<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLAIM_NO</td>
<td>CLAIM NUMBER</td>
</tr>
<tr>
<td></td>
<td>The unique number used to identify a unique claim.</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: CLAIM_NO</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: CLAIM_NO</td>
</tr>
<tr>
<td>DSYSRTKY</td>
<td>DESY SORT KEY</td>
</tr>
<tr>
<td></td>
<td>This field contains the key to link data for each beneficiary across all claim files.</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: DSYSRTKY</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: DESY_SORT_KEY</td>
</tr>
<tr>
<td>REC_LVL</td>
<td>NCH Near-Line Record Version Code</td>
</tr>
<tr>
<td></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></td>
<td>DB2 ALIAS: NCH_REC_VRSN_CD</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: REC_LVL</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: NCH_NEAR_LINE_REC_VRSN_CD</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: NCH_VERSION</td>
</tr>
<tr>
<td></td>
<td>CODES:</td>
</tr>
<tr>
<td></td>
<td>A = Record format as of January 1991</td>
</tr>
<tr>
<td></td>
<td>B = Record format as of April 1991</td>
</tr>
<tr>
<td></td>
<td>C = Record format as of May 1991</td>
</tr>
<tr>
<td></td>
<td>D = Record format as of January 1992</td>
</tr>
<tr>
<td></td>
<td>E = Record format as of March 1992</td>
</tr>
<tr>
<td></td>
<td>F = Record format as of May 1992</td>
</tr>
<tr>
<td></td>
<td>G = Record format as of October 1993</td>
</tr>
<tr>
<td></td>
<td>H = Record format as of September 1998</td>
</tr>
<tr>
<td></td>
<td>I = Record format as of July 2000</td>
</tr>
<tr>
<td>RIC_CD</td>
<td>NCN Near Line Record Identification Code</td>
</tr>
<tr>
<td></td>
<td>A code defining the type of claim record being processed.</td>
</tr>
<tr>
<td></td>
<td>COMMON ALIAS: RIC</td>
</tr>
<tr>
<td></td>
<td>DBS ALIAS: NEAR_LINE_RIC_CD</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: RIC_CD</td>
</tr>
<tr>
<td></td>
<td>CODES:</td>
</tr>
<tr>
<td></td>
<td>REFER TO: NCH_NEAR_LINE_RIC_TB IN THE CODES APPENDIX</td>
</tr>
<tr>
<td>CLM_TYPE</td>
<td>NCH Claim Type Code</td>
</tr>
<tr>
<td></td>
<td>The code used to identify the type of claim record being processed in NCH.</td>
</tr>
<tr>
<td></td>
<td>SOURCE: NCH</td>
</tr>
</tbody>
</table>
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:** UTLHOSPI_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_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_NUM  
MCO_CNTRCT_NUM  
MCO_OPTN_CD  
MCO_PRD_EFCTV_DT  
MCO_PRD_TRMNTN_DT  

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:  
(HDC processing -- AVAILABLE IN NMUD)  
FI_NUM  

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

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

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

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

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE
Variable Name | Label
--- | ---
DERIVED FROM: (AVAILABLE IN NMUD)
FI_NUM
CLM_FAC_TYPE_CD
CLM_SRVC_CLSFCTN_TYPE_CD
CLM_FREQ_CD

DERIVATION RULES:

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

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

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

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

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

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

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

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

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 - 12/4/00) WHERE THE FOLLOWING CONDITIONS ARE
Variable Name | Label
---|---

**MET:**
1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
   MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN
THE MCO_PRD_EFCTV_DT &
MCO_PRD_TRMNTN_DT ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL'
ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE
THE
FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

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

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

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one
or more line item(s) match the HCPCS on the
DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER
CLAIM--
EFFECTIVE WITH HDC PROCESSING) WHERE THE
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
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
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STATE_CD</strong></td>
<td><strong>Beneficiary Residence SSA Standard State Code</strong></td>
</tr>
<tr>
<td></td>
<td>The SSA standard state code of a beneficiary's residence.</td>
</tr>
<tr>
<td></td>
<td>DA3 ALIAS: SSA_STANDARD_STATE_CODE DB2</td>
</tr>
<tr>
<td></td>
<td>ALIAS: BENE_SSA_STATE_CD</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: STATE_CD</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: BENE_STATE_CD</td>
</tr>
<tr>
<td></td>
<td>EDIT-RULES:</td>
</tr>
<tr>
<td></td>
<td>OPTIONAL: MAY BE BLANK</td>
</tr>
<tr>
<td></td>
<td>CODES:</td>
</tr>
<tr>
<td></td>
<td>REFER TO: GEO_SSA_STATE_TB</td>
</tr>
<tr>
<td></td>
<td>IN THE CODES APPENDIX</td>
</tr>
<tr>
<td></td>
<td>COMMENT:</td>
</tr>
<tr>
<td></td>
<td>1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement.</td>
</tr>
<tr>
<td></td>
<td>2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish.</td>
</tr>
<tr>
<td></td>
<td>3. Also used for special studies.</td>
</tr>
<tr>
<td></td>
<td>SOURCE:</td>
</tr>
<tr>
<td></td>
<td>SSA/EDB</td>
</tr>
<tr>
<td><strong>THRU_DT</strong></td>
<td><strong>Claim Through Date</strong></td>
</tr>
<tr>
<td></td>
<td>The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').</td>
</tr>
<tr>
<td></td>
<td>For the ENCRYPTED Standard View of the Hospice files, the claim through date is coded as when the claim through date occurred.</td>
</tr>
<tr>
<td></td>
<td>NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.</td>
</tr>
<tr>
<td></td>
<td>8 DIGITS UNSIGNED</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: CLM_THRU_DT</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: THRU_DT</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: CLM_THRU_DT</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: THRU_DATE</td>
</tr>
<tr>
<td></td>
<td>EDIT-RULES FOR ENCRYPTED DATA:</td>
</tr>
<tr>
<td></td>
<td>CCYYMMDD WHERE CCYY REPRESENTS THE YEAR.</td>
</tr>
<tr>
<td></td>
<td>SOURCE:</td>
</tr>
<tr>
<td></td>
<td>CWF</td>
</tr>
<tr>
<td>Variable Name</td>
<td>Label</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>QUERY_CD</td>
<td>Claim Query Code</td>
</tr>
<tr>
<td>PROVIDER</td>
<td>Provider Number</td>
</tr>
<tr>
<td>SGMT_CNT</td>
<td>Claim Total Segment Count</td>
</tr>
</tbody>
</table>

**QUERY_CD**

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

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

**SOURCE:**
- CWF

**PROVIDER**

- **DB2 ALIAS**: PRVDR_NUM
- **SAS ALIAS**: PROVIDER
- **STANDARD ALIAS**: PRVDR_NUM
- **TITLE ALIAS**: PROVIDER_NUMBER

**CODES:**
- REFER TO: PRVDR_NUM_TB
- IN THE CODES APPENDIX

**SOURCE:**
- OSCAR

**SGMT_CNT**

- **DB2 ALIAS**: TOT_SGMT_CNT
- **SAS ALIAS**: SGMT_CNT
- **STANDARD ALIAS**: CLM_TOT_SGMT_CNT
- **TITLE ALIAS**: SEGMENT_COUNT

**SOURCE:**
- CWF
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SGMT_NUM</strong></td>
<td>Claim Segment Number</td>
</tr>
<tr>
<td></td>
<td>Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim. NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). For institutional claims prior to 7/00, this number will be either 1 or 2. For noninstitutional claims, the number will always be 1. 2 DIGITS UNSIGNED DB2 ALIAS: CLM_SGMT_NUM SAS ALIAS: SGMT_NUM STANDARD ALIAS: CLM_SGMT_NUM TITLE ALIAS: SEGMENT_NUMBER SOURCE: CWF</td>
</tr>
<tr>
<td><strong>PE_RIC</strong></td>
<td>NCH Payment and Edit Record Identification Code</td>
</tr>
<tr>
<td></td>
<td>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. 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</td>
</tr>
<tr>
<td><strong>TRANS_CD</strong></td>
<td>Claim Transaction Code</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td>Variable Name</td>
<td>Label</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>FAC_TYPE</td>
<td>Claim Facility Type Code</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>
|               | 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 claim in the beneficiary's current episode of care. |
|               | COMMON ALIAS: TOB3  
|               | DB2 ALIAS: CLM_FREQ_CD  
|               | SAS ALIAS: FREQ_CD  
|               | STANDARD ALIAS: CLM_FREQ_CD  
|               | SYSTEM ALIAS: LTFREQ  
|               | TITLE ALIAS: FREQUENCY_CD  
|               | CODES:  
|               | REFER TO: CLM_FREQ_TB  
|               | IN THE CODES APPENDIX  
|               | SOURCE:  
|               | CWF  |
| CNTY_CD       | Beneficiary Residence SSA Standard County Code |
|               | The SSA standard county code of a beneficiary's residence.  
|               | DA3 ALIAS: SSA_STANDARD_COUNTY_CODE  
|               | DB2 ALIAS: BENE_SSA_CNTY_CD  
|               | SAS ALIAS: CNTY_CD  
|               | STANDARD ALIAS:  
|               | TITLE ALIAS: BENE_COUNTY_CD  
|               | EDIT-RULES:  
|               | OPTIONAL: MAY BE BLANK  
<p>|               | SOURCE: SSA/EDB  |</p>
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
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<tbody>
<tr>
<td><strong>FI_NUM</strong></td>
<td><strong>FI Number</strong></td>
</tr>
<tr>
<td></td>
<td>The identification number assigned by HCFA to a fiscal intermediary authorized to process institutional claim records.</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: FI_NUM</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: FI_NUM</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: FI_NUM</td>
</tr>
<tr>
<td></td>
<td>SYSTEM ALIAS: LTFI</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: INTERMEDIARY</td>
</tr>
<tr>
<td></td>
<td>CODES:</td>
</tr>
<tr>
<td></td>
<td>REFER TO: FI_NUM_TB</td>
</tr>
<tr>
<td></td>
<td>IN THE CODES APPENDIX</td>
</tr>
<tr>
<td></td>
<td>COMMENT:</td>
</tr>
<tr>
<td></td>
<td>Prior to Version H this field was named: FICARR_IDENT_NUM.</td>
</tr>
<tr>
<td></td>
<td>SOURCE: CWF</td>
</tr>
<tr>
<td><strong>SEX</strong></td>
<td><strong>Beneficiary Sex Identification Code</strong></td>
</tr>
<tr>
<td></td>
<td>The sex of a beneficiary. COMMON ALIAS: SEX_CD DA3 ALIAS: SEX_CODE DB2 ALIAS: BENE_SEX_IDENT_CD</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: SEX</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: BENE_SEX_IDENT_CD</td>
</tr>
<tr>
<td></td>
<td>SYSTEM ALIAS: LTSEX</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: SEX_CD</td>
</tr>
<tr>
<td></td>
<td>EDIT-RULES:</td>
</tr>
<tr>
<td></td>
<td>REQUIRED FIELD</td>
</tr>
<tr>
<td></td>
<td>CODES:</td>
</tr>
<tr>
<td></td>
<td>1 = Male</td>
</tr>
<tr>
<td></td>
<td>2 = Female</td>
</tr>
<tr>
<td></td>
<td>0 = Unknown</td>
</tr>
<tr>
<td></td>
<td>SOURCE: SSA, RRB, EDB</td>
</tr>
<tr>
<td><strong>RACE</strong></td>
<td><strong>Beneficiary Race Code</strong></td>
</tr>
<tr>
<td></td>
<td>The race of a beneficiary. DA3 ALIAS: RACE_CODE DB2 ALIAS: BENE_RACE_CD</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: RACE</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: BENE_RACE_CD</td>
</tr>
<tr>
<td></td>
<td>SYSTEM ALIAS: LTRACE</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: RACE_CD</td>
</tr>
<tr>
<td></td>
<td>CODES:</td>
</tr>
<tr>
<td></td>
<td>0 = Unknown</td>
</tr>
<tr>
<td></td>
<td>1 = White</td>
</tr>
<tr>
<td></td>
<td>2 = Black</td>
</tr>
<tr>
<td></td>
<td>3 = Other</td>
</tr>
<tr>
<td></td>
<td>4 = Asian</td>
</tr>
<tr>
<td></td>
<td>5 = Hispanic</td>
</tr>
<tr>
<td></td>
<td>6 = North American Native</td>
</tr>
<tr>
<td></td>
<td>SOURCE: SSA</td>
</tr>
<tr>
<td>Variable Name</td>
<td>Label</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td><strong>BENE_DOB</strong></td>
<td><strong>Beneficiary Birth Date</strong></td>
</tr>
<tr>
<td></td>
<td>The beneficiary’s date of birth. For the ENCRYPTED Standard View of the Hospice files, the beneficiary’s date of birth (age) is coded as a range.</td>
</tr>
<tr>
<td></td>
<td>8 DIGITS UNSIGNED</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: BENE_BIRTH_DT</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: BENE_DOB</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: BENE_BIRTH_DT</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: BENE_BIRTH_DATE</td>
</tr>
<tr>
<td></td>
<td>EDIT-RULES FOR ENCRYPTED DATA:</td>
</tr>
<tr>
<td></td>
<td>0000000R</td>
</tr>
<tr>
<td></td>
<td>WHERE R HAS ONE OF THE FOLLOWING VALUES.</td>
</tr>
<tr>
<td></td>
<td>0 = Unknown</td>
</tr>
<tr>
<td></td>
<td>1 = &lt;65</td>
</tr>
<tr>
<td></td>
<td>2 = 65 Thru 69</td>
</tr>
<tr>
<td></td>
<td>3 = 70 Thru 74</td>
</tr>
<tr>
<td></td>
<td>4 = 75 Thru 79</td>
</tr>
<tr>
<td></td>
<td>5 = 80 Thru 84</td>
</tr>
<tr>
<td></td>
<td>6 = &gt;84</td>
</tr>
<tr>
<td></td>
<td>SOURCE: CWF</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>MS_CD</strong></th>
<th><strong>CWF Beneficiary Medicare Status Code</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM_THRU_DT).</td>
</tr>
<tr>
<td></td>
<td>COBOL ALIAS: MSC</td>
</tr>
<tr>
<td></td>
<td>COMMON ALIAS: MSC</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: BENE_MDCR_STUS_CD</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: MS_CD</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD</td>
</tr>
<tr>
<td></td>
<td>SYSTEM ALIAS: LTMSC</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: MSC</td>
</tr>
<tr>
<td></td>
<td>DERIVATION:</td>
</tr>
<tr>
<td></td>
<td>CWF derives MSC from the following:</td>
</tr>
<tr>
<td></td>
<td>1. Date of Birth</td>
</tr>
<tr>
<td></td>
<td>2. Claim Through Date</td>
</tr>
<tr>
<td></td>
<td>3. Original/Current Reasons for entitlement</td>
</tr>
<tr>
<td></td>
<td>4. ESRD Indicator</td>
</tr>
<tr>
<td></td>
<td>5. Beneficiary Claim Number</td>
</tr>
<tr>
<td></td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>MSC OASI DIB ESRD AGE BIC</td>
</tr>
<tr>
<td></td>
<td>10 YES N/A NO 65 and over N/A</td>
</tr>
<tr>
<td></td>
<td>11 YES N/A YES 65 and over N/A</td>
</tr>
<tr>
<td></td>
<td>20 NO YES NO under 65 N/A</td>
</tr>
<tr>
<td></td>
<td>21 NO YES YES under 65 N/A</td>
</tr>
<tr>
<td></td>
<td>31 NO NO YES any age T.</td>
</tr>
<tr>
<td></td>
<td>CODES:</td>
</tr>
<tr>
<td></td>
<td>10 = Aged without ESRD</td>
</tr>
<tr>
<td></td>
<td>11 = Aged with ESRD</td>
</tr>
<tr>
<td></td>
<td>20 = Disabled without ESRD</td>
</tr>
<tr>
<td></td>
<td>21 = Disabled with ESRD</td>
</tr>
<tr>
<td></td>
<td>31 = ESRD only</td>
</tr>
<tr>
<td>Variable Name</td>
<td>Label</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td><strong>COMMENT:</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>SOURCE:</strong></td>
<td>CWF</td>
</tr>
<tr>
<td><strong>PDGNS_CD</strong></td>
<td><strong>Claim Principal Diagnosis Code</strong></td>
</tr>
<tr>
<td>The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record chiefly responsible for the services provided.</td>
<td></td>
</tr>
<tr>
<td><strong>NOTE:</strong></td>
<td>Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer.</td>
</tr>
<tr>
<td><strong>DB2 ALIAS:</strong></td>
<td>PRNCPAL_DGNS_CD</td>
</tr>
<tr>
<td><strong>SAS ALIAS:</strong></td>
<td>PDGNS_CD</td>
</tr>
<tr>
<td><strong>STANDARD ALIAS:</strong></td>
<td>CLM_PRNCPAL_DGNS_CD</td>
</tr>
<tr>
<td><strong>TITLE ALIAS:</strong></td>
<td>PRINCIPAL_DIAGNOSIS</td>
</tr>
<tr>
<td><strong>EDIT-RULES:</strong></td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td><strong>SOURCE:</strong></td>
<td>CWF</td>
</tr>
<tr>
<td><strong>NOPAY_CD</strong></td>
<td><strong>Claim Medicare Non Payment Reason Code</strong></td>
</tr>
<tr>
<td>The reason that no Medicare payment is made for services on an institutional claim.</td>
<td></td>
</tr>
<tr>
<td><strong>NOTE:</strong></td>
<td>Effective with Version I, this field was put on all institutional claim types. Prior to Version I, this field was present only on inpatient/SNF claims.</td>
</tr>
<tr>
<td><strong>DB2 ALIAS:</strong></td>
<td>MDCR_NPMT_RSN_CD</td>
</tr>
<tr>
<td><strong>SAS ALIAS:</strong></td>
<td>NOPAY_CD</td>
</tr>
<tr>
<td><strong>STANDARD ALIAS:</strong></td>
<td>CLM_MDCR_NPMT_RSN_CD</td>
</tr>
<tr>
<td><strong>SYSTEM ALIAS:</strong></td>
<td>LTNPMT</td>
</tr>
<tr>
<td><strong>TITLE ALIAS:</strong></td>
<td>NON_PAYMENT_REASON</td>
</tr>
<tr>
<td><strong>EDIT-RULES:</strong></td>
<td>OPTIONAL</td>
</tr>
<tr>
<td><strong>CODES:</strong></td>
<td>REFER TO: CLM_MDCR_NPMT_RSN_TB</td>
</tr>
<tr>
<td><strong>SOURCE:</strong></td>
<td>CWF</td>
</tr>
</tbody>
</table>

Page 11 of 45
**Variable Name** | **Label**  
--- | ---  
**TRTMT_CD** | **Claim Excepted/Non-Excepted 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 sent; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible 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 daily per diem rate no matter what the charges are.)  
Under IP PPS, inpatient hospital services are paid based a predetermined rate per discharge, using the DRG classification system and the PRICER program. On the PPS claim, the payment amount includes the DRG approved payment amount, disproportionate share (5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). It does NOT include the pass thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement.  
Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center '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 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 an appropriate case mix category known as the Home 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 episode payment. The payment is then wage index. For the final claim, PRICER calculates 100% of the due, because the final claim is processed as an 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
STANDARD ALIAS: CLM_PMT_AMT
TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:
+9(9).99

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

SOURCE:
CWF

LIMITATIONS:
Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM_DISP_CD of '02', the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRPAYAMT</td>
<td>NCH Primary Payer Claim Paid Amount</td>
</tr>
</tbody>
</table>

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.

9.2 DIGITS SIGNED

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

EDIT-RULES:
+9(9).99

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

SOURCE:
NCH

<table>
<thead>
<tr>
<th>PRPAY_CD</th>
<th>NCH Primary Payer Code</th>
</tr>
</thead>
</table>

The code, on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary’s health insurance bills.

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

DERIVATION:
DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES

SET NCH_PRMRY_PYR_CD TO ‘A’ WHERE THE CLM_VAL_CD = ‘12’
SET NCH_PRMRY_PYR_CD TO ‘B’ WHERE THE CLM_VAL_CD = ‘13’
SET NCH_PRMRY_PYR_CD TO ‘C’ WHERE THE CLM_VAL_CD = ‘16’ and CLM_VAL_AMT is zeroes
SET NCH_PRMRY_PYR_CD TO ‘D’ WHERE THE CLM_VAL_CD = ‘14’
SET NCH_PRMRY_PYR_CD TO ‘E’ WHERE THE CLM_VAL_CD = ‘15’
SET NCH_PRMRY_PYR_CD TO ‘F’ WHERE THE CLM_VAL_CD = ‘16’ (CLM_VAL_AMT not equal to zeroes)
SET NCH_PRMRY_PYR_CD TO ‘G’ WHERE THE CLM_VAL_CD = ‘43’
Variable Name | Label
---|---

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_CNCL_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:
CWF
Variable Name | Label
--- | ---
**PRSTATE** | **NCH Provider State Code**

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

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

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

DERIVATION:
DERIVED FROM:
NCH PRVDR_NUM

DERIVATION RULES:

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

CODES:
REFER TO: GEO_SSA_STATE_TB
IN THE CODES APPENDIX

SOURCE:
NCH

**AT_UPIN** | **Claim Attending Physician UPIN Number**

On an institutional claim, the unique physician identification number (UPIN) of the physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the beneficiary's medical care and treatment (attending physician).

This field is ENCRYPTED for the ENCRYPTED Standard View of the Hospice files.

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

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

SOURCE:
CWF
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OP_UPIN</strong></td>
<td>Claim Operating Physician UPIN Number</td>
</tr>
<tr>
<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. This field is ENCRYPTED for the ENCRYPTED Standard View of the Hospice files.</td>
<td></td>
</tr>
<tr>
<td>DB2 ALIAS: OPRTG_UPIN</td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: OP_UPIN</td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: CLM_OPRTG_PHYSN_UPIN_NUM</td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: OPRTG_UPIN</td>
<td></td>
</tr>
<tr>
<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>
<td></td>
</tr>
<tr>
<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>
<td></td>
</tr>
<tr>
<td>SOURCE: CWF</td>
<td></td>
</tr>
<tr>
<td><strong>OT_UPIN</strong></td>
<td>Claim Other Physician UPIN Number</td>
</tr>
<tr>
<td>On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim. This field is ENCRYPTED for the ENCRYPTED Standard View of the Hospice files.</td>
<td></td>
</tr>
<tr>
<td>DB2 ALIAS: OTHR_UPIN</td>
<td></td>
</tr>
<tr>
<td>SAS ALIAS: OT_UPIN</td>
<td></td>
</tr>
<tr>
<td>STANDARD ALIAS: CLM_OTHR_PHYSN_UPIN_NUM</td>
<td></td>
</tr>
<tr>
<td>TITLE ALIAS: OTH_PHYSN_UPIN</td>
<td></td>
</tr>
<tr>
<td>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).</td>
<td></td>
</tr>
<tr>
<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>
<td></td>
</tr>
<tr>
<td>SOURCE: CWF</td>
<td></td>
</tr>
</tbody>
</table>
**Variable Name** | **Label** | **Description**
--- | --- | ---
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

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
Variable Name | Label
--- | ---
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.

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

CODES:
REFER TO: CLM_PPS_IND_TB
IN THE CODES APPENDIX

SOURCE:
CWF

TOT_CHRG | Claim Total Charge Amount

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

9.2 DIGITS SIGNED

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

EDIT-RULES:
+9(9).99

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

SOURCE:
CWF

HSDGNCNT | Hospice Claim Diagnosis Code Count

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

2 DIGITS UNSIGNED

DB2 ALIAS: HOSPCLM_DGNS_CD_CNT
SAS ALIAS: HSDGNCNT
STANDARD ALIAS: HOSP_CLM_DGNS_CD_CNT

EDIT-RULES:
RANGE: 0 TO 10
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
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<tbody>
<tr>
<td>HSPRCNT</td>
<td>Hospice Claim Procedure Code Count</td>
</tr>
<tr>
<td></td>
<td>The count of the number of procedure codes (both principal and other) reported on a hospice claim. The purpose of this count is to indicate how many claim procedure trailers are present.</td>
</tr>
<tr>
<td></td>
<td>2 DIGITS UNSIGNED</td>
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<tr>
<td></td>
<td>DB2 ALIAS: HOSPC_PRCDR_CD_CNT</td>
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<tr>
<td></td>
<td>SAS ALIAS: HSPRCNT</td>
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<tr>
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<td>STANDARD ALIAS: HOSPC_CLM_PRCDR_CD_CNT</td>
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<td>SOURCE: CWF</td>
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<tr>
<td>HSCONCNT</td>
<td>Hospice Claim Related Condition Code Count</td>
</tr>
<tr>
<td></td>
<td>The count of the number of condition codes reported on a hospice claim. The purpose of this count is to indicate how many condition code trailers are present.</td>
</tr>
<tr>
<td></td>
<td>2 DIGITS UNSIGNED</td>
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<tr>
<td>HSOCRCNT</td>
<td>Hospice Claim Related Occurrence Code Count</td>
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<tr>
<td></td>
<td>The count of the number of occurrence codes reported on a hospice claim. The purpose of this count is to indicate how many occurrence code trailers are present.</td>
</tr>
<tr>
<td></td>
<td>2 DIGITS UNSIGNED</td>
</tr>
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<td>Variable Name</td>
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<td>-------</td>
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<tr>
<td><strong>HSVALCNT</strong></td>
<td><strong>Hospice Claim Value Code Count</strong></td>
</tr>
<tr>
<td></td>
<td>The count of the number of value codes reported on a hospice claim. The purpose of the count is to indicate how many value code trailers are present.</td>
</tr>
<tr>
<td></td>
<td>2 DIGITS UNSIGNED</td>
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<tr>
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<td></td>
<td>SOURCE: NCH</td>
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<tr>
<td><strong>HSREVCNT</strong></td>
<td><strong>Hospice Revenue Center Code Count</strong></td>
</tr>
<tr>
<td></td>
<td>The count of the number of revenue codes reported on a hospice claim. The purpose of the count is to indicate how many revenue center trailers are present.</td>
</tr>
<tr>
<td></td>
<td>2 DIGITS UNSIGNED</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: HOSPC_REV_CNTR_CD_CNT</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: HSREVCNT</td>
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<td>STANDARD ALIAS: HOSPC_REV_CNTR_CD_CNT</td>
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<td></td>
<td>SOURCE: NCH</td>
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</tbody>
</table>

If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).
### PTNTSTUS  
**Label:** NCH Patient Status Indicator Code

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

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

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

**DERIVATION RULES:**
- SET NCH_PTNT_STUS_IND_CD TO 'A' WHERE THE PTNT_DSCHRG_STUS_CD NOT EQUAL TO '20' - '30' OR '40' - '42'.
- SET NCH_PTNT_STUS_IND_CD TO 'B' WHERE THE PTNT_DSCHRG_STUS_CD EQUAL TO '20' - '29' OR '40' - '42'.
- SET NCH_PTNT_STUS_IND_CD TO 'C' WHERE THE PTNT_DSCHRG_STUS_CD EQUAL TO '30'.

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

**SOURCE:**
- NCH QA Process

### HSPCSTRT  
**Label:** Claim Hospice Start Date

On an institutional claim, the date the beneficiary was admitted to the hospice.

For the ENCRYPTED Standard View of the Hospice files, the claim hospice start date is coded as the quarter of the calendar year when the claim hospice start date occurred.

- **8 DIGITS UNSIGNED**

- **DB2 ALIAS:** CLM_HOSPC_STRT_DT
- **SAS ALIAS:** HSPCSTRT
- **STANDARD ALIAS:** CLM_HOSPC_STRT_DT
- **TITLE ALIAS:** HOSPC_START_DT

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

**COMMENT:**
Prior to Version H, this field was named:
CLM_ADMSN_DT

**SOURCE:**
- CWF
**Variable Name** | **Label**
--- | ---
**DSCHRGDT** | NCH Beneficiary Discharge Date

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

For the ENCRYPTED Standard View of the Hospice files, the beneficiary’s discharge date is coded as the when the discharge occurred.

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

8 DIGITS UNSIGNED
DB2 ALIAS: NCH_BENE_DSCHRG_DT
SAS ALIAS: DSCHRGDT
STANDARD ALIAS: NCH_BENE_DSCHRG_DT
TITLE ALIAS: DISCHARGE_DT

EDIT-RULES FOR ENCRYPTED DATA:
CCYYMMDD WHERE CCYY REPRESENTS THE YEAR.

DERIVATION:
DERIVED FROM:
NCH_PTNT_STUS_IND_CD
CLM_THRU_DT

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

SOURCE:
NCH QA Process

**UTIL_DAY** | Claim Utilization Day Count

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

3 DIGITS SIGNED

DB2 ALIAS: CLM_UTLZTN_DAY_CNT
SAS ALIAS: UTIL_DAY
STANDARD ALIAS: CLM_UTLZTN_DAY_CNT
TITLE ALIAS: UTILIZATION_DAYS

EDIT - RULES: +999

SOURCE:
CWF
**Variable Name**  
**HOSPCPRD**  

**Label**  
**Beneficiary's Hospice Period Count**  
The count of the number of hospice period trailers present for the beneficiary's record. Prior to BBA a entitled to a maximum of 4 hospice benefit periods that may be elected in lieu of standard Part A hospital benefits. The BBA changed the hospice benefit to the following: 2 initial 90 day periods followed by an unlimited number of 60 day periods (effective 8/5/97).

1 DIGIT UNSIGNED  
DB2 ALIAS: BENE_HOSPC_PRD_CNT  
SAS ALIAS: HOSPCPRD  
STANDARD ALIAS: BENE_HOSPC_PRD_CNT  
TITLE ALIAS: HOSPICE_PERIOD_COUNT  
EDIT-RULES:  
RANGE: 1 THRU 3: 1 = 1st 90-day period; 2=2nd 90 -day period and 3 = 3rd 90-day period (3 or greater periods)  
SOURCE: CWF

**Claim Diagnosis Code**  
**DGNSCD\{x\}**  
where \{ x \} ranges from 1 to 10  
The ICD-9-CM based code identifying the beneficiary's principal or other diagnosis (including E code).  
NOTE:  
Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM_PRNCPAL_DGNS_CD was added as the first occurrence.

DB2 ALIAS: CLM_DGNS_CD  
SAS ALIAS: DGNSCD(x)  
STANDARD ALIAS: CLM_DGNS_CD  
TITLE ALIAS: DIAGNOSIS  
EDIT-RULES:  
ICD-9-CM  
COMMENT:  
Prior to Version H this field was named: CLM_OTHR_DGNS_CD.

**Claim Procedure Code**  
**PRCDRCD\{x\}**  
where \{ x \} ranges from 1 to 6  
The ICD-9-CM code that indicates the principal or other procedure performed during the period covered by the institutional claim.

DB2 ALIAS: CLM_PRCDR_CD  
SAS ALIAS: PRCDRCD(x)  
STANDARD ALIAS: CLM_PRCDR_CD  
TITLE ALIAS: PROCEDURE_CODE  
EDIT-RULES:  
ICD-9-CM  
SOURCE: CWF
### Variable Name: PRCDRDT\{x\}

**Label:** Claim Procedure Performed Date

where \( x \) ranges from 1 to 6

On an institutional claim, the date on which the principal or other procedure was performed. For the ENCRYPTED Standard View of the Hospice files, the claim procedure performed date is coded as when the procedure was performed.

8 DIGITS UNSIGNED

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

EDIT-RULES FOR ENCRYPTED DATA: CCYYMMDD WHERE CCYY REPRESENTS THE YEAR.

SOURCE: CWF

### Variable Name: RLTCND\{x\}

**Label:** Claim Related Condition Code

where \( x \) ranges from 1 to 30

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

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

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

CODES:
REFER TO: CLM_RLT_COND_TB
IN THE CODES APPENDIX

SOURCE: CWF
**Variable Name** | **Label**
--- | ---
*OCRCCD{x}* | Claim Related Occurrence Code

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

DB2 ALIAS: CLM_RLT_OCRNC_CD
SAS ALIAS: OCRCCD{x}
STANDARD ALIAS: CLM_RLT_OCRNC_CD
SYSTEM ALIAS: LTOCRNC
TITLE ALIAS: OCCURRENCE_CD

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

CODES:
REFER TO: CLM_RLT_OCRNC_TB
IN THE CODES APPENDIX

SOURCE:
CWF

---

*OCRCDT{x}* | Claim Related Occurrence Date

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

For the ENCRYPTED Standard View of the Hospice files, the claim related occurrence date is coded as when the claim related occurrence occurred.

8 DIGITS UNSIGNED

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

EDIT-RULES FOR ENCRYPTED DATA:
CCYYMMDD WHERE CCYY REPRESENTS THE YEAR.

SOURCE:
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<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
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<tbody>
<tr>
<td>VAL_CD{x}</td>
<td>Claim Value Code</td>
</tr>
<tr>
<td>VALAMT{x}</td>
<td>Claim Value Amount</td>
</tr>
<tr>
<td>RVCNTR{x}</td>
<td>Revenue Center Code</td>
</tr>
</tbody>
</table>

**VAL_CD\{x\}**

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:
REFERR TO: CLM_VAL_TB
IN THE CODES APPENDIX

SOURCE:
CWF

**VALAMT\{x\}**

where \{ x \} ranges from 1 to 36

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

9.2 DIGITS SIGNED

- DB2 ALIAS: CLM_VAL_AMT
- SAS ALIAS: VALAMT\{x\}
- STANDARD ALIAS: CLM_VAL_AMT
  
- EDIT-RULES:
  +9(9).99

SOURCE:
CWF

**RVCNTR\{x\}**

where \{ x \} ranges from 1 to 45

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

The provider-assigned revenue code for each cost center for which a separate charge is billed (type of ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology).

EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

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

CODES:
REFERR TO: REV_CNTR_TB
IN THE CODES APPENDIX
SOURCE: CWF
Variable Name | Label
--- | ---
REV_DT\[x\] | Revenue Center Date

where \( x \) ranges from 1 to 45

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

Effective with 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.

For the ENCRYPTED Standard View of the Hospice files, the date applicable to the service represented by the revenue center code is coded as the service represented by the revenue center code occurred.

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\[x\]
STANDARD ALIAS: REV_CNTR_DT
TITLE ALIAS: REV_CNTR_DATE

EDIT-RULES FOR ENCRYPTED DATA:
CCYYMMDD WHERE CCY REPRESENTS THE YEAR.

SOURCE:
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<tr>
<th>Variable Name</th>
<th>Label</th>
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</thead>
<tbody>
<tr>
<td>APCPPS{x}</td>
<td>Revenue Center APC/HIPPS Code</td>
</tr>
<tr>
<td>HCPSCD{x}</td>
<td>Revenue Center HCFA Common Procedure Coding</td>
</tr>
</tbody>
</table>

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

Effective with Outpatient PPS (OPPS), the Ambulatory Payment Classification (APC) code used to identify groupings of outpatient services. APC codes are used to calculate payment for services under OPPS.

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

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

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

**DB2 ALIAS: REV_APCC_HIPPS_CD**
**SAS ALIAS: APCPPS\{x\}**
**STANDARD ALIAS: REV_CNTR_APCC_HIPPS_CD**
**SYSTEM ALIAS: LTAPC**
**TITLE ALIAS: APC_HIPPS**

**CODES:**
**REFER TO: REV_CNTR_APCC_TB**
**IN THE CODES APPENDIX**

**SOURCE:**
CWF

**DB2 ALIAS: REV_CNTR_HCPCS_CD**
**SAS ALIAS: HCPSCD\{x\}**
**STANDARD ALIAS: REV_CNTR_HCPCS_CD**
**SYSTEM ALIAS: LTHIPPS**
**TITLE ALIAS: HCPCS_CD**

**CODES:**
**REFER TO: CLM_HIPPS_TB**
**IN THE CODES APPENDIX**
Variable Name | Label

COMMENT:
Prior to Version H this field was named:
HCPCS_CD. With Version H, a prefix
was added to denote the location of this field
on each claim type (institutional: REV_CNTR and
non-institutional: LINE).

NOTE: When revenue center code = '0022' (SNF PPS)
or '0023' (HH PPS), this field contains the Health
Insurance PPS (HIPPS) code. The HIPPS code for
SNF PPS contains the rate code/assessment type that
identifies (1) RUG-III group the beneficiary was
classified into as of the RAI MDS assessment
reference date and (2) the type of assessment for
payment purposes.
The HIPPS code for Home Health PPS identifies
(1) the three case-mix dimensions of the HHRG
system: clinical, functional and utilization, from which a
beneficiary is assigned to one of the 80 HHRG
categories and (2) it identifies whether or not
the elements of the code were computed or derived.
The HHRGs, represented by the HIPPS coding, will
be the basis of payment for each episode.

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

Level I
Codes and descriptors copyrighted by the American
Medical Association’s Current Procedural
Terminology, Fourth Edition (CPT-4). These are
5 position numeric codes representing physician
and nonphysician services.

**** Note: ****
CPT-4 codes including both long and short
descriptions shall be used in accordance with the
HCFA/AMA agreement. Any other use violates the
AMA copyright.

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

Level III
Codes and descriptors developed by Medicare
carriers for use at the local (carrier) level. These
are 5 position alpha-numeric codes in the W, X,
Y or Z series representing physician
and nonphysician services that are not
represented in the level I or level II codes.
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDCD1_{x}</td>
<td>Revenue Center HCPCS Initial Modifier Code</td>
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<tr>
<td>where ( x )</td>
<td>( x ) ranges from 1 to 45</td>
</tr>
<tr>
<td></td>
<td>If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).</td>
</tr>
<tr>
<td></td>
<td>A first modifier to the procedure code to enable a more specific procedure identification for the claim.</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: REV_HCPCS_MDFR_CD</td>
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<tr>
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<td>SAS ALIAS: MDCD1_{x}</td>
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<tr>
<td></td>
<td>STANDARD ALIAS: REV_CNTR_HCPCS_INITL_MDFR_CD</td>
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<td></td>
<td>TITLE ALIAS: INITIAL_MODIFIER</td>
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<td>EDIT-RULES:</td>
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<td>Carrier Information File</td>
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<td>COMMENT:</td>
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<td>Prior to Version H this field was named:</td>
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<td></td>
<td>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>
</tr>
<tr>
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<td>SOURCE:</td>
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<tr>
<td></td>
<td>CWF</td>
</tr>
<tr>
<td>MDCD2_{x}</td>
<td>Revenue Center HCPCS Second Modifier Code</td>
</tr>
<tr>
<td>where ( x )</td>
<td>( x ) ranges from 1 to 45</td>
</tr>
<tr>
<td></td>
<td>If there are more than 45 revenue center trailer elements from the source file, then there is one segment for each set of 45 revenue center trailer elements, up to a maximum of 10 segments (total maximum = 450 revenue center trailer elements).</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: REV_HCPCS_2ND_CD</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: MDCD2_{x}</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: REV_CNTR_HCPCS_2ND_MDFR_CD</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: SECOND_MODIFIER</td>
</tr>
<tr>
<td></td>
<td>EDIT-RULES:</td>
</tr>
<tr>
<td></td>
<td>CARRIER INFORMATION FILE</td>
</tr>
<tr>
<td></td>
<td>COMMENT:</td>
</tr>
<tr>
<td></td>
<td>Prior to Version H this field was named:</td>
</tr>
<tr>
<td></td>
<td>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).</td>
</tr>
<tr>
<td></td>
<td>SOURCE:</td>
</tr>
<tr>
<td></td>
<td>CWF</td>
</tr>
</tbody>
</table>
Variable Name | Label |
---|---|
MDCD3_{x} | Revenue Center HCPCS Third Modifier Code |

where \( x \) ranges from 1 to 45

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

Effective with 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: MDCD3_{x}
STANDARD ALIAS: REV_CNTR_HCPCS_3RD_MDFR_CD
TITLE ALIAS: THIRD_MODIFIER

EDIT-RULES:
CARRIER INFORMATION FILE
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

MDCD4_{x} | Revenue Center HCPCS Fourth Modifier Code |

where \( x \) ranges from 1 to 45

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

Effective with 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: MDCD4_{x}
STANDARD ALIAS: REV_CNTR_HCPCS_4TH_MDFR_CD
TITLE ALIAS: FOURTH_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
\textit{MDCD}{x}_5} \quad \textit{Revenue Center HCPCS Fifth Modifier Code} \\
\textit{PMTTHD}{x} \quad \textit{Revenue Center Payment Method Indicator Code}

\begin{itemize}
\item \textit{MDCD}{x}_5} \quad \textit{Revenue Center HCPCS Fifth Modifier Code} \\
\textit{PMTTHD}{x} \quad \textit{Revenue Center Payment Method Indicator Code}
\end{itemize}

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

Effective with 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.

\begin{itemize}
\item DB2 ALIAS: REV_HCPICS_5TH_CD
\item SAS ALIAS: MDCDS_{x}_5
\item STANDARD ALIAS: REV_CNTR_HCPICS_5TH_MDFR_CD
\item TITLE ALIAS: FIFTH_MDFR
\end{itemize}

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

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

Effective with 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.

\begin{itemize}
\item DB2 ALIAS: REV_PMT_MTHD_CD
\item SAS ALIAS: PMTTHD{x}
\item STANDARD ALIAS: REV_CNTR_PMT_MTHD_IND_CD
\item SYSTEM ALIAS: LTPMTTHD
\item TITLE ALIAS: PMT_MTHD
\end{itemize}

CODES:
REFER TO: REV_CNTR_PMT_MTHD_IND_TB
IN THE CODES APPENDIX
SOURCE:
CWF
**Variable Name** | **Label**
--- | ---
**DSCTND[x]** | Revenue Center Discount Indicator Code
where { x } ranges from 1 to 45

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

Effective with 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.

DB2 ALIAS: REV_DSCNT_IND_CD
SAS ALIAS: DSCTND(x)
STANDARD ALIAS: REV_CNTR_DSCNT_IND_CD
SYSTEM ALIAS: LTDSCNT
TITLE ALIAS: REV_CNTR_DSCNT_IND_CD

CODES:
*DISCOUNTING FORMULAS*
1 = 1.0
2 = (1.0+D(U-1))/U
3 = T/U
4 = (1+D)/U
5 = D
6 = TD/U
7 = D(1+D)/U
8 = 2.0/U

SOURCE:
CWF

---

**PCKGND[x]** | Revenue Center Packaging Indicator Code
where { x } ranges from 1 to 45

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

Effective with 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: PCKGND(x)
STANDARD ALIAS: REV_CNTR_PCKG_IND_CD
SYSTEM ALIAS: LTPACKG
TITLE ALIAS: REV_CNTR_PCKG_IND
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRICNG{x}</td>
<td>Revenue Center Pricing Indicator Code</td>
</tr>
<tr>
<td></td>
<td>If there are more than 45 revenue center trailer elements from</td>
</tr>
<tr>
<td></td>
<td>the source file, then there is one segment for each set of 45</td>
</tr>
<tr>
<td></td>
<td>revenue center trailer elements, up to a maximum of 10 segments</td>
</tr>
<tr>
<td></td>
<td>(total maximum = 450 revenue center trailer elements).</td>
</tr>
<tr>
<td></td>
<td>Effective with Version 'I', the code used to identify if there</td>
</tr>
<tr>
<td></td>
<td>was a deviation from the standard method of calculating</td>
</tr>
<tr>
<td></td>
<td>payment amount.</td>
</tr>
<tr>
<td></td>
<td>NOTE: Beginning with NCH weekly process date 8/18/00, this field</td>
</tr>
<tr>
<td></td>
<td>will be populated with data. Claims processed prior to 8/18/00 will</td>
</tr>
<tr>
<td></td>
<td>contain spaces in this field.</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: REV_PRICNG_IND_CD</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: PRICNG</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: REV_CNTR_PRICNG_IND_CD</td>
</tr>
<tr>
<td></td>
<td>SYSTEM ALIAS: LTPRICNG</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: REV_CNTR_PRICNG_IND</td>
</tr>
<tr>
<td></td>
<td>CODES: REFERENCE TO: REV_CNTR_PRICNG_IND_TB</td>
</tr>
<tr>
<td></td>
<td>IN THE CODES APPENDIX</td>
</tr>
<tr>
<td></td>
<td>SOURCE: CWF</td>
</tr>
<tr>
<td>OTAF1{x}</td>
<td>Revenue Center Obligation to Accept As Full (OTAF)</td>
</tr>
<tr>
<td></td>
<td>If there are more than 45 revenue center trailer elements from</td>
</tr>
<tr>
<td></td>
<td>the source file, then there is one segment for each set of 45</td>
</tr>
<tr>
<td></td>
<td>revenue center trailer elements, up to a maximum of 10 segments</td>
</tr>
<tr>
<td></td>
<td>(total maximum = 450 revenue center trailer elements).</td>
</tr>
<tr>
<td></td>
<td>Effective with Version 'I' the code used to indicate that the</td>
</tr>
<tr>
<td></td>
<td>provider was obligated to accept as full payment the amount</td>
</tr>
<tr>
<td></td>
<td>received from the primary (or secondary) payer.</td>
</tr>
<tr>
<td></td>
<td>NOTE: Beginning with NCH weekly process date 7/7/00, this field</td>
</tr>
<tr>
<td></td>
<td>will be populated with data. Claims processed prior to 7/7/00 will</td>
</tr>
<tr>
<td></td>
<td>contain spaces in this field.</td>
</tr>
<tr>
<td></td>
<td>DB2 ALIAS: REV_OTAF1_IND_CD</td>
</tr>
<tr>
<td></td>
<td>SAS ALIAS: OTAF1{x}</td>
</tr>
<tr>
<td></td>
<td>STANDARD ALIAS: REV_CNTR_OTAF1_IND_CD</td>
</tr>
<tr>
<td></td>
<td>TITLE ALIAS: REV_CNTR_OTAF1_IND_CD</td>
</tr>
<tr>
<td></td>
<td>EDIT-RULES: Y = provider is obligated to accept the payment</td>
</tr>
<tr>
<td></td>
<td>as payment in full for the service.</td>
</tr>
<tr>
<td></td>
<td>N or blank = provider is not obligated to accept the payment, or</td>
</tr>
<tr>
<td></td>
<td>there is no payment by a prior payer.</td>
</tr>
<tr>
<td></td>
<td>SOURCE: CWF</td>
</tr>
</tbody>
</table>
Variable Name  | Label
---|---
IDENDC\{x\} | Revenue Center IDE, NDC, UPC Number

Where \{x\} ranges from 1 to 45

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

Effective with 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’.

NOTE1: 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: 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.

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 ANOMALY/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.

DB2 ALIAS: IDE_NDC_UPC_NUM
SAS ALIAS: IDENDC
STANDARD ALIAS: REV_CNTR_IDE_NDC_UPC_NUM
TITLE ALIAS: IDE_NDC_UPC

SOURCE:
CWF
Variable Name | Label
--- | ---
RVUNT{x} | Revenue Center Unit Count

where \( x \) ranges from 1 to 45

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

A quantitative measure (unit) of the number of times the service or procedure being reported was performed to the revenue center/HCPCS code definition as 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 code and, if applicable, the number of visits for each rehab therapy code.

7 DIGITS SIGNED

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

EDIT- RULES:
+9(7)

SOURCE:
CWF

RVRT{x} | Revenue Center Rate Amount
where \( x \) ranges from 1 to 45

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

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

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

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

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

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

9.2 DIGITS SIGNED

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>DB2 ALIAS: REV_CNTR_RATE_AMT</td>
<td>SAS ALIAS: RVRT(x)</td>
</tr>
<tr>
<td>STANDARD ALIAS: REV_CNTR_RATE_AMT</td>
<td>TITLE ALIAS: CHARGE_PER_UNIT</td>
</tr>
<tr>
<td>EDIT-RULES: +9(9).99</td>
<td>EFFECTIVE-DATE: 10/01/1993</td>
</tr>
<tr>
<td>COMMENT: Prior to Version H the size of this field was: S9(7)99.</td>
<td>SOURCE: CWF</td>
</tr>
</tbody>
</table>

**RVBLD{x}** Revenue Center Blood Deductible Amount where { x } ranges from 1 to 45

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

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

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>DB2 ALIAS: REV_BLOOD_DDCTBL</td>
<td>SAS ALIAS: RVBLD(x)</td>
</tr>
<tr>
<td>STANDARD ALIAS: REV_CNTR_BLOOD_DDCTBL_AMT</td>
<td>TITLE ALIAS: BLOOD_DDCTBL_AMT</td>
</tr>
<tr>
<td>EDIT-RULES: +9(9).99</td>
<td>EFFECTIVE-DATE: 10/01/1993</td>
</tr>
<tr>
<td>SOURCE: CWF</td>
<td>COMMENT: Prior to Version H the size of this field was: S9(7)99.</td>
</tr>
</tbody>
</table>
Variable Name | Label
--- | ---
RVDTBL\{x\} | Revenue Center Cash Deductible Amount

where \{ x \} ranges from 1 to 45

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

Effective with Version 'I' the amount of cash deductible the beneficiary paid 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_CASH_DDCTBL
SAS ALIAS: RVDTBL\{x\}
STANDARD ALIAS: REV_CNTR_CASH_DDCTBL_AMT
TITLE ALIAS: CASH_DDCTBL

EDIT-RULES:
+9(9).99

SOURCE:
CWF

WGDJ\{x\} | Revenue Center Coinsurance/Wage Adjusted

where \{ x \} ranges from 1 to 45

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

Effective with 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: WGDJ\{x\}
STANDARD ALIAS:
REV_CNTR_WAGE_ADJSTD_COINS_AMT
TITLE ALIAS: WAGE_ADJSTD_COINS
<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RDCDCN[x]</strong></td>
<td>Revenue Center Reduced Coinsurance Amount</td>
</tr>
<tr>
<td>where ( x ) ranges from 1 to 45</td>
<td></td>
</tr>
</tbody>
</table>

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

Effective with 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
SAS ALIAS: RDCDCN(x)
STANDARD ALIAS: REV_CNTR_RDCD_COINS_AMT
TITLE ALIAS: REDUCED_COINS

EDIT-RULES:
+9(9).99

SOURCE: CWF

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RVMS1_{x}</strong></td>
<td>Revenue Center 1st Medicare Secondary Payer Paid</td>
</tr>
<tr>
<td>where ( x ) ranges from 1 to 45</td>
<td></td>
</tr>
</tbody>
</table>

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

Effective with 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: RVMS1_{x}
STANDARD ALIAS: REV_CNTR_MSP1_PD_AMT
TITLE ALIAS: MSP PAID AMOUNT

EDIT-RULES:
+9(9).99

SOURCE: CWF
**Variable Name** | **Label**
---|---
RVMS2_{x} | Revenue Center 2nd Medicare Secondary Payer Paid

where {x} ranges from 1 to 45

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

Effective with 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: RVMS2_{x}
STANDARD ALIAS: REV_CNTR_MSP2_PD_AMT
TITTLE ALIAS: MSP PAID AMOUNT
EDIT-RULES:
+9(9).99
SOURCE:
CWF

---

RPRPMT{y} | Revenue Center Provider Payment Amount

where {y} ranges from 1 to 45

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

Effective with 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: RPRPMT{x}
STANDARD ALIAS: REV_CNTR_PRVDR_PMT_AMT
TITTLE ALIAS: REV_PRVDR_PMT
EDIT-RULES:
+9(9).99
SOURCE:
CWF
**Variable Name** | **Label**
---|---
*RBNPMT*<sub>x</sub> | Revenue Center Beneficiary Payment Amount

where *x* ranges from 1 to 45

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

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: RBNPMT<sub>x</sub>
STANDARD ALIAS: REV_CNTR_BENE_PMT_AMT
TITLE ALIAS: REV_BENE_PMT

EDIT-RULES:
+9(9).99

SOURCE: CWF

---

**PTNRSP*<sub>x</sub>** | Revenue Center Patient Responsibility Payment Amount

where *x* ranges from 1 to 45

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

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: PTNRSP<sub>x</sub>
STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT
TITLE ALIAS: REV_BENE_PMT

EDIT-RULES:
+9(9).99

SOURCE: CWF
**Variable Name** | **Label**
--- | ---
REVPMT\{x\} | Revenue Center Payment Amount

where \( x \) ranges from 1 to 45

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

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 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:
+9(9).99

SOURCE:
CWF

**Variable Name** | **Label**
--- | ---
RVCHRG\{x\} | Revenue Center Total Charge Amount

where \( x \) ranges from 1 to 45

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

The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the 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 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.
### Variable Name | Label

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(4) For Home Health PPS (final claim), when revenue code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023').</td>
<td></td>
</tr>
<tr>
<td>(5) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the charges will be $1 (rate) times units (days).</td>
<td></td>
</tr>
</tbody>
</table>

#### 9.2 DIGITS SIGNED

**DB2 ALIAS:** REV_TOT_CHRG_AMT  
**SAS ALIAS:** RVCNRG(x)  
**STANDARD ALIAS:** REV_CNTR_TOT_CHRG_AMT  
**TITLE ALIAS:** REVENUE_CENTER_CHARGES

**EDIT-RULES:**  
+9(9).99

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

**SOURCE:**  
CWF

#### RVNCVR[x]  
**Revenue Center Non-Covered Charge Amount**

where { x } ranges from 1 to 45

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

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

**NOTE:** Prior to Version H the field size was S9(7)V99 the element was only present on the Inpatient/SNF As of NCH weekly process date 10/3/97 this field was to all institutional claim types.

#### 9.2 DIGITS SIGNED

**DB2 ALIAS:** REV_NCVR_CHRG_AMT  
**SAS ALIAS:** RVNCVR(x)  
**STANDARD ALIAS:** REV_CNTR_NCVR_CHRG_AMT  
**TITLE ALIAS:**

**EDIT-RULES:**  
+9(9).99

**SOURCE:**  
CWF
RVDDCD\{x\}  Revenue Center Deductible Coinsurance Code

where \{ x \} ranges from 1 to 45

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

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

DB2 ALIAS: DDCTBL_COINSRNC_CD
SAS ALIAS: RVDDCD(x)
STANDARD ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD

CODES:
REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB
IN THE CODES APPENDIX

SOURCE:
CWF