} | Revenue Center 4th ANSI Code<br>where \{ x \} ranges from 1 to 58
The fourth code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).<br>Note: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.<br>DB2 ALIAS: REV_CNTR_ANSI4_CD<br>SAS ALIAS: REVANSI4<br>STANDARD ALIAS: REV_CNTR_ANSI_4_CD<br>TITLE ALIAS: ANSI_CD<br>SOURCE: CWF<br>APCPPS{\text{x}} | Revenue Center APC/HIPPS Code<br>where \{ x \} ranges from 1 to 58
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.<br>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.
Variable Name | Label
---|---

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: APCHIPPS
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 System Code
where \{ x \} ranges from 1 to 58

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: HCPCS_CD
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
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>the basis of payment for each episode.</td>
<td>For both SNF PPS &amp; HH PPS HiPPS values see CLM_HIPPS_TB.</td>
</tr>
<tr>
<td>Level I</td>
<td>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.</td>
</tr>
<tr>
<td>**** Note: ****</td>
<td>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.</td>
</tr>
<tr>
<td>Level II</td>
<td>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.</td>
</tr>
<tr>
<td>Level III</td>
<td>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.</td>
</tr>
<tr>
<td>MDFCD1{[x]}</td>
<td>Revenue Center HCPCS Initial Modifier Code</td>
</tr>
<tr>
<td>where {x} ranges from 1 to 58</td>
<td>A first modifier to the procedure code to enable a more specific procedure identification for the claim.</td>
</tr>
<tr>
<td>DB2 ALIAS: REV_HCPCS_MDFR_CD</td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: MDFR_CD1</td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: REV_CNTR_HCPCS_INITL_MDFR_CD</td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: INITIAL_MODIFIER</td>
<td></td>
</tr>
<tr>
<td>EDIT-RULES: Carrier Information File</td>
<td></td>
</tr>
<tr>
<td>COMMENT: Prior to Version H this field was named: HCPCS_INITL_MDFR_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).</td>
<td></td>
</tr>
<tr>
<td>SOURCE: CWF</td>
<td></td>
</tr>
<tr>
<td>MDFCD2{[x]}</td>
<td>Revenue Center HCPCS Second Modifier Code</td>
</tr>
<tr>
<td>where {x} ranges from 1 to 58</td>
<td></td>
</tr>
</tbody>
</table>
**Variable Name**

Variable Name: A second modifier to the procedure code to make it more specific than the first modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS: REV_HCPCS_2ND_CD
SAS ALIAS: MDFR_CD2
STANDARD ALIAS: REV_CNTR_HCPCS_2ND_MDFR_CD
TITLE ALIAS: SECOND_MODIFIER
EDIT-RULES:
COMMENT:
Prior to Version H this field was named: HCPCS_2ND_MDFR_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).
SOURCE:
CWF

**Label**

**Label**: Revenue Center HCPCS Third Modifier Code

Effective with Version I, a third modifier to the procedure code to make it more specific than the second modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS: REV_HCPCS_3RD_CD
SAS ALIAS: MDFR_CD3
STANDARD ALIAS: REV_CNTR_HCPCS_3RD_MDFR_CD
TITLE ALIAS: THIRD_MODIFIER
EDIT-RULES:
COMMENT:
NOTE: 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.
SOURCE:
CWF

**MDFCD3[x]**

where \( x \) ranges from 1 to 58

**MDFCD4[x]**

where \( x \) ranges from 1 to 58

Effective with Version I, a fourth modifier to the procedure code to make it more specific than the third modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS: REV_HCPCS_4TH_CD
SAS ALIAS: MDFR_CD4
STANDARD ALIAS: REV_CNTR_HCPCS_4TH_MDFR_CD
TITLE ALIAS: FOURTH_MODIFIER
EDIT-RULES:
COMMENT:
NOTE: 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.
SOURCE:
CWF
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDFCD5{(x)}</td>
<td>Revenue Center HCPCS Fifth Modifier Code</td>
</tr>
<tr>
<td>PMTTHD{(x)}</td>
<td>Revenue Center Payment Method Indicator Code</td>
</tr>
<tr>
<td>DSCTND{(x)}</td>
<td>Revenue Center Discount Indicator Code</td>
</tr>
</tbody>
</table>

**MDFCD5{\(x\)}**

Effective with Version I, a fifth modifier to the procedure code to make it more specific than the fourth modifier code to identify the procedures performed on the beneficiary for the claim.

- **DB2 ALIAS**: REV_HCPCS_5TH_CD
- **SAS ALIAS**: MDFR_CD5
- **STANDARD ALIAS**: REV_CNTR_HCPCS_5TH_MDFR_CD
- **TITLE ALIAS**: FIFTH_MODIFIER

**EDIT-RULES:**
- CARRIER INFORMATION FILE
- COMMENT:
  - NOTE: 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.
- **SOURCE**: CWF

**PMTTHD{\(x\)}**

Effective with Version 'I', the code used to identify how the service is priced for payment. This field is made up of two pieces of data, 1st position being the service indicator and the 2nd position being the payment indicator.

- **NOTE**: 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_PMT_MTHD_CD
- **SAS ALIAS**: PMTTHD
- **STANDARD ALIAS**: REV_CNTR_PMT_MTHD_IND_CD
- **SYSTEM ALIAS**: LTPMTHD
- **TITLE ALIAS**: PMT_MTHD

**CODES:**
- **REFER TO**: REV_CNTR_PMT_MTHD_IND_TB
- **IN THE CODES APPENDIX**
- **SOURCE**: CWF

**DSCTND{\(x\)}**

Effective with Version 'I', for all services subject to Outpatient PPS, this code represents a factor that specifies the amount of any APC discount. The discounting factor is applied to a line item with a service indicator (part of the REV_CNTR_PMT_MTHD_IND_CD) of 'T'. The flag is applicable when more than one significant procedure is performed. **If there is no discounting the factor will be 1.0.**

- **NOTE1**: 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.
- **SOURCE**: CWF
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>DB2 ALIAS: REV_DSCNT_IND_CD</td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: DSCNTIND</td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: REV_CNTR_DSCNT_IND_CD</td>
<td></td>
</tr>
<tr>
<td>SYSTEM ALIAS: LTDSCNT</td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: REV_CNTR_DSCNT_IND_CD</td>
<td></td>
</tr>
<tr>
<td>CODES:</td>
<td></td>
</tr>
<tr>
<td><em>DISCOUNTING FORMULAS</em></td>
<td></td>
</tr>
<tr>
<td>1 = 1.0</td>
<td></td>
</tr>
<tr>
<td>2 = (1.0+D(U-1))/U</td>
<td></td>
</tr>
<tr>
<td>3 = T/U</td>
<td></td>
</tr>
<tr>
<td>4 = (1+D)/U</td>
<td></td>
</tr>
<tr>
<td>5 = D</td>
<td></td>
</tr>
<tr>
<td>6 = TD/U</td>
<td></td>
</tr>
<tr>
<td>7 = D(1+D)/U</td>
<td></td>
</tr>
<tr>
<td>8 = 2.0U</td>
<td></td>
</tr>
<tr>
<td>SOURCE: CWF</td>
<td></td>
</tr>
</tbody>
</table>

**PCKGND\{x\}**  
Revenue Center Packaging Indicator Code  
where \{ x \} ranges from 1 to 58

Effective with Version 'I', for all services subject to Outpatient PPS, the code used to identify those services that are packaged/bundled with another service.  
NOTE: 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_PACKG_IND_CD  
SAS ALIAS: PACKGIND  
STANDARD ALIAS: REV_CNTR_PACKG_IND_CD  
SYSTEM ALIAS: LTPACKG  
TITLE ALIAS: REV_CNTR_PACKG_IND  
CODES:  
0 = Not packaged  
1 = Packaged service (service indicator N)  
2 = Packaged as part of partial hospitalization per diem or daily mental health service per diem  
SOURCE: CWF

**PRICNG\{x\}**  
Revenue Center Pricing Indicator Code  
where \{ x \} ranges from 1 to 58

Effective with Version 'I', the code used to identify if there was a deviation from the standard method of calculating payment amount.  
NOTE: 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_PRICNG_IND_CD  
SAS ALIAS: PRICNG  
STANDARD ALIAS: REV_CNTR_PRICNG_IND_CD  
SYSTEM ALIAS: LTPRICNG  
TITLE ALIAS: REV_CNTR_PRICNG_IND  
CODES:
Variable Name | Label | Source
---|---|---
OTAF_1{x} | Revenue Center Obligation to Accept As Full (OTAF) Payment | CWF

where \( x \) ranges from 1 to 58

Effective with Version 'I' the code used to indicate that the provider was obligated to accept as full payment the amount received from the primary (or secondary) payer.

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS: REV_OTAF1_IND_CD
SAS ALIAS: OTAF_1

STANDARD ALIAS: REV_CNTR_OTAF_1_IND_CD
TITLE ALIAS: REV_CNTR_OTAF_1_IND_CD
EDIT-RULES:
\( Y = \) provider is obligated to accept the payment as payment in full for the service.
\( N \) or blank \( = \) provider is not obligated to accept the payment, or there is no payment by a prior payer.

SOURCE:
CWF

OTAF_2{x} | Revenue Center Obligation to Accept As Full (OTAF) Payment | CWF

where \( x \) ranges from 1 to 58

***********FIELD NOT POPULATED************

This field was intended to collect information for two payers if Medicare was tertiary. It was discovered that MSP system only deals with one payer so there is no need to have 2 OTAF fields.

DB2 ALIAS: REV_OTAF2_IND_CD
SAS ALIAS: OTAF_2

STANDARD ALIAS: REV_CNTR_OTAF_2_IND_CD
TITLE ALIAS: REV_CNTR_OTAF_2_IND_CD
SOURCE:
CWF

IDENDC{x} | Revenue Center IDE, NDC, UPC Number | CWF

where \( x \) ranges from 1 to 58

Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. HCFA established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95. IDE's are always associated with revenue center code '0624'.

NOTE: Prior to Version H a 'dummy' revenue center code '0624' trailer was created to store IDE's. The IDE number was housed in two fields:
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'. There can be up to 7 distinct IDE numbers associated with an '0624' dummy trailer. During the Version H conversion IDE's were moved from the dummy '0624' trailer to this dedicated field.</td>
</tr>
<tr>
<td></td>
<td>NOTE2: Effective with Version 'I', this field was renamed to eventually accommodate the National Drug (NDC) and the Universal Product Code (UPC). This field could contain either of these 3 fields (there would never be an instance where more than one would come in on a claim). The size of this field was expanded to X(24) to accommodate either of the new fields (under Version 'H' it was X(7)). DATA ANOMOLY/LIMITATION: During an CWFMQA review an edit revealed the IDE was missing. The problem occurs in claim with an NCH weekly process dates of 6/9/00 through 9/8/00. During processing of the new format the program receives the IDE but then blanked out the data.</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: IDE_NDC_UPC_NUM</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: IDENDC</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: REV_CNTR_IDE_NDC_UPC_NUM</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: IDE_NDC_UPC</td>
</tr>
<tr>
<td></td>
<td>SOURCE: CWF</td>
</tr>
<tr>
<td>RVUNT{x}</td>
<td>Revenue Center Unit Count</td>
</tr>
<tr>
<td>where { x } ranges from 1 to 58</td>
<td>A quantitative measure (unit) of the number of times the service or procedure being reported was performed to the revenue center/HCPCS code definition as described an institutional claim. Depending on type of service, units are measured by 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</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: REV_CNTR_UNIT_CNT</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: REV_UNIT</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: REV_CNTR_UNIT_CNT</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: UNITS</td>
</tr>
<tr>
<td></td>
<td>SOURCE: CWF</td>
</tr>
<tr>
<td>RVRT{x}</td>
<td>Revenue Center Rate Amount</td>
</tr>
<tr>
<td>where { x } ranges from 1 to 58</td>
<td>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 = '0022') 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</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: REV_CNTR_UNIT_CNT</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: REV_UNIT</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: REV_CNTR_UNIT_CNT</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: UNITS</td>
</tr>
<tr>
<td></td>
<td>SOURCE: CWF</td>
</tr>
</tbody>
</table>
Variable Name  | Label
---|---
| 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: REV_RATE
STANDARD ALIAS: REV_CNTR_RATE_AMT
TITLE ALIAS: CHARGE_PER_UNIT
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
---|---
where \{ x \} ranges from 1 to 58

Effective with Version 'I', the amount of money for which the intermediary determined the beneficiary is liable for the blood deductible for the line item service.

NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

9.2 DIGITS SIGNED
DB2 ALIAS: REV_BLOOD_DDCTBL
SAS ALIAS: REVBLOOD
STANDARD ALIAS: REV_CNTR_BLOOD_DDCTBL_AMT
TITLE ALIAS: BLOOD_DDCTBL_AMT
SOURCE:
CWF

RVDTBL{x}  | Revenue Center Cash Deductible Amount
---|---
where \{ x \} ranges from 1 to 58

Effective with Version 'I' the amount of cash deductible the beneficiary paid for the line item service.
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.</td>
<td></td>
</tr>
<tr>
<td>9.2 DIGITS SIGNED</td>
<td></td>
</tr>
<tr>
<td>DB2 ALIAS: REV_CASH_DDCTBL</td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: REVDCCTBL</td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: REV_CNTR_CASH_DDCTBL_AMT</td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: CASH_DDCTBL</td>
<td></td>
</tr>
<tr>
<td>SOURCE: CWF</td>
<td></td>
</tr>
</tbody>
</table>

**WGDJ[x]**  
**Revenue Center Coinsurance/Wage Adjusted Coinsurance**  
where \( x \) ranges from 1 to 58  

Effective with Version 'I', the amount of coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted.  

NOTE1: This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification.  

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.  

9.2 DIGITS SIGNED  
DB2 ALIAS: ADJSTD_COINSRNC  
SAS ALIAS: WAGEADJ  
STANDARD ALIAS: REV_CNTR_WAGE_ADJSTD_COINS_AMT  
TITLE ALIAS: WAGE_ADJSTD_COINS  
SOURCE: CWF  

**RDCDCN[x]**  
**Revenue Center Reduced Coinsurance Amount**  
where \( x \) ranges from 1 to 58  

Effective with Version 'I', for all services subject to Outpatient PPS, the amount of coinsurance applicable to particular service (HCPCS) for which the provider has elected to reduce the coinsurance amount.  

NOTE1: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.  

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.  

9.2 DIGITS SIGNED  
DB2 ALIAS: RDCD_COINSRNC
**Variable Name** | **Label**
---|---
| SAS ALIAS: RDCDCOIN  
STANDARD ALIAS: REV_CNTR_RDCD_COINS_AMT  
TITLE ALIAS: REDUCED_COINS  
SOURCE: CWF  
**RVMSP1{x}** | Revenue Center 1st Medicare Secondary Payer Paid Amount  
where { x } ranges from 1 to 58  
| Effective with Version 'I', the amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary or tertiary).  
NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.  
9.2 DIGITS SIGNED  
DB2 ALIAS: REV_MSP1_PD_AMT  
SAS ALIAS: REV_MSP1  
STANDARD ALIAS: REV_CNTR_MSP1_PD_AMT  
TITLE ALIAS: MSP PAID AMOUNT  
SOURCE: CWF  
**RVMSP2{x}** | Revenue Center 2nd Medicare Secondary Payer Paid Amount  
where { x } ranges from 1 to 58  
| Effective with Version 'I', the amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer).  
NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.  
9.2 DIGITS SIGNED  
DB2 ALIAS: REV_MSP2_PD_AMT  
SAS ALIAS: REV_MSP2  
STANDARD ALIAS: REV_CNTR_MSP2_PD_AMT  
TITLE ALIAS: MSP PAID AMOUNT  
SOURCE: CWF  
**RVPCHG{x}** | Revenue Center Professional Component Amount  
where { x } ranges from 1 to 58  
| ***************FIELD NOT POPULATED*************** Intended to be populated for line item services subject to PPS, as the amount associated with Value Code '05'. However, with line item date of service reporting, there is no way to correctly allocate professional component charges reported in value code '05' to specific line items on the claim.  
9.2 DIGITS SIGNED  
DB2 ALIAS: REV_PROFNL_CMPNT  
SAS ALIAS: REVPCCHG  
STANDARD ALIAS: REV_CNTR_PROFNL_CMPNT_AMT  
TITLE ALIAS: PROFNL_CMPNT_CHARGES  
SOURCE: CWF
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>RPRPMT[x]</td>
<td>Revenue Center Provider Payment Amount</td>
<td>Effective with Version 'I', the amount paid to the provider for the services reported on the line item. NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_PRVDR_PMT_AMT SAS ALIAS: RPRVDPMT STANDARD ALIAS: REV_CNTR_PRVDR_PMT_AMT TITLE ALIAS: REV_PRVDR_PMT SOURCE: CWF</td>
</tr>
<tr>
<td>RBNPMT[x]</td>
<td>Revenue Center Beneficiary Payment Amount</td>
<td>Effective with Version 'I', the amount paid to the beneficiary for the services reported on the line item. NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_BENE_PMT_AMT SAS ALIAS: RBENEPMT STANDARD ALIAS: REV_CNTR_BENE_PMT_AMT TITLE ALIAS: REV_BENE_PMT SOURCE: CWF</td>
</tr>
<tr>
<td>PTNRSP[x]</td>
<td>Revenue Center Patient Responsibility Payment Amount</td>
<td>Effective with Version 'I', the amount paid by the beneficiary to the provider for the line item service. NOTE: Beginning with NCH weekly process date 7/7/00 this field was populated with data. Claims processed prior to 7/7/00 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_PTNT_RESP_AMT SAS ALIAS: PTNTRESP STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT TITLE ALIAS: REV_PTNT_RESP SOURCE: CWF</td>
</tr>
<tr>
<td>REVPMT[x]</td>
<td>Revenue Center Payment Amount</td>
<td>Effective with Version 'I', the line item Medicare payment amount for the specific revenue center. Under OP PPS, PRICER will compute the standard OPPS payment for a line item based on the payment APC. Under HH PPS, PRICER will compute/return</td>
</tr>
</tbody>
</table>

Page 69 of 71
**Variable Name** | **Label**
---|---
| a line item payment amount for the case-mixed, wage-index adjusted HIPPS code assigned to the '0023' revenue center line. The HIPPS code will be stored in the Revenue Center HCPCS code field. | 
| 9.2 DIGITS SIGNED | COMMON ALIAS: REIMBURSEMENT
DB2 ALIAS: REV_CNTR_PMT_AMT
SAS ALIAS: REVPMT
STANDARD ALIAS: REV_CNTR_PMT_AMT
TITLE ALIAS: REIMBURSEMENT | 
| EDIT-RULES: | $$$$$$$$$$CC
SOURCE: | 

**RVCHRG{x}** | **Revenue Center Total Charge Amount**
---|---
where \{x\} ranges from 1 to 58 | 

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 applicable if the provider had not been participating in the demo).
2. For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero.
3. For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line.
4. For Home Health PPS (final claim), when revenue center code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023').
5. For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be $1 (rate) times units (days).

**9.2 DIGITS SIGNED**
DB2 ALIAS: REV_TOT_CHRG_AMT
SAS ALIAS: REV_CHRG
STANDARD ALIAS: REV_CNTRTOT_CHRG_AMT
TITLE ALIAS: REVENUE_CENTER_CHARGES
EDIT-RULES: | $$$$$$$$$$CC
COMMENT: | Prior to Version H the size of this field was: S9(7)V99.
SOURCE: | CWF
### Variable Name: `RVNCVR{x}`  
**Label:** Revenue Center Non-Covered Charge Amount  
where `{ x }` ranges from 1 to 58

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: REV_NCVR  
STANDARD ALIAS: REV_CNTR_NCVR_CHRG_AMT  
TITLE ALIAS: REV_CENTER_NONCOVERED_CHARGES  
**EDIT-RULES:**  
$$$$$$$$$$CC  
**SOURCE:**  
CWF

### Variable Name: `RVDDCD{x}`  
**Label:** Revenue Center Deductible Coinsurance Code  
where `{ x }` ranges from 1 to 58

Code indicating whether the revenue center charges are subject to deductible and/or coinsurance.  
DB2 ALIAS: DDCTBL_COINSRNCD_CD  
SAS ALIAS: REVDEDCCD  
STANDARD ALIAS: REV_CNTR_DDCTBL_COINSRNCD_CD  
TITLE ALIAS: REVENUE_CENTER_Deductible_CD  
**CODES:**  
REFER TO: REV_CNTR_DDCTBL_COINSRNCD_TB  
IN THE CODES APPENDIX  
**SOURCE:**  
CWF

### Variable Name: `EOR`  
**Label:** End of Record Code

Effective with Version 'I', the code used to identify the end of a record/segment or the end of the claim.  
DB2 ALIAS: END_REC_CD  
SAS ALIAS: EOR  
STANDARD ALIAS: END_REC_CD  
TITLE ALIAS: END_OF_REC  
**CODES:**  
EOR = End of Record/Segment  
EOC= End of Claim  
**COMMENT:**  
Prior to Version I this field was named:  
END_REC_CNSTNT.  
**SOURCE:**  
NCH