# Transforming Episode Accountability Model (TEAM):

# Custom Export Tool Participant User Guide

December 2025

v.3

## Table of Contents

## 1. Introduction

The purpose of this user guide is to provide Transforming Episode Accountability Model (TEAM) participants with the information necessary to effectively access and use the TEAM Custom Export Tool (CET) through the Innovation Support Platform (ISP) Expanded Data Feedback Reporting (eDFR) application.

At this time, data custodians listed on the Data Sharing Agreement and Data Request and Attestation (DRA) form can use the **Custom Export Tool** to download the regional-level preliminary target price and spending summary files applicable to the region (i.e. census division) the TEAM participant is located in; and participant-specific preliminary target price files. Contingent on the data types selected in the DRA form, the data custodians may download historic episode and claims data covering episodes that began on or after January 1, 2022, and have anchor hospitalization discharge dates/anchor procedure end dates on or before December 31, 2024; and baseline summary data providing aggregate information on episode spending, winsorization, and exclusions. This user guide will be updated as applicable for each release of the TEAM CET.

In the future, the TEAM participant will be able to use this application to download monthly episodes and claims data, and quarterly regional spending and trend reports. Further, this application will also house reconciliation files including episodes, claims, and aggregate reports including reconciliation reports and quality performance reports.

### *1.1 Overview*

The TEAM CET will allow TEAM participants to understand the cost and utilization patterns within the Original Medicare beneficiary population initiating episodes at their hospitals. TEAM participants can also use this data to compare their own spending to regional averages and assess the spending patterns of post-acute care providers. TEAM participants are encouraged to use this data to inform their decision-making as they seek to transform how they deliver care.

### *1.2 Conventions*

This document provides screenshots and corresponding descriptions on how to access and use the TEAM CET and more information about the data available via the TEAM CET.

### *1.3 Cautions and Warnings*

The TEAM CET resides within the Expanded Data Feedback Reporting (eDFR) application of the Innovation Support Platform (ISP). Users access the TEAM CET via the Innovation Center (IC) Application within the CMS Enterprise Portal (ePortal).

When signing into the CMS ePortal, the system asks you to agree to the terms and conditions for use of the CMS.gov ePortal, content, and applications. You can select the **Terms & Conditions** hyperlink to view the detailed terms and conditions, which you should read thoroughly, as it explains the penalties and consequences of misusing the system(s) and its contents.

**Note**: Screens that display in the system may differ slightly from the sample images used in this document.

## 2. Getting Started

The following sub-sections describe setup considerations for using the TEAM CET, user access considerations, how to access the tool, and system organization and navigation.

### *2.1 Set-up Considerations*

The TEAM CET is best viewed using Google Chrome, Microsoft Edge (Chromium), Mozilla Firefox, or Apple Safari. For additional setup considerations, refer to *Section 2.1 – Set-up Considerations* under *Getting Started* in the PDF version of the **CMS Enterprise Portal User Guide**.

### *2.2 User Access Considerations*

Approved Data Custodians will access the TEAM CET through the CMS ePortal. Authorized users have access to tools and functionality based on their assigned role. TEAM participants will be assigned the "**Model Participant**" user role.

### *2.3 Accessing the TEAM CET*

The following sub-sections provide instructions on how to gain access to the TEAM CET. There are four steps in gaining access:

1. Registering for an Identity Management (IDM) System account

2. Requesting an IC Application role
3. Requesting access to the TEAM CET
4. Accessing the TEAM CET

If you have any issues requesting access, contact the TEAM Help Desk at CMMI_TEAM@cms.hhs.gov or at 888-734-6433.

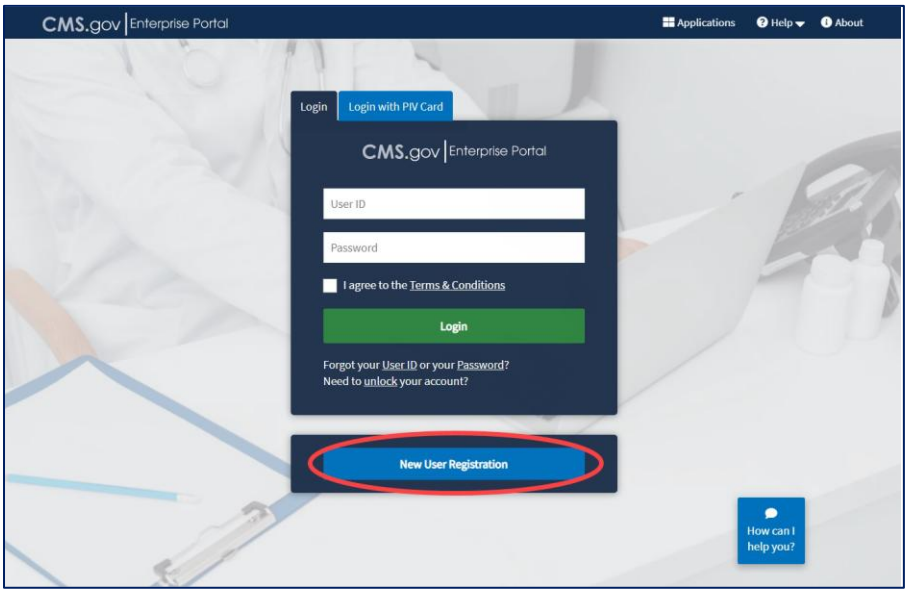
### *2.3.1 Registering for an Identity Management (IDM) System Account*

**NOTE:** If you already have an IDM account, continue to section 2.3.2 to request an IC Application Role.

To log in to the CMS ePortal **(https://portal.cms.gov/portal/)** you need to create a user ID and password by completing the IDM new user registration process. The following are the step-by-step instructions.

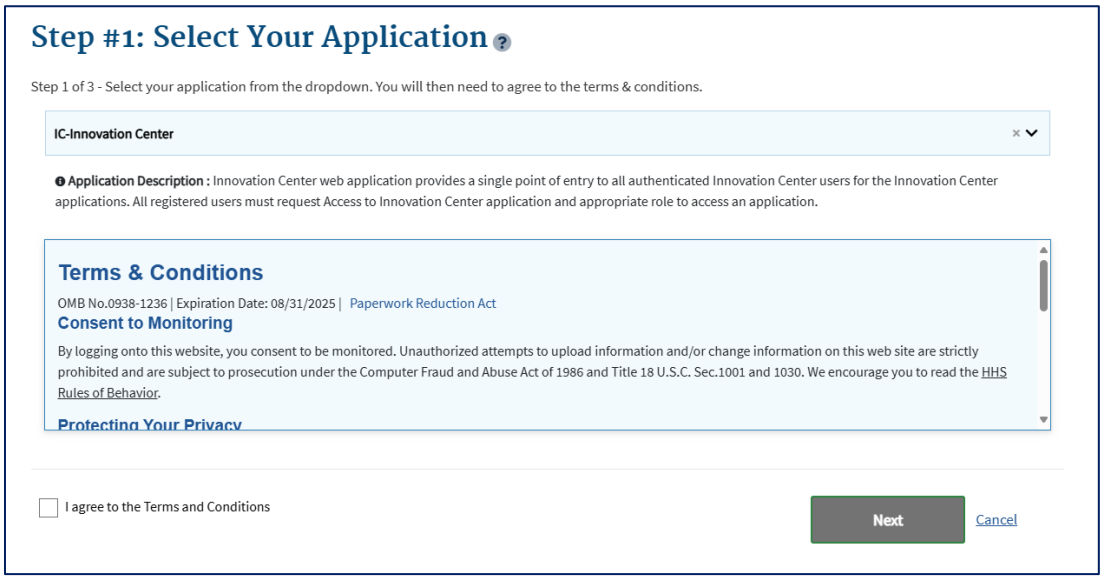
1. On the CMS ePortal home page, click the **New User Registration** button.

*Figure 1. New User Registration Button on ePortal Home Page*




2. On the **Step #1: Select Your Application** page, select "IC-Innovation Center" from the **Select Your Application** drop-down list.

*Figure 2. Step 1 of New User Registration – Choose Your Application*




3. Read the Terms & Conditions, select **I agree to the Terms and Conditions**, and then click **Next** to continue with the registration process.
4. Provide the information requested on the **Step #2: Register Your Information** page. All fields are required and must be completed unless marked "Optional". After all required information has been provided, click **Next** to continue.
5. On the **Step #3: Create User ID, Password & Security Question/Answer** page:
    a. Create and enter a user ID in the **Enter User ID** field.
    b. Create and enter a password in the **Enter Password** field. Enter the same password in the Enter Confirm Password field.
    c. Select a question in the **Select Your Security Question** drop-down list and enter the answer you want to be saved with the question.
    d. **Note:** Instructions are displayed, in the form of tool tips, on what you are required to include in your user ID, password, and security question answer.
    e. Click **Next** to complete the registration process.

6. The **New User Registration Summary** page displays. Review the information you entered, make any necessary changes and then click the **Submit User** button.
7. The **Confirmation** page is displayed acknowledging your successful registration and informs you that you should receive a confirmation email.

For additional instructions on completing the registration process, refer to *Section 3 – Registering for CMS Enterprise Portal* in the PDF version of the **CMS Enterprise Portal User Guide**.

Once you have successfully completed IDM registration, you may log in to ePortal and request an IC Application role.

### *2.3.2 Requesting an IC Application Role*

To access the TEAM CET, you need to request an IC Application user role. To request this role, you must successfully complete the Remote Identity Proofing (RIDP) process and register your Multi-Factor Authentication (MFA) device.

The following are the instructions on how to request an IC Application user role:

1. Go to the ePortal **(https://portal.cms.gov/portal/)** and log in using your IDM user ID and password that you created above.

   **NOTE:** All users who sign in for the first time after creating an account will automatically be prompted to confirm their email as their default MFA device. Users will be prompted to authenticate with an MFA device that is registered to their account each time they sign into the Enterprise System.
2. On the **My Portal** page, click the **Add Application** button.
3. On the **Request Application Access** page:
   a. In **Step 1 – Select an Application**, choose "IC-Innovation Center".
   b. In **Step 2 – Select a Role**, choose "Innovation Center Privileged User".
   c. In **Step 3 - Complete Identity Verification**, click on the **Launch** button to begin the Identity Verification process.

4. Read the **Terms and Conditions** information on this page and indicate your agreement by selecting the **I agree to the Terms and Conditions** checkbox. Click the **Next** button to continue.
5. Enter your information into the required fields of the **Enter Your Information** page. Click **Next** to continue the identity verification process.
6. Provide an answer to each question and then click **Next** to continue.
7. If successful, a **confirmation** message is displayed.

For additional instructions, refer to *Section 9.3 – Requesting a Role* in the PDF version of the **CMS Enterprise Portal User Guide**.

Once you have successfully requested an IC Application user role, log out of the ePortal and follow the steps in section 2.3.3 below to request access to the TEAM CET.

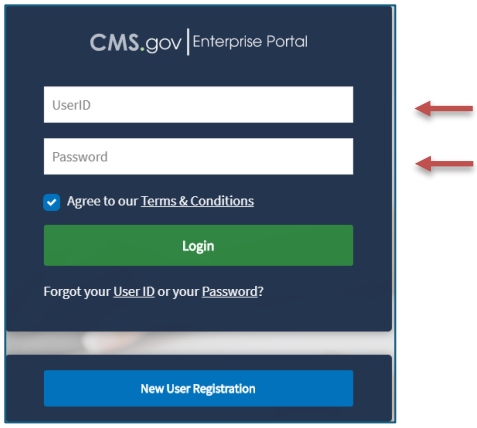
### *2.3.3 Requesting Access to the TEAM Custom Export Tool (CET)*

**NOTE**: TEAM CET access requests will only be approved for TEAM participants who submitted a signed Data Sharing Agreement (DSA) and Data Request and Attestation (DRA) Form, which lists the requesting user as a Data Custodian. Users that are not assigned the Data Custodian role will not be granted access to the TEAM CET.

To request access to the TEAM CET, complete the following steps:

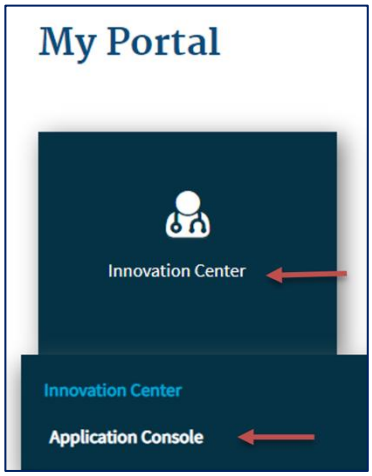
1. Go to the ePortal **(https://portal.cms.gov/portal/)** and log back in using your IDM user ID, password, and MFA-generated security code.

*Figure 3. CMS ePortal Login*



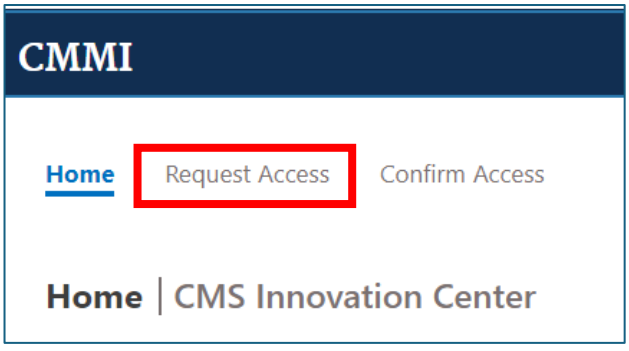
2. On the **My Portal** page, select the **Innovation Center** widget. Then select the **Application Console** link.

*Figure 4. My Portal Page*



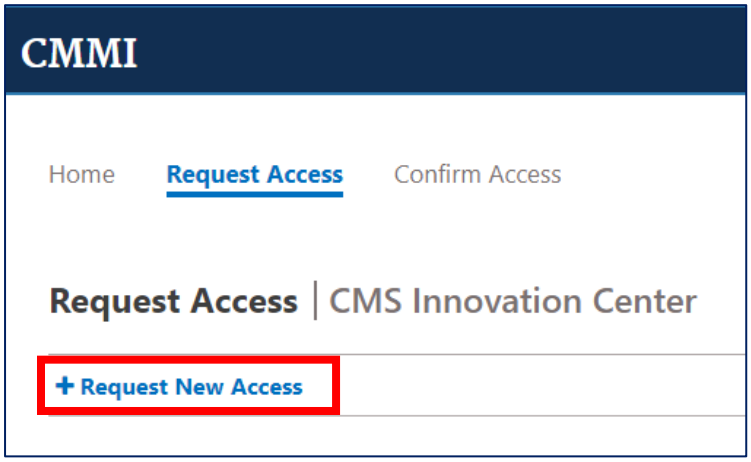

3. Select **Request Access**. You will be directed to a new screen to request access.

*Figure 5. Landing Page with Request Access Highlighted*



4. On the **Request Access** tab, select **Request New Access**. You will be directed to a new screen to make your selections.

*Figure 6.Landing Page with Request New Access Link Highlighted*

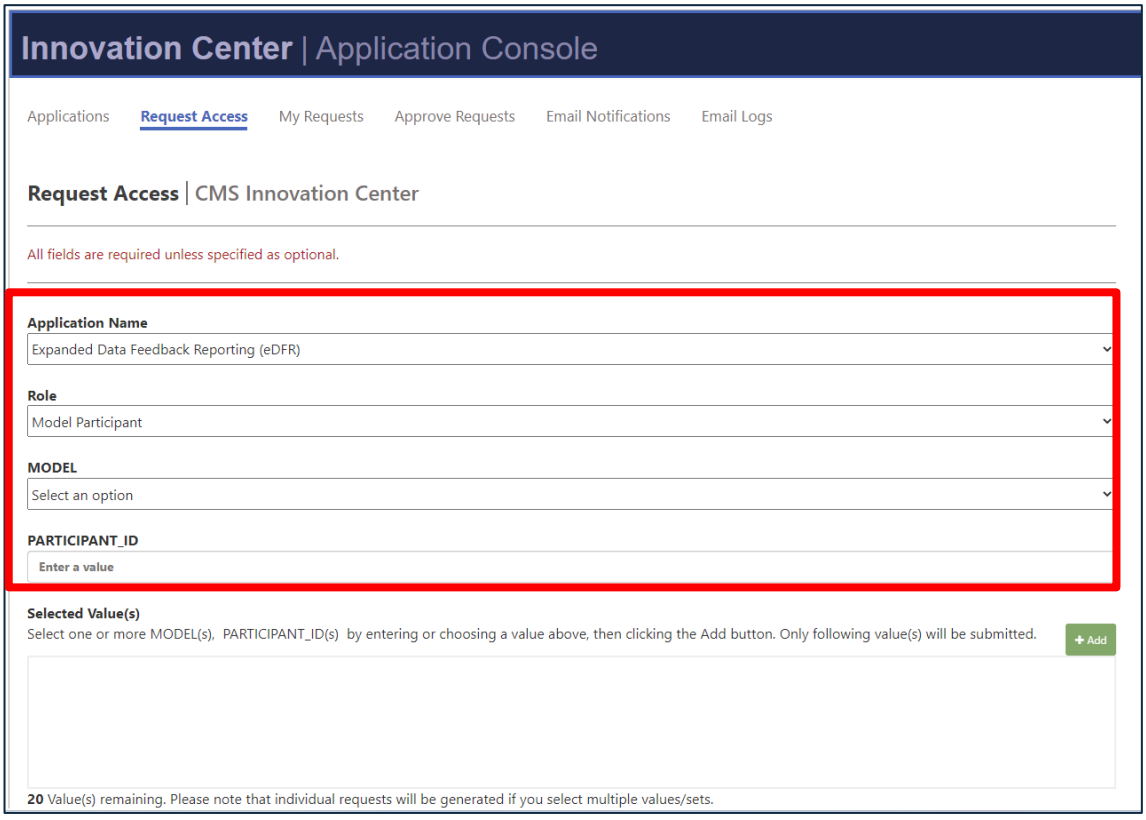



5. Select **Expanded Data Feedback Reporting (eDFR)** from the **Application Name** dropdown. Then select your role – **Model Participant** – from the **Role** dropdown. Application permissions are granted based on user role.

6. When you select the **Model Participant** role, you are required to select a **Model** and a **Participant ID** since this user role is granted access to models at the entity level. Each entity within a model has its own Participant ID. In TEAM, your Participant ID is the term 'TEAM' followed immediately by your 6-digit hospital CMS Certification Number (CCN), formatted as follows – TEAMXXXXXX (e.g., TEAM123456).

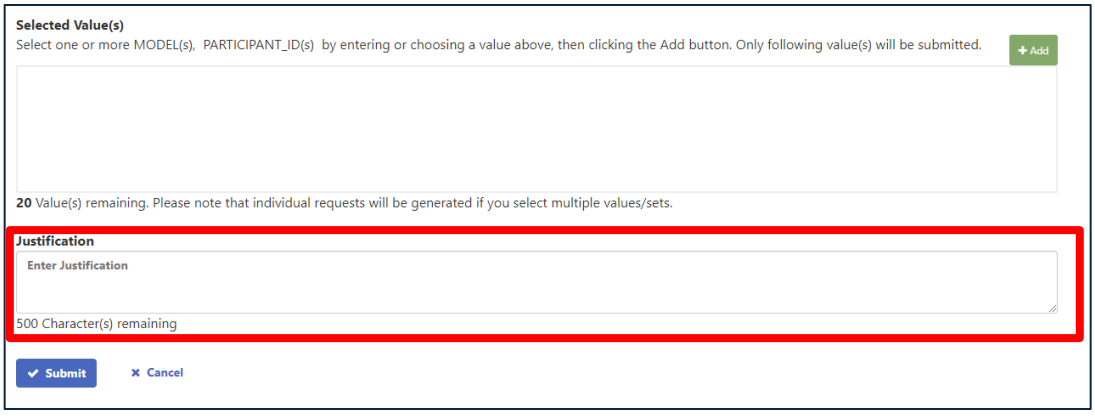
   After selecting **Transforming Episode Accountability Model** from the **Model** dropdown, begin typing your Participant ID in the **Participant ID** field to display the IDs for selection. Then select the **Add** button to add the values to your request.

*Figure 7. Sample Access Request with Application Name, Role, Model, and Participant ID Highlighted*



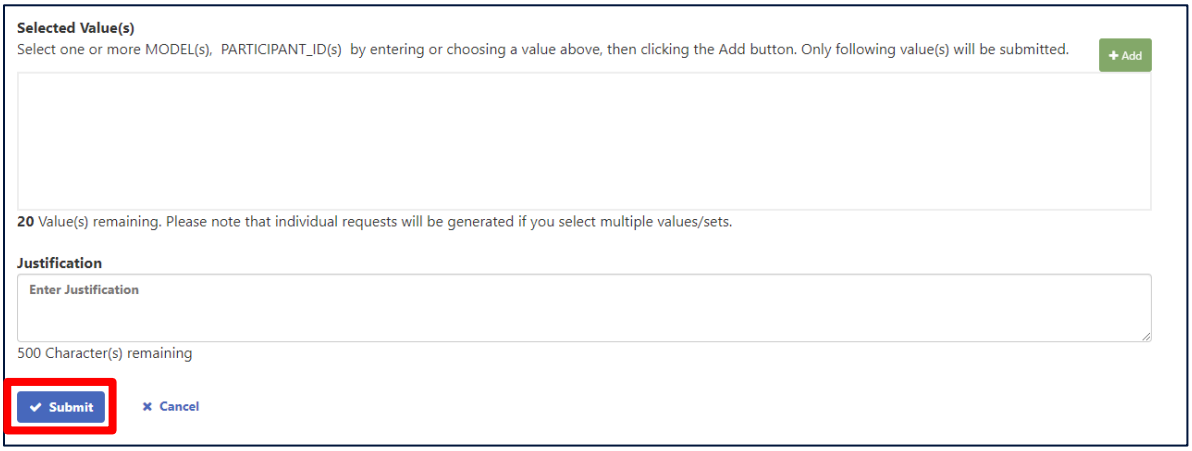

7. Enter the justification for your access in the **Justification** field. For example, indicate that you are an approved data user for the TEAM CET.

*Figure 8. Sample Access Request with Justification Highlighted*



8. Select the **Submit** button to submit your request. After you have submitted your request, you will receive an email notification stating whether your request is approved or denied. Notification is not immediate.

*Figure 9. Sample Access Request with Submit Highlighted*

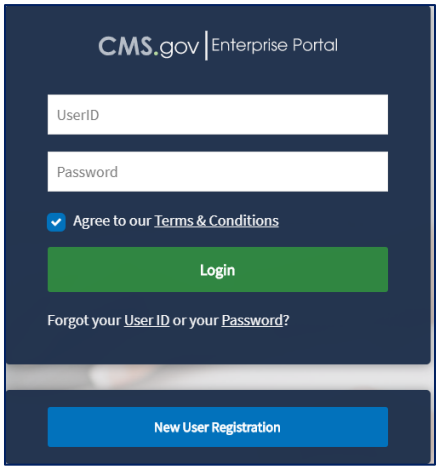


### *2.3.4 Accessing the TEAM Custom Export Tool with your New Login*

Once you have established access to the ePortal, complete the following steps to access the TEAM CET:

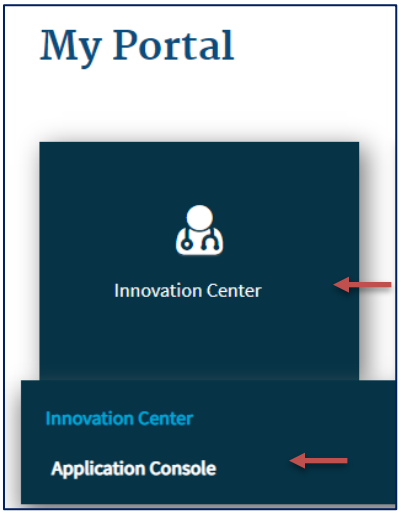
1. Go to the ePortal **(**https://portal.cms.gov/portal/**)** and log in using your IDM user ID, password, and MFA-generated security code.

*Figure 10. CMS ePortal Login*



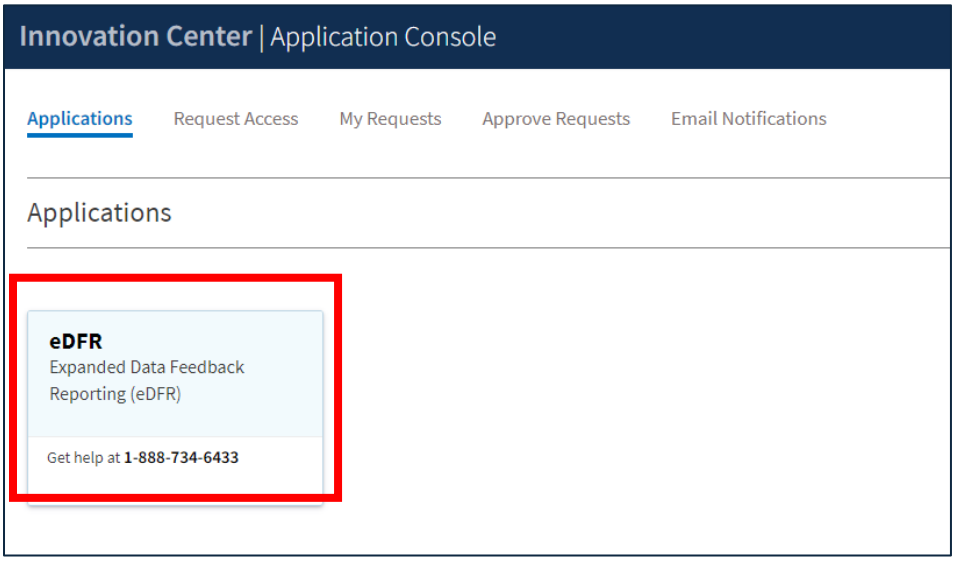

2. On the **My Portal** page, select the **Innovation Center** widget. Then select the **Application Console** link.

*Figure 11. My Portal Page*



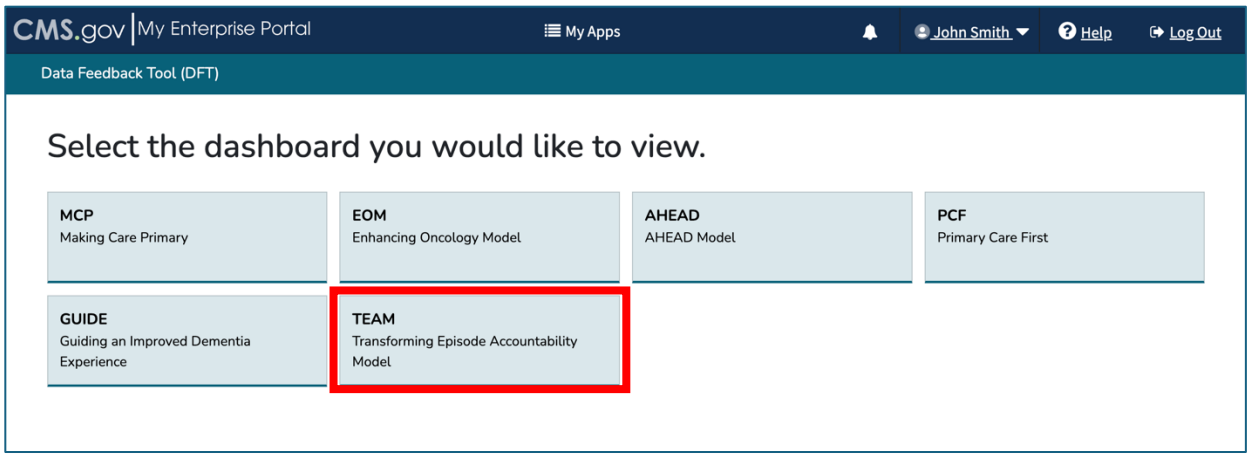
3. On the Innovation Center **Home** page, select the **eDFR** widget.

*Figure 12. Innovation Center Home Page eDFR Widget*




4. Select the TEAM DFT by selecting the "TEAM" tile.

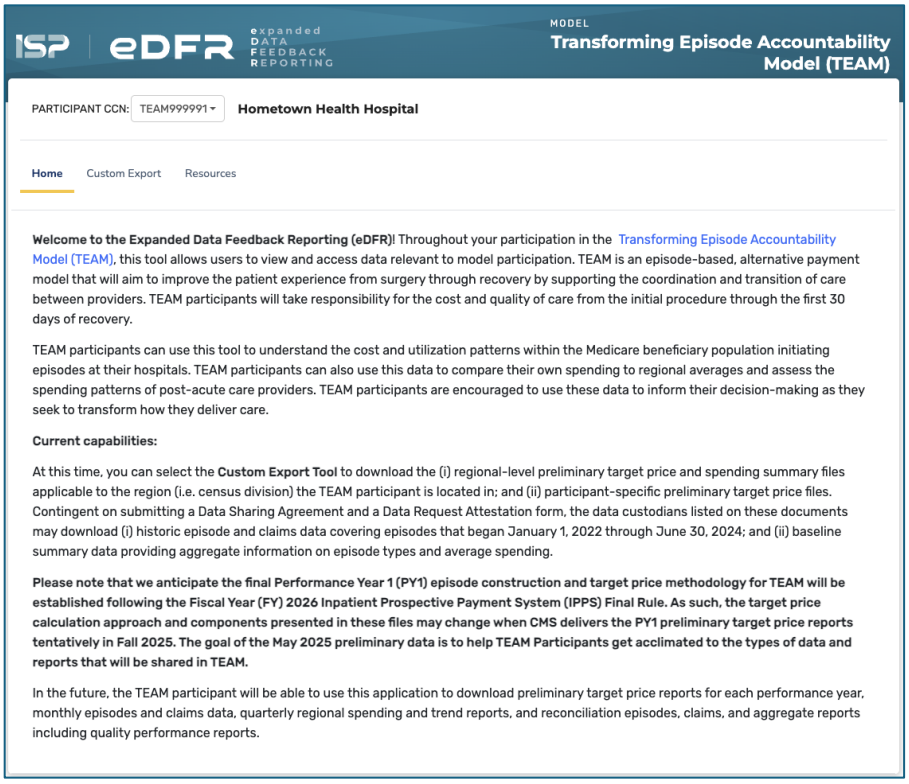
*Figure 13. Model dashboard Section with TEAM Highlighted*




**NOTE**: You will be able to select only the model dashboard(s) or DFT(s) that you have been approved to access.

5. The TEAM Data Feedback Tool **Home** Page will be displayed.

*Figure 14. Custom Export Tool Sample Home Page*




### *2.4 HIPAA Access Requirements*

Throughout your participation in TEAM, you will be able to view and download requested data through this Innovation Support Platform (ISP) Expanded Data Feedback Reporting (eDFR) application. To view requested data, your Data Sharing Agreement (DSA) must be executed, and your Data Request and Attestation (DRA) Form must be completed and up to date. Your hospital will only receive data that is selected on the DRA, and only the Data Custodians listed on the DSA and DRA will be able to access the data in the TEAM CET.

If you have any questions related to the completion of the DSA or DRA Form, please contact the TEAM Help Desk at CMMI_TEAM@cms.hhs.gov for further assistance.

## 3. Using the Custom Export Tool

### *3.1 Understanding the Custom Export Tool*

The **Custom Export Tool** (CET) allows you to download "*Episode and Claims Data"* and "*Summary Reports"*. For the initial release of the TEAM CET, the Spring 2025 Episode and Claims Data and Summary Reports were made available for download. This data refresh in December 2025, provides performance year 1 (PY1) preliminary target price reports and historic episode and claims data covering episodes that began on or after January 1, 2022 with anchor hospitalization discharge dates/anchor procedure end dates on or before December 31, 2024.

In the future, TEAM participants will be able to use this application to download monthly episodes and claims data, and quarterly regional spending and trend reports. Further, this application will also house reconciliation files including episodes, claims, and aggregate reports including reconciliation reports and quality performance reports.

**Data source**: The data source for the data and summary reports in the TEAM CET is Medicare administrative data, including claims for Medicare Parts A and B, retrieved from the Centers for Medicare and Medicaid Services' (CMS') Integrated Data Repository (IDR).

**Episode Construction:** Episode construction is determined through the methodology described in the Clinical Episode Construction specifications (available on the resources page of the CET).

### *3.2 System Organization and Navigation*

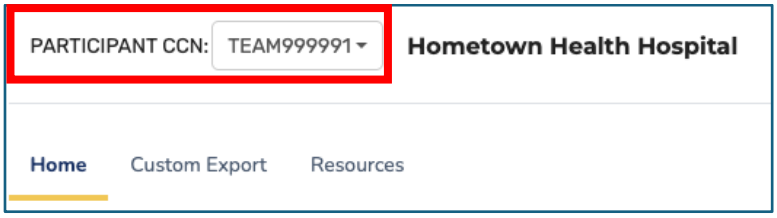
This section provides detailed information on how to navigate within the TEAM CET and use common features.

#### *3.2.1 Participant CCN*

The **Participant CCN** header will remain at the top of the page and display the unique number identifying the participant (in the format – TEAMXXXXXX, where "XXXXXX" is your hospital's CCN) and the full TEAM participant's name in bold.

The dropdown will automatically display the first TEAM participant in the list. If you have access to more than one TEAM participant's information, you can view the Custom Export Tool for each TEAM participant by selecting the **Participant CCN** from the dropdown.

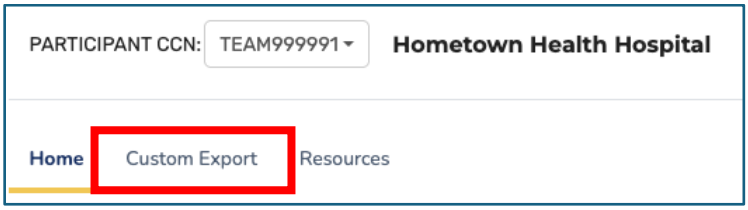
*Figure 15. Participant CCN Name and Dropdown Menu*




### *3.2.2 Home Page*

The Home page serves as the landing page of the TEAM CET. This page welcomes the user to the Transforming Episode Accountability Model and gives a brief overview of what the alternative payment model is designed to do. Selecting the "Custom Export" tile at the top of the page brings you to the Custom Export page.

*Figure 16. Custom Export Tool Tile*




### *3.2.3 Custom Export Tool Page*

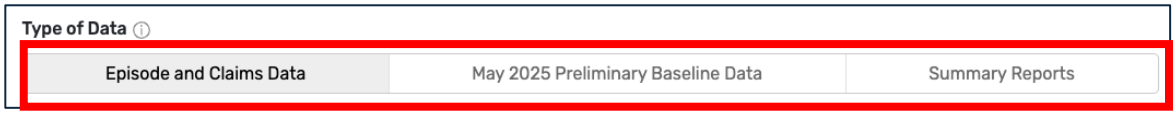
To use the Custom Export Tool:

- Select the **Type of Data** you would like to download.
    - Select "Episode and Claims Data" if you would like to download historic episode and claims data used for performance year 1, covering episodes that began on or after January 1, 2022 and have an anchor hospitalization discharge date or anchor procedure end date on or before December 31, 2024
    - Select "May 2025 Preliminary Baseline Data" if you would like to download historic episode and claims data not used for performance year 1, covering episodes that began on or after January 1, 2022 and have an anchor

hospitalization discharge date or anchor procedure end date on or before June 30, 2024.

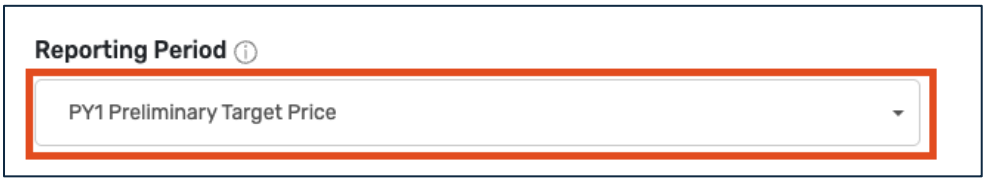
- Select "Summary Reports" if you would like to download baseline summary data providing aggregate information on preliminary target prices, episode spending, winsorization, and exclusions.

*Figure 17. Custom Export Tool Type of Data Selection*



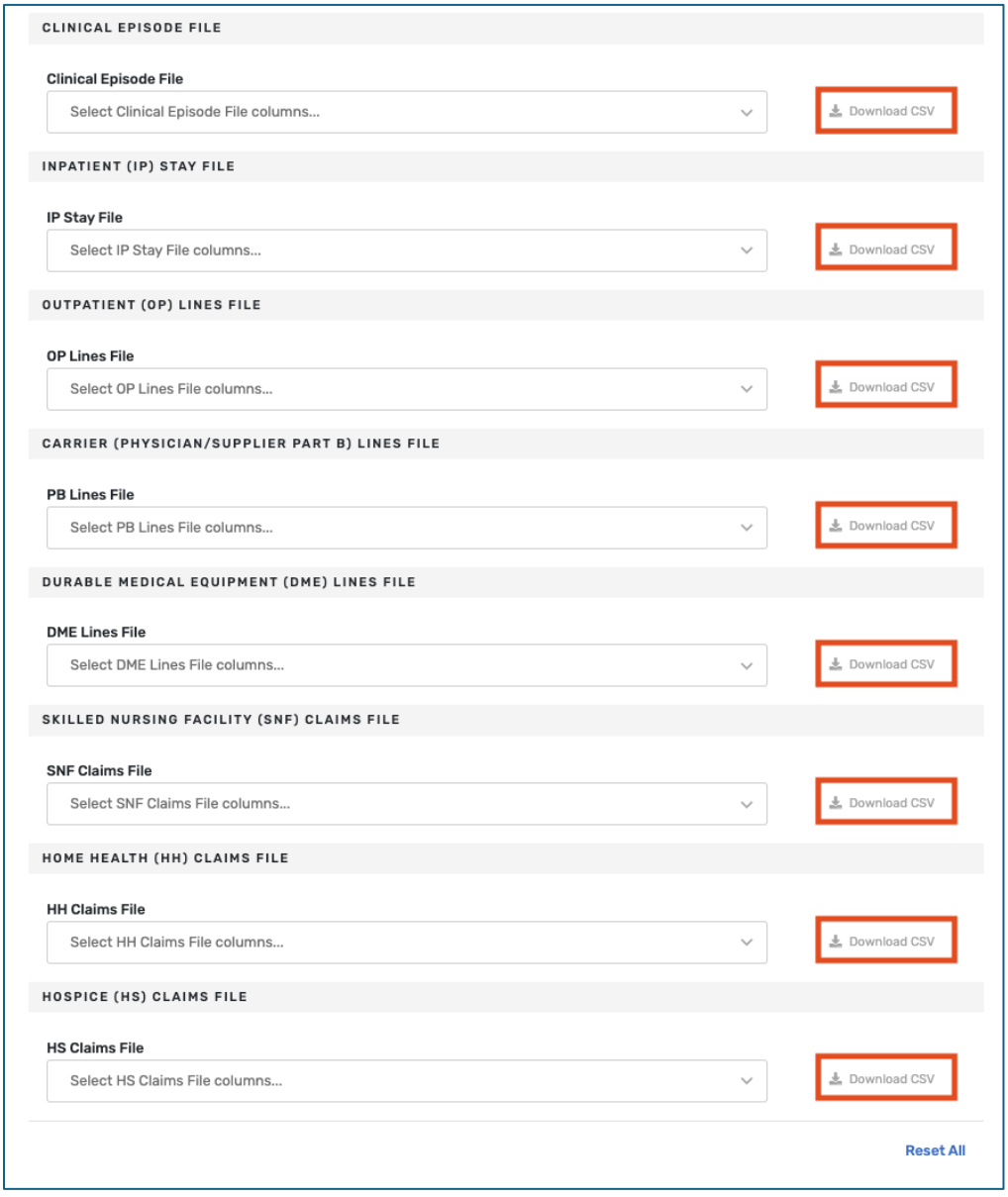

- For "Episode and Claims Data", select the desired **Reporting Period** you would like to include in your file. Currently, only "PY1 Preliminary Target Price" is available to select. Beginning in early 2026, monthly claims data will become available and will be included in the reporting period options.

*Figure 18. Custom Export Tool Reporting Period Selection*




- Then select the file and the columns you would like to include and select **Download CSV** next to the drop-down to download your file.

*Figure 19. Download CSV*



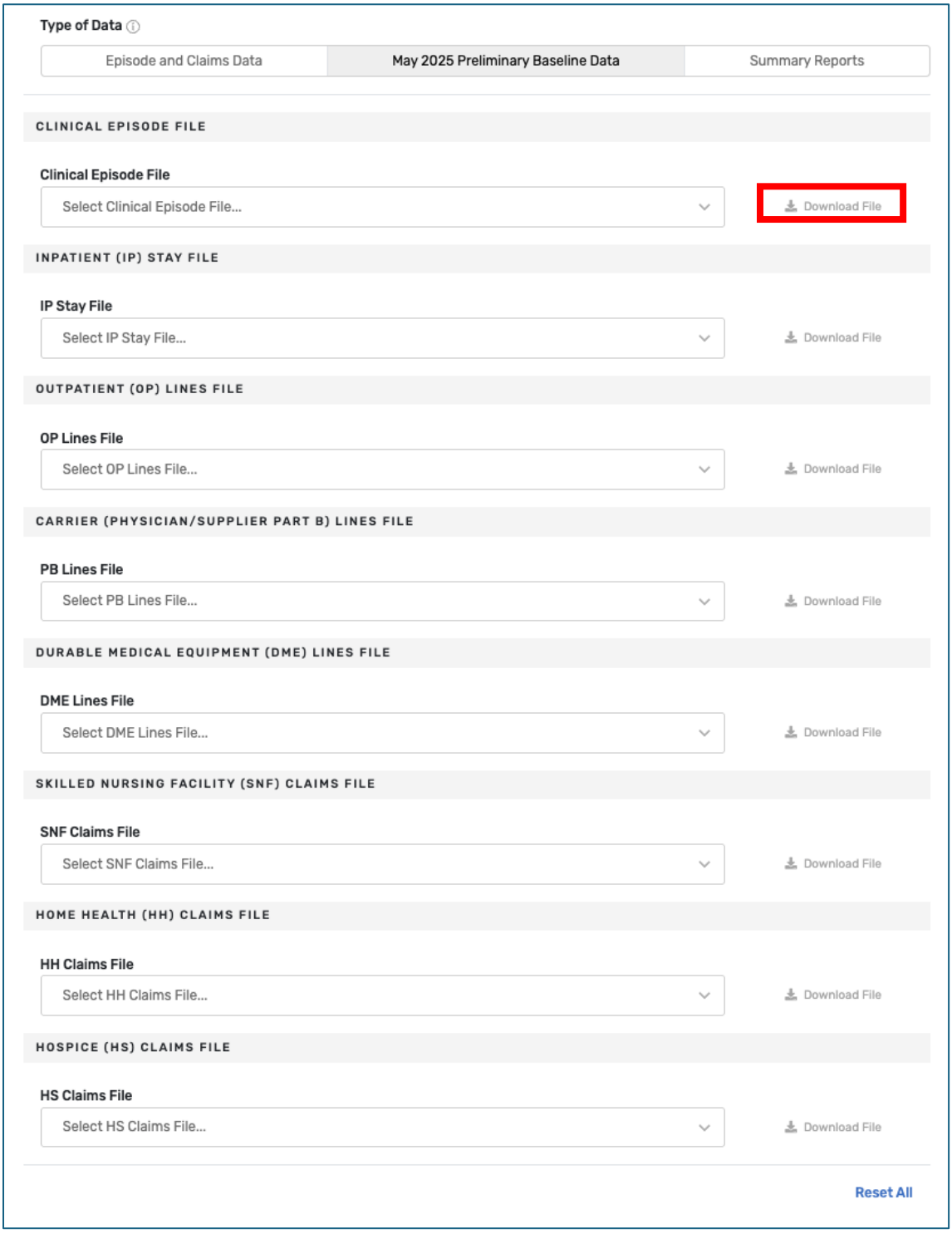

- **Note:** Both a 'Reporting Period' and at least one 'Column' must be selected for "Download CSV" to be activated. Large files may take time to download. For best performance, download one file at a time. Remember that very large files will not open properly if Excel is used to view the file.

- Your selected columns will be retained for your next session to allow you to quickly re-download any updated files. These selections will reset if you clear your cache or use a different browser.
- You can reset your selection and start over by selecting **Reset All** at the bottom left of the screen. This will also reset your selections for your next session.

*Figure 20. Reset All*

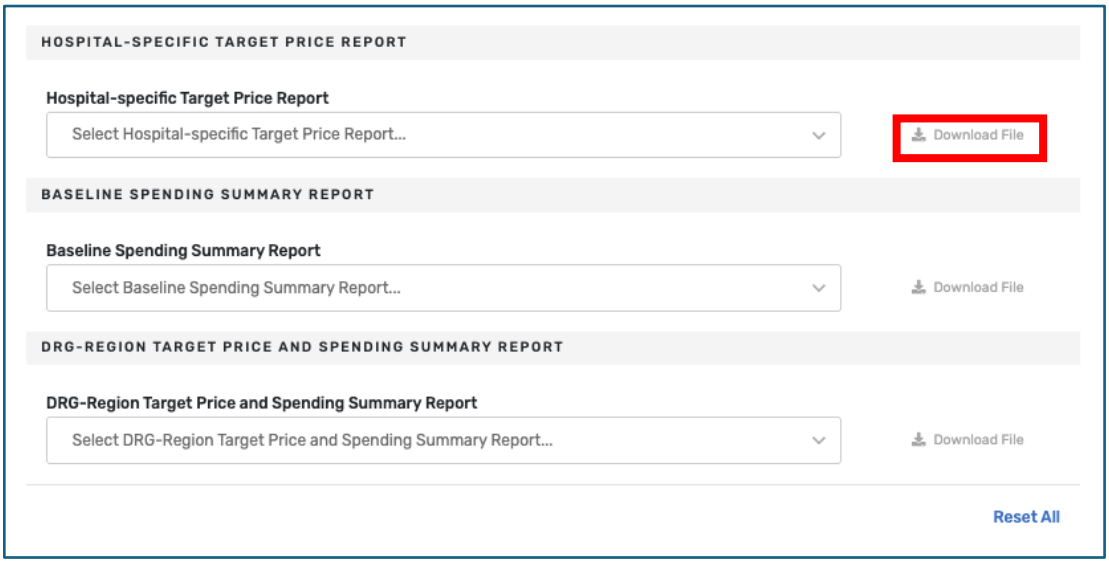

- For "May 2025 Preliminary Baseline Data", select the desired file, then select **Download File** next to the drop-down to download your file.
- **Note:** The May 2025 Preliminary Baseline Data are only available as static files as originally released. Starting with the PY1 preliminary data, you will be able to download customized episode and claims CSV files (see "Episode and Claims Data" section above).

*Figure 21. May 2025 Preliminary Baseline Data Section*



- For Summary Reports data, select the desired report, then select **Download File** next to the drop-down to download your file.

*Figure 22. Summary Reports Section*




For **Episode and Claims Data** and **May 2025 Preliminary Baseline Data**, there are a total of 8 possible CSV files available for download. The CSV files available for download are:

- The **Clinical Episode File** provides data for clinical episodes for the selected reporting period.
- The **Inpatient (IP) Stay File** provides data for grouped IP stays occurring during the episode window.
- The **Outpatient (OP) Lines File** provides data for grouped OP claims occurring during the episode window.
- The **Carrier (Physician/Supplier Part B) Lines File** provides data for grouped physician/supplier Part B (PB) claims occurring during the episode window.
- The **Durable Medical Equipment (DME) Lines File** provides data for grouped DME claims occurring during the episode window.
- The **Skilled Nursing Facility (SNF) Claims File** provides data for grouped SNF claims occurring during the episode window.

- The **Home Health (HH) Claims File** provides data for grouped HH claims occurring during the episode window.
- The **Hospice (HS) Claims File** provides data for grouped HS claims occurring during the episode window.

The **Episode and Claims Data and May 2025 Preliminary Baseline Data** available for download are based on Medicare administrative data, including claims for Medicare Parts A and B, retrieved from the Centers for Medicare and Medicaid Services' (CMS') Integrated Data Repository (IDR).

Review **Appendix B: Custom Export Tool Data Dictionary – Episode and Claims Data** for a complete list of all the data included in these files. The Data Dictionary includes a list of data element names, data type, length, format, and descriptions.

For **Summary Reports**, there are a total of 3 files available for download. The files available for download are:

- Hospital-specific Target Price Report
- Hospital-specific Baseline Spending Summary Report
- Region-specific Target Price and Spending Summary Report

You will be able to download the Hospital-specific Target Price and Baseline Spending Summary reports (if available for your hospital) and Region-level Target Price and Spending Summary reports in Excel format. The files will be available for download as they are released annually for each performance year. These reports offer a summary of hospital-specific and regional level clinical episode spending, participant-specific target prices, and target price components.

#### *3.2.4 Resources Page*

The resources page displays links containing useful information for users. In addition to this TEAM User Guide, the Resources page includes:

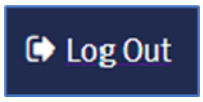
- TEAM Clinical Episode Construction Specifications
- TEAM Target Price Construction Specifications
- TEAM Preliminary Target Price Fact Sheet

- TEAM Exclusion List
- TEAM Community Deprivation Index Specifications
- TEAM Webpage links to the official CMS.gov webpage for TEAM. It provides users with a model overview, participant list, additional information and factsheets, and links to proposed and final rules.
- TEAM Participant Portal links to the CMS IDM login page for the TEAM Portal.

### *3.2.5 Exiting the System*

To log out of the TEAM Data Feedback Tool, select the Log Out button on the upper right side of the screen. You will be directed back to the CMS ePortal login page **https://portal.cms.gov/**

*Figure 23. Log Out Button*

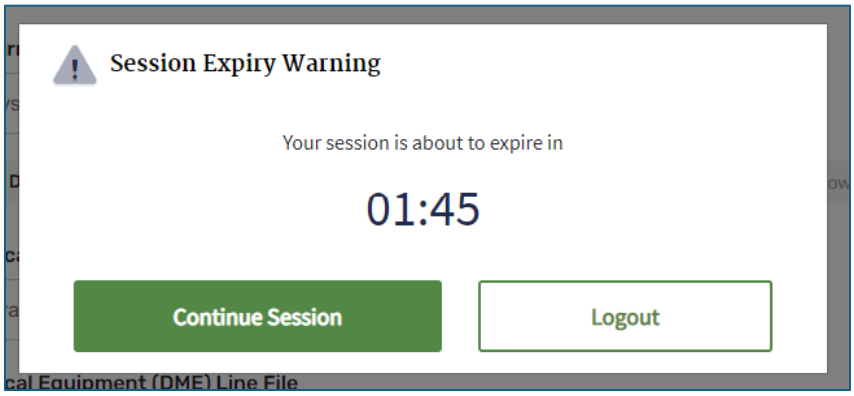


## 4. Troubleshooting and Support

### *4.1 Warning Messages*

For security purposes, a two-minute Session Expiry Warning will ask you to “Continue Session” or “Logout” after a period of inactivity. Select “Continue Session” if you wish to continue, or you will be automatically logged out and directed to the CMS ePortal login page https://portal.cms.gov/portal/.

*Figure 24. Session Expiry Warning Message*




### *4.2 Support*

For any issues pertaining to the TEAM CET, please contact TEAM Help Desk at CMMI_TEAM@cms.hhs.gov or at 888-734-6433.

## Appendix A: Acronyms

*Table 1. List of Acronyms*

| Acronym | Definition |
|---|---|
| CCLF | Claim and Claim Line Feed files |
| CET | Custom Export Tool |
| CMMI | CMS Innovation Center |
| CMS | Centers for Medicare & Medicaid Services |
| CSV | Comma Separated Values |
| DFT | Data Feedback Tool |
| DME | Durable medical equipment |
| DRA | Data Request and Attestation |
| DSA | Data Sharing Agreement |
| ePortal | Enterprise Portal |
| HHA | Home Health Agency |
| HIPAA | Health Insurance Portability and Accountability Act |
| HS | Hospice |
| IC | Innovation Center |
| IDR | Integrated Data Repository |
| IDM | Identity Management System Account |
| IP | Inpatient |
| ISP | Innovation Support Platform |
| MFA | Multi-Factor Authentication |
| OP | Outpatient |
| PB | Physician/supplier Part B |
| PDF | Portable Document Format |
| RIDP | Remote Identity Proofing |
| SNF | Skilled nursing facility |
| TEAM | Transforming Episode Accountability Model |

## Appendix B: Custom Export Tool Data Dictionary – Episode and Claims Data

*Table 2. Episode and Claims Data Dictionary*

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| **Clinical Episode File** | | | | | |
| Episode ID | EPISODE_ID | NUM | 16 | Numeric | Unique clinical episode identifier |
| Episode Type | EPISODE_TYPE | CHAR | 40 | Alphanumeric | Represents one of the five episode types in TEAM: Inpatient (IP) - Coronary Artery Bypass Graft Surgery (CABG), Multi-setting (MS) - Lower Extremity Joint Replacement (LEJR), IP - Major Bowel Procedure, IP-Surgical Hip/Femur Fracture Treatment (SHFFT) and MS-Spinal Fusion |
| Provider CCN | ANCHOR_PROVIDER | CHAR | 6 | Alphanumeric | CCN of the hospital anchoring the episode |
| Enrollment Database Beneficiary ID | BENE_SK | NUM | 16 | Numeric | A unique number assigned by the Enrollment Data Base (EDB) to each EDB record to identify a beneficiary |
| Medicare Beneficiary Identifier | BENE_MBI_ID | CHAR | 11 | Alphanumeric | Unique Medicare Beneficiary Identifier (MBI) |
| Beneficiary First Name | BENE_1ST_NAME | CHAR | 40 | Alphanumeric | Beneficiary's first name |
| Beneficiary Middle Name | BENE_MIDL_NAME | CHAR | 30 | Alphanumeric | Beneficiary's middle name |
| Beneficiary Last Name | BENE_LAST_NAME | CHAR | 40 | Alphanumeric | Beneficiary's last name |
| Beneficiary Sex | BENE_SEX | CHAR | 6 | Alphanumeric | Beneficiary's sex |
| Beneficiary Birth Date | BENE_BRTH_DT | DATE | 10 | YYYY-MM-DD | Beneficiary's date of birth |
| Beneficiary Death Date | BENE_DEATH_DT | DATE | 10 | YYYY-MM-DD | Beneficiary's date of death |
| Beneficiary Age at the time of Discharge | BENE_AGE | NUM | 3 | Numeric | Beneficiary's age as of the date of discharge from the hospital anchoring the IP or OP episode |
| Anchor Type | ANCHOR_TYPE | CHAR | 2 | Alphanumeric | Indicates whether an episode is triggered in the IP setting (anchor hospitalization) or OP setting (anchor procedure) |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| Anchor Trigger MS-DRG or HCPCS | ANCHOR_TRIGGER_CD | CHAR | 5 | Numeric | Indicates the original MS-DRG or HCPCS triggering an episode in the baseline period |
| Remapped MS-DRG | DRG_2026 | CHAR | 3 | Numeric | Represents the MS-DRG that the anchor MS-DRG are mapped to in Fiscal Year (FY) 2026 |
| HCPCS Remapped to MS-DRG | ANCHOR_TRIGGER_CD_WINS | CHAR | 3 | Numeric | Represents the MS-DRG that the HCPCS are mapped to for the purposes of calculating target prices. |
| Anchor APC | ANCHOR_APC | CHAR | 4 | Alphanumeric | Ambulatory Payment Classification (APC) that the anchoring HCPCS maps to in the respective baseline year |
| Remapped APCs | PERF_APC | CHAR | 4 | Alphanumeric | APC that the anchoring HCPCS maps to in Calendar Year (CY) 2025 |
| Anchor Attending National Provider Identifier (NPI) | CLM_ATNDG_PRVDR_NPI_NUM | CHAR | 10 | Alphanumeric | Attending physician's National Provider Identifier (NPI) associated with the anchoring IP hospitalization or OP procedure |
| Anchor Operating National Provider Identifier (NPI) | CLM_OPRTG_PRVDR_NPI_NUM | CHAR | 10 | Alphanumeric | Operating physician's NPI associated with the anchoring IP hospitalization or OP procedure |
| Anchor Hospitalization or Procedure Start Date | ANCHOR_BEG_DT | DATE | 10 | YYYY-MM-DD | Start date of an episode's anchor period. Corresponds to the admission date for an IP stay and revenue center date for an OP procedure |
| Anchor Hospitalization or Procedure End Date | ANCHOR_END_DT | DATE | 10 | YYYY-MM-DD | End date of an episode's anchor period. Corresponds to the discharge date for an IP stay and revenue center date for an OP procedure |
| Post-Discharge Begin Date | POST_DSCH_BEG_DT | DATE | 10 | YYYY-MM-DD | Start date of an episode's post-discharge period. Corresponds to the anchor end date |
| Post-Discharge End Date | POST_DSCH_END_DT | DATE | 10 | YYYY-MM-DD | End date of an episode's post-discharge period. Corresponds to the anchor end date + 29 days. If the beneficiary died during the episode's post-discharge period, this corresponds to the beneficiary death date. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| Three-day IP/OP overlap indicator | OP_3DAY_OVERLAP | NUM | 1 | Numeric | Indicates whether the anchor start date of the IP episode is updated to that of an overlapping OP episode which occurred on the same day or within three days of an overlapping OP episode |
| Death During the Post-Discharge Period | DEATH_DUR_POSTDSCHRG | NUM | 1 | Numeric | Indicates whether the beneficiary died during the episode's post-discharge period |
| Anchor Allowed Amount in Standardized Dollars (Before Scaling) | ANCHOR_STANDARD_ALLOWED_AMT | NUM | 16.2 | Numeric | Total standardized allowed amount associated with the IP stay or OP claim anchoring an episode before the scaling factor is applied. Allowed amount is the sum of the Medicare Paid Amount, Beneficiary Deductible, and Beneficiary Co-Insurance. |
| Anchor Allowed Amount in Real Dollars | ANCHOR_ALLOWED_AMT | NUM | 16.2 | Numeric | Total raw allowed amount associated with the IP stay or OP claim anchoring an episode. Allowed amount is the sum of the Medicare Paid Amount, Beneficiary Deductible, and Beneficiary Co-Insurance. |
| Anchor Scaled Allowed Amount in Standardized Dollars (After Scaling) | SC_ANCHOR_STANDARD_ALLOWED_AMT | NUM | 16.2 | Numeric | Total standardized allowed amount associated with the IP stay or OP claim anchoring an episode after the scaling factor is applied |
| Total Standardized Allowed Amount of the Episode (After Scaling but Before Winsorization) | SC_TOT_STD_ALLOWED | NUM | 16.2 | Numeric | Total standardized allowed amount of the clinical episode after scaling is applied but before winsorization |
| Total Raw Allowed Amount of the Episode (Before Scaling or Winsorization) | SC_TOT_RAW_ALLOWED | NUM | 16.2 | Numeric | Total raw allowed amount of the clinical episode, before scaling or winsorization is applied. The raw allowed amounts are not used in target price calculations. "SC" in the variable name is for consistency with standardized allowed amount variable. |
| Total Standardized Allowed Amount of the Episode (After Scaling) In the OP setting | SC_TOT_STD_ALLOWED_OPL | NUM | 16.2 | Numeric | Total standardized allowed amount of the clinical episode in the OP setting (after the scaling factor is applied) |
| Total Standardized Allowed Amount of the | SC_TOT_STD_ALLOWED_IP | NUM | 16.2 | Numeric | Total standardized allowed amount of the clinical episode in the IP setting (after the scaling factor is applied) |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| Episode (After Scaling) In the IP setting | | | | | |
| Total Standardized Allowed Amount of the Episode In the DME setting | SC_TOT_STD_ALLOWED_DM | NUM | 16.2 | Numeric | Total standardized allowed amount of the clinical episode in the Durable Medicare Equipment (DME) setting. Scaling is not applicable to DME claims. "SC" in the variable name is for consistency with IP and OP settings. |
| Total Standardized Allowed Amount of the Episode In the Carrier setting | SC_TOT_STD_ALLOWED_PB | NUM | 16.2 | Numeric | Total standardized allowed amount of the clinical episode in the Carrier Claims (PB) setting. Scaling is not applicable to PB claims. "SC" in the variable name is for consistency with IP and OP settings. |
| Total Standardized Allowed Amount of the Episode In the SNF setting | SC_TOT_STD_ALLOWED_SN | NUM | 16.2 | Numeric | Total standardized allowed amount of the clinical episode in the Skilled Nursing Facility (SNF) setting. Scaling is not applicable to SNF claims. "SC" in the variable name is for consistency with IP and OP settings. |
| Total Standardized Allowed Amount of the Episode In the Hospice setting | SC_TOT_STD_ALLOWED_HS | NUM | 16.2 | Numeric | Total standardized allowed amount of the clinical episode in Hospice (HS) setting. Scaling is not applicable to HS claims. "SC" in the variable name is for consistency with IP and OP settings. |
| Total Standardized Allowed Amount of the Episode In the Home Health setting | SC_TOT_STD_ALLOWED_HH | NUM | 16.2 | Numeric | Total standardized allowed amount of the clinical episode in Home Health (HH) non-Request for Anticipated Payment (non-RAP) setting. Scaling is not applicable to HH claims. "SC" in the variable name is for consistency with IP and OP settings. |
| Winsorization (i.e., Capping) Indicator | WINSORIZE_EPI_99 | NUM | 1 | Numeric | Indicates whether an episode underwent winsorization at the 99th percentile i.e., if the episode's spending was capped at the 99th percentile |
| Total Standardized Allowed Amount of the Episode (After Scaling and Winsorization) | EPI_STD_PMT_FCTR_WIN_99 | NUM | 16.2 | Numeric | Episode standardized allowed amount after the scaling factor is applied and after winsorization at the 99th percentile. This value will be the same as the TOT_STD_ALLOWED if WINSORIZE_EPI_99 = 0. |
| OP Episode Anchor Claim Number | ANCHOR_CLAIMNO | CHAR | 32 | Alphanumeric | Indicate the corresponding claim number in the OP claim file that was used to trigger the episode |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| OP Episode Anchor Line Item | ANCHOR_CLM_LINE_NUM | NUM | 16 | Numeric | Indicates the corresponding line item in the OP claim file that was used to trigger the episode |
| Anchor Stay ID | ANCHOR_STAY_ID | NUM | 16 | Numeric | Inpatient stay identifier that is used to construct the anchor hospitalization. This will match the IP_stay_ID in the IP file. |
| Age Group Flag - Under 65 | AGE_UNDER_65 | NUM | 1 | Numeric | Equals 1 if the beneficiary falls under the age group bucket of beneficiaries less than 65 years old, 0 otherwise |
| Age Group Flag - 65 to 74 | AGE_65_74 | NUM | 1 | Numeric | Equals 1 if the beneficiary falls under the age group bucket of beneficiaries from 65 to 74 years old, 0 otherwise |
| Age Group Flag - 75 to 84 | AGE_75_84 | NUM | 1 | Numeric | Equals 1 if the beneficiary falls under the age group bucket of beneficiaries from 75 to 84 years old, 0 otherwise |
| Age Group Flag - 85 and older | AGE_85_PLUS | NUM | 1 | Numeric | Equals 1 if the beneficiary falls under the age group bucket of beneficiaries 85 years old or older, 0 otherwise |
| Medicare/Medicaid Dual Eligibility Indicator | ANY_DUAL | NUM | 1 | Numeric | Equals 1 if the beneficiary has either full Medicare and Medicaid dual enrollment status, 0 otherwise |
| Low Income Subsidy Indicator | LIS | NUM | 1 | Numeric | Equals 1 if the beneficiary receives Low Income Subsidy Copayment (LIS), 0 otherwise |
| National Community Deprivation Index Indicator | NATIONAL_CDI_FLAG | NUM | 1 | Numeric | Equals 1 if the beneficiary's address is in a census block group with national Community Deprivation Index (CDI) ranking > 80, 0 otherwise |
| Beneficiary Economic Indicator | BENE_ECON_FLAG | NUM | 1 | Numeric | Equals 1 if ANY_DUAL=1 or LIS=1 or National_CDI=1, 0 otherwise |
| ORIGDS | ORIGDS | NUM | 1 | Numeric | Equals 1 if the beneficiary was originally enrolled in Medicare due to disability, 0 otherwise. Applicable to the MS-LEJR episode type only |
| Long Term Institutionalization | LTI | NUM | 1 | Numeric | Equals 1 if the beneficiary was enrolled in long-term institutional care in the 180 days pre-clinical episode period, 0 otherwise. Applicable to IP-Major Bowel Procedure episode type only. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| Prior Post Acute Care | PRIOR_PAC_FLAG | NUM | 1 | Numeric | Equals 1 if the beneficiary had any IP, LTCH, SN, HH, or IRF stay in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR and MS-Spinal Fusion episode types only. |
| Total Hip Arthroplasty or Hip Resurfacing | THA_HIP_RESURF | NUM | 1 | Numeric | Equals 1 if the anchor hospitalization or procedure of a MS-LEJR clinical episode has a procedure code for total hip arthroplasty or hip resurfacing procedure, 0 otherwise |
| Partial Hip Procedure | PARTIAL_HIP | NUM | 1 | Numeric | Equals 1 if the anchor hospitalization or procedure of a MS-LEJR clinical episode has a procedure code for partial hip procedure, 0 otherwise |
| Partial Knee Arthroplasty | PARTIAL_KA | NUM | 1 | Numeric | Equals 1 if the anchor hospitalization or procedure of a MS-LEJR clinical episode has a procedure code for partial knee arthroplasty, 0 otherwise |
| Total Knee Arthroplasty | TKA | NUM | 1 | Numeric | Equals 1 if the anchor hospitalization or procedure of a MS-LEJR clinical episode has a procedure code for total knee arthroplasty, 0 otherwise |
| Ankle Procedures or Reattachments | ANKLE_REATTACH_OTHER | NUM | 1 | Numeric | Equals 1 if the anchor hospitalization or procedure of a MS-LEJR clinical episode has a procedure code for ankle procedures or reattachments or other procedures, 0 otherwise |
| HCC Count Indicator - 0 HCCs | HCC_0 | NUM | 1 | Numeric | Indicates if the beneficiary has zero Hierarchical Condition Category (HCC) based on the diagnosis codes and hierarchy created under the v28 HCC model. CMS takes all HCCs applicable to a beneficiary into consideration in creating this flag, not just the specific HCC risk-adjuster variables available in the episode files. |
| HCC Count Indicator - 1 HCC | HCC_1 | NUM | 1 | Numeric | Indicates if the beneficiary has only one HCC based on the diagnosis codes and hierarchy created under the v28 HCC model. CMS takes all HCCs applicable to a beneficiary into consideration in creating this flag, not just the specific HCC risk-adjuster variables available in the episode files. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| HCC Count Indicator - 2 HCCs | HCC_2 | NUM | 1 | Numeric | Indicates if the beneficiary has only two HCCs based on the diagnosis codes and hierarchy created under the v28 HCC model. CMS takes all HCCs applicable to a beneficiary into consideration in creating this flag, not just the specific HCC risk-adjuster variables available in the episode files. |
| HCC Count Indicator - 3 HCCs | HCC_3 | NUM | 1 | Numeric | Indicates if the beneficiary has only three HCCs based on the diagnosis codes and hierarchy created under the v28 HCC model. CMS takes all HCCs applicable to a beneficiary into consideration in creating this flag, not just the specific HCC risk-adjuster variables available in the episode files. |
| HCC Count Indicator - 4 + HCCs | HCC_4_PLUS | NUM | 1 | Numeric | Indicates if the beneficiary has four HCCs or more based on the diagnosis codes and hierarchy created under the v28 HCC model. CMS takes all HCCs applicable to a beneficiary into consideration in creating this flag, not just the specific HCC risk-adjuster variables available in the episode files. |
| HCC 17 | HCC17 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has cancer metastatic to lung, liver, brain, and other organs; acute myeloid leukemia except promyelocytic in the 180-days pre-Clinical Episode period, 0 otherwise. Applicable to MS-LEJR, IP-Major Bowel Procedure, and MS-Spinal Fusion episode types only. |
| HCC 18 | HCC18 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has cancer metastatic to bone, other and unspecified metastatic cancer; acute leukemia except myeloid in the 180-days pre-Clinical Episode period, 0 otherwise. Applicable to MS-Spinal Fusion episode type only. |
| HCC 22 | HCC22 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has bladder, colorectal, and other cancers in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-Major Bowel Procedure episode type only. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| HCC 36 | HCC36 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has diabetes with severe acute complications in the 180-days pre-clinical episode period, 0 otherwise. Applicable to MS-LEJR and IP-SHFFT episode types only. |
| HCC 37 | HCC37 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has diabetes with chronic complications in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, IP-Major Bowel Procedure, IP-SHFFT, and MS-Spinal Fusion episode types. |
| HCC 38 | HCC38 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has diabetes with glycemic, unspecified, or no complications in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-SHFFT episode type only. |
| HCC 48 | HCC48 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has morbid obesity in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, IP- Major Bowel Procedure, IP-SHFFT, and MS-Spinal Fusion episode types. |
| HCC 63 | HCC63 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has chronic liver failure/end-stage liver disorders in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-SHFFT episode type only. |
| HCC 78 | HCC78 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has intestinal obstruction/perforation in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-Major Bowel Procedure episode type only. |
| HCC 93 | HCC93 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has rheumatoid arthritis and other specified inflammatory rheumatic disorders in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-SHFFT and MS-Spinal Fusion episode types only. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| HCC 109 | HCC109 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has acquired hemolytic, aplastic, and sideroblastic anemias in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-SHFFT episode type only. |
| HCC 125 | HCC125 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has dementia (severe) in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, IP-Major Bowel Procedure, IP-SHFFT, and MS-Spinal Fusion episode types. |
| HCC 126 | HCC126 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has dementia (moderate) in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, IP-Major Bowel Procedure, IP-SHFFT, and MS-Spinal Fusion episode types. |
| HCC 127 | HCC127 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has dementia (mild or unspecified) in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, IP-Major Bowel Procedure, IP-SHFFT, and MS-Spinal Fusion episode types. |
| HCC 151 | HCC151 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has schizophrenia in the 180-days pre-clinical episode period, 0 otherwise. Applicable to MS-LEJR and IP-Major Bowel Procedure episode types only. |
| HCC 155 | HCC155 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has major depression, moderate or severe, without psychosis in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, IP-Major Bowel Procedure, and MS-Spinal Fusion episode types only. |
| HCC 180 | HCC180 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has quadriplegia in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-SHFFT and MS-Spinal Fusion episode types only. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| HCC 181 | HCC181 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has paraplegia in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-SHFFT and MS-Spinal Fusion episode types only. |
| HCC 182 | HCC182 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has spinal cord disorders/injuries in the 180-days pre-clinical episode period, 0 otherwise. Applicable to MS-Spinal Fusion episode type only. |
| HCC 191 | HCC191 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has quadriplegic cerebral palsy in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-SHFFT episode type only. |
| HCC 192 | HCC192 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has cerebral palsy, except quadriplegic in the 180-days pre-clinical episode period, 0 otherwise. Applicable to MS-Spinal Fusion episode type only. |
| HCC 193 | HCC193 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has chronic inflammatory demyelinating polyneuritis and multifocal motor neuropathy in the 180-days pre-clinical episode period, 0 otherwise. Applicable to MS-Spinal Fusion episode type only. |
| HCC 198 | HCC198 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has multiple sclerosis in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-SHFFT episode type only. |
| HCC 199 | HCC199 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has Parkinson and other degenerative disease of basal ganglia in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, IP- Major Bowel Procedure, IP-SHFFT, and MS-Spinal Fusion episode types. |
| HCC 201 | HCC201 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has seizure disorders and convulsions in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP- Major Bowel Procedure episode type only. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| HCC 211 | HCC211 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has respirator dependence/tracheostomy status/complications in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP- Major Bowel Procedure and IP-SHFFT episode types only. |
| HCC 213 | HCC213 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has cardio-respiratory failure and shock in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, IP- Major Bowel Procedure, and IP-SHFFT episode types only. |
| HCC 224 | HCC224 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has acute chronic heart failure in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, IP- Major Bowel Procedure, and MS-Spinal Fusion episode types only. |
| HCC 225 | HCC225 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has acute heart failure (excludes acute on chronic) in the 180-days pre-clinical episode period, 0 otherwise. Applicable to MS-LEJR episode type only. |
| HCC 226 | HCC226 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has heart failure, except end-stage and acute in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, IP- Major Bowel Procedure, IP-SHFFT episode types, and MS-Spinal Fusion episode types. |
| HCC 228 | HCC228 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has acute myocardial infarction in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG episode type only. |
| HCC 229 | HCC229 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has unstable angina and other acute ischemic heart disease in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG episode type only. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| HCC 238 | HCC238 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has specified heart arrhythmias in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, IP- Major Bowel Procedure, IP-SHFFT, and MS-Spinal Fusion episode types. |
| HCC 249 | HCC249 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has ischemic or unspecified stroke in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, IP-SHFFT, and MS-Spinal Fusion episode types only. |
| HCC 253 | HCC253 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has hemiplegia/hemiparesis in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, IP- Major Bowel Procedure, IP-SHFFT, and MS-Spinal Fusion episode types. |
| HCC 254 | HCC254 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has monoplegia, other paralytic syndromes in the 180-days pre-clinical episode period, 0 otherwise. Applicable to MS-Spinal Fusion episode type only. |
| HCC 263 | HCC263 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has atherosclerosis of arteries of the extremities with ulceration or gangrene in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG episode type only. |
| HCC 267 | HCC267 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has deep vein thrombosis and pulmonary embolism in the 180-days pre-clinical episode period, 0 otherwise. Applicable to MS-LEJR, IP-Major Bowel Procedure, and MS-Spinal Fusion episode types only. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| HCC 280 | HCC280 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has chronic obstructive pulmonary disease, interstitial lung disorders, and other chronic lung disorders in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, IP-Major Bowel Procedure, and IP-SHFFT episode types only. |
| HCC 298 | HCC298 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has severe diabetic eye disease, retinal vein occlusion, and vitreous hemorrhage in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG episode type only. |
| HCC 326 | HCC326 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has chronic kidney disease, stage 5 in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, IP-Major Bowel Procedure, IP-SHFFT, and MS-Spinal Fusion episode types. |
| HCC 327 | HCC327 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has chronic kidney disease, severe (stage 4) in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, and IP- Major Bowel Procedure episode types only. |
| HCC 383 | HCC383 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has chronic ulcer of skin, except pressure, not specified as through to bone or muscle in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG, MS-LEJR, IP-Major Bowel Procedure, IP-SHFFT, and MS-Spinal Fusion episode types. |
| HCC 401 | HCC401 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has vertebral fractures without spinal cord injury in the 180-days pre-clinical episode period, 0 otherwise. Applicable to MS-Spinal Fusion episode type only. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| HCC 402 | HCC402 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has hip fracture/dislocation in the 180-days pre-clinical episode period, 0 otherwise. Applicable to MS-LEJR and IP-SHFFT episode types only. |
| HCC 409 | HCC409 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has amputation status, lower limb/amputation complications in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-CABG episode type only. |
| HCC 463 | HCC463 | NUM | 1 | Numeric | Equals 1 if the Medicare claims indicate that the beneficiary has artificial openings for feeding or elimination in the 180-days pre-clinical episode period, 0 otherwise. Applicable to IP-Major Bowel Procedure episode type only. |
| **Inpatient (IP) stay file** | | | | | |
| Episode ID | EPISODE_ID | NUM | 16 | Numeric | Unique clinical episode identifier |
| Enrollment Database Beneficiary ID | BENE_SK | NUM | 16 | Alphanumeric | A unique number assigned by the Enrollment Data Base (EDB) to each EDB record to identify a beneficiary. |
| Medicare Beneficiary Identifier | BENE_MBI_ID | CHAR | 11 | Alphanumeric | Unique Medicare Beneficiary Identifier (MBI) |
| IP Stay Admission Date | CLM_ACTV_CARE_FROM_DT | DATE | 10 | YYYY-MM-DD | On an institutional claim, the date the beneficiary was admitted |
| IP Stay Discharge Date | CLM_DSCHRG_DT | DATE | 10 | YYYY-MM-DD | The date the beneficiary was discharged from the facility or died |
| IP Stay Start Date | CLM_FROM_DT | DATE | 10 | YYYY-MM-DD | First day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date') |
| IP Stay End Date | CLM_THRU_DT | DATE | 10 | YYYY-MM-DD | Last day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers Thru Date') |
| Provider CCN | CLM_BLG_PRVDR_OSCAR_NUM | NUM | 6 | Alphanumeric | Medicare Provider Number of the hospital anchoring the episode |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| Attending National Provider Identifier (NPI) | CLM_ATNDG_PRVDR_NPI_NUM | CHAR | 10 | Alphanumeric | Attending physician's National Provider Identifier (NPI) associated with the IP hospitalization |
| Operating National Provider Identifier (NPI) | CLM_OPRTG_PRVDR_NPI_NUM | CHAR | 10 | Alphanumeric | Operating physician's National Provider Identifier (NPI) associated with the IP hospitalization |
| IP Stay MS-DRG Code | DGNS_DRG_CD | CHAR | 3 | Numeric | Diagnosis Related Group Code on the IP claim |
| Diagnosis Codes | CLM_DGNS_CD01-CLM_DGNS_CD25 | CHAR | 7 | Alphanumeric | Primary and Secondary Diagnosis Codes |
| Procedure Codes | CLM_PRCDR_CD01-CLM_PRCDR_CD25 | CHAR | 7 | Alphanumeric | Procedure Codes |
| Patient Discharge Status Code | BENE_PTNT_STUS_CD | CHAR | 2 | Numeric | A code identifying where the patient is at the conclusion of a health care facility encounter or at the end of a billing cycle (the 'through' date of a claim) |
| Inpatient Stay ID | IP_STAY_ID | CHAR | 16 | Alphanumeric | Unique inpatient stay identifier |
| IP Stay Medicare Payment Amount | STAY_PMT_AMT | NUM | 16.2 | Numeric | Total Stay Payment Amount i.e. amount paid by Medicare for the stay |
| Total Raw Allowed Amount (Before Scaling or Proration) | CLM_RAW_ALOWD_AMT | NUM | 16.2 | Numeric | Total Raw Allowed Amount before scaling or proration |
| Total Standardized Allowed Amount (Before Scaling or Proration) | CLM_STD_ALOWD_AMT | NUM | 16.2 | Numeric | Total Standardized Allowed Amount before scaling or proration |
| Total Standardized Allowed Amount (After Scaling and Proration) | CLM_FINAL_STD_ALOWD_AMT | NUM | 16.2 | Numeric | Total Standardized Allowed Amount after scaling and proration included as part of the clinical episode observed spending |
| Patient Claim Control Number | CLM_PTNT_CNTL_NUM | CHAR | 80 | Alphanumeric | Unique alphanumeric identifier assigned by the provider to the institutional claim to facilitate retrieval of individual case records and posting of payment |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| Claim Inpatient Admission Source Code | CLM_ADMSN_SRC_CD | CHAR | 2 | Alphanumeric | Claim Source Inpatient Admission Code: indicates the means by which the beneficiary was admitted to the inpatient health care facility |
| Claim Admission Diagnosis Code | CLM_ADMTG_DGNS_CD | CHAR | 7 | Alphanumeric | The diagnosis code provided at time of admission |
| Claim Inpatient Admission Type Code | CLM_ADMSN_TYPE_CD | CHAR | 2 | Alphanumeric | Claim Inpatient Admission Type Code: indicates the type of inpatient admission |
| **Outpatient (OP) lines file** | | | | | |
| Episode ID | EPISODE_ID | NUM | 16 | Numeric | Unique clinical episode identifier |
| Enrollment Database Beneficiary ID | BENE_SK | CHAR | 16 | Alphanumeric | A unique number assigned by the Enrollment Data Base (EDB) to each EDB record to identify a beneficiary. |
| Medicare Beneficiary Identifier | BENE_MBI_ID | CHAR | 11 | Alphanumeric | Unique Medicare Beneficiary Identifier (MBI) |
| OP Claim Number | CLAIMNO | CHAR | 32 | Alphanumeric | Unique OP claim identifier |
| OP Line Item | CLM_LINE_NUM | NUM | 16 | Numeric | OP Line item number within a claim |
| OP Claim Line From Date | CLM_FROM_DT | DATE | 10 | YYYY-MM-DD | First day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date') |
| OP Claim Line Thru date | CLM_THRU_DT | DATE | 10 | YYYY-MM-DD | Last day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers Thru Date') |
| Revenue Center Code | CLM_LINE_REV_CTR_CD | CHAR | 4 | Alphanumeric | A unique identifier of a Uniform Billing Revenue Type. The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). |
| Revenue Center Date | CLM_LINE_INSTNL_REV_CTR_DT | DATE | 10 | YYYY/MM/DD | The date that applies to the service associated with the Revenue Center code |
| Revenue Center Status Indicator | CLM_REV_CNTR_STUS_CD | CHAR | 2 | Alphanumeric | Code used to identify the status of the line item service. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| Attending National Provider Identifier (NPI) | CLM_ATNDG_PRVDR_NPI_NUM | CHAR | 10 | Alphanumeric | Claim Attending Physician NPI Number |
| Operating National Provider Identifier (NPI) | CLM_OPRTG_PRVDR_NPI_NUM | CHAR | 10 | Alphanumeric | Claim Operating Physician NPI Number |
| Provider Number | CLM_BLG_PRVDR_OSCAR_NUM | CHAR | 6 | Alphanumeric | Medicare Provider Number |
| Healthcare Common Procedure Coding System (HCPCS) Code | CLM_LINE_HCPCS_CD | CHAR | 5 | Alphanumeric | A code identifying a HCPCS procedure, supply, product, or service provided to a Medicare beneficiary |
| Line Medicare Payment Amount | CLM_LINE_CVRD_PD_AMT | NUM | 16.2 | Numeric | Total Line Medicare Payment Amount i.e., amount paid by Medicare on an adjudicated line-item |
| Line Raw Allowed Amount (Before Scaling or Proration) | CLM_LINE_RAW_ALOWD_AMT | NUM | 16.2 | Numeric | Total Line Raw Allowed Amount before scaling or proration. Allowed amount is the sum of the Medicare Payment Amount, Beneficiary Deductible, and Beneficiary Co-Insurance/Co-Pay. |
| Line Standardized Allowed Amount (Before Scaling or Proration) | CLM_LINE_STD_ALOWD_AMT | NUM | 16.2 | Numeric | Total Line Standardized Allowed Amount before scaling or proration |
| Line Standardized Allowed Amount (After Scaling and Proration) | CLM_LINE_FINAL_STD_ALOWD_AMT | NUM | 16.2 | Numeric | Total Line Standardized Allowed Amount after scaling and proration included as part of the clinical episode observed spending |
| Revenue Center Beneficiary Payment Amount | CLM_LINE_BENE_PD_AMT | NUM | 16.2 | Numeric | Payment made to a beneficiary for a detail line of service |
| Diagnosis Codes | CLM_DGNS_CD01-CLM_DGNS_CD25 | CHAR | 7 | Alphanumeric | Primary and Secondary Diagnosis Codes |
| **Durable medical equipment (DME) lines file** | | | | | |
| Episode ID | EPISODE_ID | NUM | 16 | Numeric | Unique clinical episode identifier |
| Enrollment Database Beneficiary ID | BENE_SK | CHAR | 15 | Alphanumeric | A unique number assigned by the Enrollment Data Base (EDB) to each EDB record to identify a beneficiary. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| Medicare Beneficiary Identifier | BENE_MBI_ID | CHAR | 11 | Alphanumeric | Unique Medicare Beneficiary Identifier (MBI) |
| DME Claim Number | CLAIMNO | CHAR | 32 | Alphanumeric | Unique DME claim identifier |
| DME Line Item | CLM_LINE_NUM | NUM | 16 | Numeric | DME Line item number within a claim |
| DME Claim Line From Date | CLM_FROM_DT | DATE | 10 | YYYY-MM-DD | First day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date') |
| DME Claim Line Thru date | CLM_THRU_DT | DATE | 10 | YYYY-MM-DD | Last day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers Thru Date') |
| Line First Expense Date | CLM_LINE_FROM_DT | DATE | 10 | YYYY-MM-DD | Beginning date (first expense) for this line item service |
| Line Last Expense Date | CLM_LINE_THRU_DT | DATE | 10 | YYYY-MM-DD | Ending date (last expense) for this line item service |
| Claim Rendering Provider NPI Number | CLM_RNDRG_PRVDR_NPI_NUM | CHAR | 10 | Alphanumeric | National Provider Identifier assigned to the supplier of the Part B service/DMEPOS line item |
| Claim Rendering Provider Tax Number | CLM_RNDRG_PRVDR_TAX_NUM | NUM | 10 | Numeric | The federal taxpayer identification number (TIN) that identifies the physician/practice/supplier to whom payment is made for the line-item service. This number may be an employer identification number (EIN) or social security number (SSN). |
| Healthcare Common Procedure Coding System (HCPCS) Code | CLM_LINE_HCPCS_CD | CHAR | 5 | Alphanumeric | A code identifying a HCPCS procedure, supply, product, or service provided to a Medicare beneficiary |
| Line Medicare Payment Amount | CLM_PMT_AMT | NUM | 16.2 | Numeric | Total Line Payment Amount i.e. amount paid by Medicare on an adjudicated line-item |
| Line Raw Allowed Amount (Before Proration) | CLM_LINE_RAW_ALOWD_AMT | NUM | 16.2 | Numeric | Total Line Raw Allowed Amount before proration. Allowed amount is the sum of the Medicare Payment Amount, Beneficiary Deductible, and Beneficiary Co-Insurance/Co-Pay. Scaling is not applicable to DME claims. |
| Line Standardized Allowed Amount (Before Proration) | CLM_LINE_STD_ALOWD_AMT | NUM | 16.2 | Numeric | Total Line Standardized Allowed Amount before proration. Scaling is not applicable to DME claims. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| Line Standardized Allowed Amount (After Proration) | CLM_LINE_FINAL_STD_ALOWD_AMT | NUM | 16.2 | Numeric | Total Line Standardized Allowed Amount after proration included as part of the clinical episode observed spending. Scaling is not applicable to DME claims. |
| Diagnosis Codes | CLM_DGNS_CD01-CLM_DGNS_CD12 | CHAR | 7 | Alphanumeric | Primary and Secondary Diagnosis Codes |
| Line Diagnosis Code | CLM_LINE_DGNS_CD | CHAR | 7 | Alphanumeric | Code indicating the diagnosis supporting this line item procedure/service on the non-institutional claim |
| **Home Health (HH) claims file** | | | | | |
| Episode ID | EPISODE_ID | NUM | 16 | Numeric | Unique clinical episode identifier |
| Enrollment Database Beneficiary ID | BENE_SK | NUM | 16 | Numeric | A unique number assigned by the Enrollment Data Base (EDB) to each EDB record to identify a beneficiary. |
| Medicare Beneficiary Identifier | BENE_MBI_ID | CHAR | 11 | Alphanumeric | Unique Medicare Beneficiary Identifier (MBI) |
| HH Claim Number | CLAIMNO | CHAR | 32 | Alphanumeric | Unique HH claim identifier |
| Segment Number | SGMT_NUM | NUM | 16 | Numeric | Segment number of the claim |
| HH From Date | CLM_FROM_DT | DATE | 10 | YYYY-MM-DD | First day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date') |
| HH Thru Date | CLM_THRU_DT | DATE | 10 | YYYY-MM-DD | Last day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers Thru Date') |
| Provider Number | CLM_BLG_PRVDR_OSCAR_NUM | CHAR | 6 | Alphanumeric | Medicare Provider Number |
| Healthcare Common Procedure Coding System (HCPCS) Code | CLM_LINE_HCPCS_CD01-CLM_LINE_HCPCS_CD45 | CHAR | 5 | Alphanumeric | A code identifying a HCPCS procedure, supply, product, or service provided to a Medicare beneficiary |
| Medicare Claim Payment Amount | CLM_PMT_AMT | Currency | 16.2 | Currency | Claim Payment Amount i.e. amount paid by Medicare on an adjudicated claim |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| Revenue Center Non-Covered Charge Amount | CLM_LINE_NCVRD_CHRG_AMT01-CLM_LINE_NCVRD_CHRG_AMT45 | Currency | 16.2 | Currency | The charge amount related to a revenue center code for services that are not covered by Medicare |
| Revenue Center Total Charge Amount | CLM_LINE_SBMT_CHRG_AMT01-CLM_LINE_SBMT_CHRG_AMT45 | Currency | 16.2 | Currency | Line total charges submitted by the provider |
| Revenue Center Code | CLM_LINE_REV_CNTR_CD01-CLM_LINE_REV_CNTR_CD45 | CHAR | 4 | Alphanumeric | A unique identifier of a Uniform Billing Revenue Type |
| Revenue Center Date | CLM_LINE_INSTNL_REV_CTR_DT01-CLM_LINE_INSTNL_REV_CTR_DT45 | DATE | 10 | YYYY-MM-DD | The date that applies to the service associated with the Revenue Center code |
| Revenue Center Unit Count | CLM_LINE_SRVC_UNIT_QTY01-CLM_LINE_SRVC_UNIT_QTY45 | NUM | 16 | Numeric | The number of dosage units of the medication that were dispensed in this fill. The unit being a precisely specified quantity in terms of which the magnitudes of other quantities of the same kind can be stated. |
| Claim HHA Low Utilization Payment Adjustment (LUPA) Indicator Code | CLM_HHA_LUP_IND_CD | CHAR | 1 | Alphanumeric | Low-Utilization Payment Adjustment (LUPA) Indicator Code |
| Claim Pricer Return Code | CLM_PRCR_RTRN_CD | CHAR | 2 | Alphanumeric | Pricer Return Code - determines the payment to be made. |
| Claim Raw Allowed Amount (Before Proration) | CLM_RAW_ALOWD_AMT | NUM | 16.2 | Numeric | Total Raw Allowed Amount before proration. Allowed amount is the sum of the Medicare Payment Amount, Beneficiary Deductible, and Beneficiary Co-Insurance/Co-Pay. Scaling is not applicable to HH claims. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| Claim Standardized Allowed Amount (Before Proration) | CLM_STD_ALOWD_AMT | NUM | 16.2 | Numeric | Total Standardized Allowed Amount before proration. Scaling is not applicable to HH claims. |
| Claim Standardized Allowed Amount (After Proration) | CLM_FINAL_STD_ALOWD_AMT | NUM | 16.2 | Numeric | Total Standardized Allowed Amount after proration included as part of the clinical episode observed spending. Scaling is not applicable to HH claims. |
| Diagnosis Codes | CLM_DGNS_CD01-CLM_DGNS_CD25 | CHAR | 7 | Alphanumeric | Primary and Secondary Diagnosis Codes |
| **Hospice (HS) claims file** | | | | | |
| Episode ID | EPISODE_ID | NUM | 16 | Numeric | Unique clinical episode identifier |
| Enrollment Database Beneficiary ID | BENE_SK | NUM | 16 | Alphanumeric | A unique number assigned by the Enrollment Data Base (EDB) to each EDB record to identify a beneficiary. |
| Medicare Beneficiary Identifier | BENE_MBI_ID | CHAR | 11 | Alphanumeric | Unique Medicare Beneficiary Identifier (MBI) |
| Hospice Claim Number | CLAIMNO | CHAR | 32 | Alphanumeric | Unique HS claim identifier |
| Segment Number | SGMT_NUM | NUM | 16 | Alphanumeric | Segment number of the claim |
| Claim Demonstration Identification Number 1 | CLM_DEMO_1ST_NUM | CHAR | 2 | Alphanumeric | CMS demonstration project identifier #1 |
| Claim Demonstration Identification Number 2 | CLM_DEMO_2ND_NUM | CHAR | 2 | Alphanumeric | CMS demonstration project identifier #2 |
| Claim Demonstration Identification Number 3 | CLM_DEMO_3RD_NUM | CHAR | 2 | Alphanumeric | CMS demonstration project identifier #3 |
| Claim Demonstration Identification Number 4 | CLM_DEMO_4TH_NUM | CHAR | 2 | Alphanumeric | CMS demonstration project identifier #4 |
| Claim Demonstration Identification Number 5 | CLM_DEMO_5TH_NUM | CHAR | 2 | Alphanumeric | CMS demonstration project identifier #5 |
| Claim Facility Type Code | CLM_BILL_FAC_TYPE_CD | CHAR | 1 | Numeric | A code identifying the type of facility that provided care to a beneficiary on an institutional claim. |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| Claim From Date | CLM_FROM_DT | DATE | 10 | YYYY-MM-DD | First day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date') |
| Claim Through Date | CLM_THRU_DT | DATE | 10 | YYYY-MM-DD | Last day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers Thru Date') |
| Provider Number | CLM_BLG_PRVDR_OSCAR_NUM | CHAR | 6 | Alphanumeric | Medicare Provider Number |
| Medicare Claim Payment Amount | CLM_PMT_AMT | NUM | 16.2 | Numeric | Total Claim Payment Amount i.e. amount paid by Medicare on an adjudicated claim |
| Claim Raw Allowed Amount (Before Proration) | CLM_RAW_ALOWD_AMT | NUM | 16.2 | Numeric | Total Raw Allowed Amount before proration. Allowed amount is the sum of the Medicare Payment Amount, Beneficiary Deductible, and Beneficiary Co-Insurance/Co-Pay. Scaling is not applicable to HS claims. |
| Claim Standardized Allowed Amount (Before Proration) | CLM_STD_ALOWD_AMT | NUM | 16.2 | Numeric | Total Standardized Allowed Amount before proration. Scaling is not applicable to HS claims. |
| Claim Standardized Allowed Amount (After Proration) | CLM_FINAL_STD_ALOWD_AMT | NUM | 16.2 | Numeric | Total Standardized Allowed Amount after proration included as part of the clinical episode observed spending. Scaling is not applicable to HS claims. |
| Claim Service classification Type Code | CLM_BILL_CLSFCTN_CD | CHAR | 1 | Numeric | A code classifying the type of service provided to a beneficiary on an institutional claim |
| Diagnosis Codes | CLM_DGNS_CD01-CLM_DGNS_CD25 | CHAR | 7 | Alphanumeric | Primary and Secondary Diagnosis Codes |
| **Physician/supplier Part B (PB) lines file** | | | | | |
| Episode ID | EPISODE_ID | NUM | 16 | Numeric | Unique clinical episode identifier |
| Enrollment Database Beneficiary ID | BENE_SK | CHAR | 16 | Alphanumeric | A unique number assigned by the Enrollment Data Base (EDB) to each EDB record to identify a beneficiary. |
| Medicare Beneficiary Identifier | BENE_MBI_ID | CHAR | 11 | Alphanumeric | Unique Medicare Beneficiary Identifier (MBI) |
| Carrier Claim Number | CLAIMNO | CHAR | 32 | Alphanumeric | Unique PB claim identifier |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| Carrier Line Item Number | CLM_LINE_NUM | NUM | 16 | Numeric | Line item within a claim |
| Carrier Claim From Date | CLM_FROM_DT | DATE | 10 | YYYY-MM-DD | First day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date') |
| Carrier Claim Thru date | CLM_THRU_DT | DATE | 10 | YYYY-MM-DD | Last day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers Thru Date') |
| Line First Expense Date | CLM_LINE_FROM_DT | DATE | 10 | YYYY-MM-DD | Beginning date (first expense) for this line item service |
| Line Last Expense Date | CLM_LINE_THRU_DT | DATE | 10 | YYYY-MM-DD | Last date for this line item service |
| Healthcare Common Procedure Coding System (HCPCS) Code | CLM_LINE_HCPCS_CD | CHAR | 5 | Alphanumeric | A code identifying a HCPCS procedure, supply, product, or service provided to a Medicare beneficiary |
| Carrier Line Performing NPI Number | CLM_RNDRG_PRVDR_NPI_NUM | CHAR | 10 | Alphanumeric | Carrier Line Performing NPI Number |
| Line Provider Tax Number | CLM_RNDRG_PRVDR_TAX_NUM | CHAR | 10 | Alphanumeric | The federal taxpayer identification number (TIN) that identifies the physician/practice/supplier to whom payment is made for the line-item service. This number may be an employer identification number (EIN) or social security number (SSN). |
| HCPCS Initial Modifier Code | HCPCS_1_MDFR_CD | CHAR | 2 | Alphanumeric | A code representing the initial modifier to the HCPCS |
| HCPCS Second Modifier Code | HCPCS_2_MDFR_CD | CHAR | 2 | Alphanumeric | A code representing the second modifier to the HCPCS |
| HCPCS Third Modifier Code | HCPCS_3_MDFR_CD | CHAR | 2 | Alphanumeric | A code representing the third modifier to the HCPCS |
| HCPCS Fourth Modifier Code | HCPCS_4_MDFR_CD | CHAR | 2 | Alphanumeric | A code representing the fourth modifier to the HCPCS |
| Line Place of Service Code | CLM_POS_CD | CHAR | 2 | Alphanumeric | Indication of where the service was performed. |
| Line Medicare Payment Amount | CLM_LINE_CVRD_PD_AMT | NUM | 16.2 | Numeric | Total Line Payment Amount i.e. amount paid by Medicare on an adjudicated line-item |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| Line Raw Allowed Amount (Before Proration) | CLM_LINE_RAW_ALOWD_AMT | NUM | 16.2 | Numeric | Total Line Raw Allowed Amount before proration. Allowed amount is the sum of the Medicare Payment Amount, Beneficiary Deductible, and Beneficiary Co-Insurance/Co-Pay. Scaling is not applicable to PB claims. |
| Line Standardized Allowed Amount (Before Proration) | CLM_LINE_STD_ALOWD_AMT | NUM | 16.2 | Numeric | Total Line Standardized Allowed Amount before proration. Scaling is not applicable to PB claims. |
| Line Standardized Allowed Amount (After Proration) | CLM_LINE_FINAL_STD_ALOWD_AMT | NUM | 16.2 | Numeric | Total Line Standardized Allowed Amount after proration included as part of the clinical episode observed spending. Scaling is not applicable to PB claims. |
| Diagnosis Codes | CLM_DGNS_CD01-CLM_DGNS_CD12 | CHAR | 7 | Alphanumeric | Primary and Secondary Diagnosis Codes |
| Line Diagnosis Code | CLM_LINE_DGNS_CD | CHAR | 7 | Alphanumeric | Code indicating the diagnosis supporting this line item procedure/service on the non-institutional claim |
| **Skilled Nursing Facility (SNF) claims file** | | | | | |
| Episode ID | EPISODE_ID | NUM | 16 | Numeric | Unique clinical episode identifier |
| Enrollment Database Beneficiary ID | BENE_SK | CHAR | 16 | Alphanumeric | A unique number assigned by the Enrollment Data Base (EDB) to each EDB record to identify a beneficiary. |
| Medicare Beneficiary Identifier | BENE_MBI_ID | CHAR | 11 | Alphanumeric | Unique Medicare Beneficiary Identifier (MBI) |
| SNF Claim Number | CLAIMNO | CHAR | 32 | Alphanumeric | Unique SNF claim identifier |
| Segment Number | SGMT_NUM | CHAR | 16 | Alphanumeric | Segment number of the claim |
| Beneficiary Admission Date | CLM_ACTV_CARE_FROM_DT | DATE | 10 | YYYY-MM-DD | On an institutional claim, the date the beneficiary was admitted |
| Beneficiary Discharge Date | CLM_DSCHRG_DT | DATE | 10 | YYYY-MM-DD | The date the beneficiary was discharged from the facility or died |
| SNF Claim From Date | CLM_FROM_DT | DATE | 10 | YYYY-MM-DD | First day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date') |

| Episode and Claims Data | | | | | |
|---|---|---|---|---|---|
| Label | Data Element | Type | Length | Format | Description |
| SNF Claim Thru date | CLM_THRU_DT | DATE | 10 | YYYY-MM-DD | Last day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers Thru Date') |
| Provider Number | CLM_BLG_PRVDR_OSCAR_NUM | CHAR | 6 | Alphanumeric | Medicare Provider Number |
| Patient Discharge Status Code | BENE_PTNT_STUS_CD | CHAR | 2 | Alphanumeric | A code identifying where the patient is at the conclusion of a health care facility encounter or at the end of a billing cycle (the 'through' date of a claim) |
| Medicare Claim Payment Amount | CLM_PMT_AMT | NUM | 16.2 | Numeric | Total Claim Payment Amount i.e., amount paid by Medicare on an adjudicated claim |
| Raw Allowed Amount (Before Proration) | CLM_RAW_ALOWD_AMT | NUM | 16.2 | Numeric | Total Raw Allowed Amount before proration. Allowed amount is the sum of the Medicare Payment Amount, Beneficiary Deductible, and Beneficiary Co-Insurance/Co-Pay. Scaling is not applicable to SNF claims. |
| Standardized Allowed Amount (Before Proration) | CLM_STD_ALOWD_AMT | NUM | 16.2 | Numeric | Total Standardized Allowed Amount before proration. Scaling is not applicable to SNF claims. |
| Standardized Allowed Amount (After Proration) | CLM_FINAL_STD_ALOWD_AMT | NUM | 16.2 | Numeric | Total Standardized Allowed Amount after proration included as part of the clinical episode observed spending. Scaling is not applicable to SNF claims. |
| Claim Source Inpatient Admission Code | CLM_ADMSN_SRC_CD | CHAR | 2 | Alphanumeric | The means by which the beneficiary was admitted to the inpatient health care facility or SNF if the type of admission is: (1) emergency, (2) urgent, or (3) elective |
| Claim Inpatient Admission Type Code | CLM_ADMSN_TYPE_CD | CHAR | 2 | Numeric | Claim Inpatient Admission Code Type: indicates the type of SNF admission |
| Claim Admitting Diagnosis Code | CLM_ADMTG_DGNS_CD | CHAR | 7 | Alphanumeric | The diagnosis code provided at time of admission |
| Diagnosis Codes | CLM_DGNS_CD01-CLM_DGNS_CD25 | CHAR | 7 | Alphanumeric | Primary and Secondary Diagnosis Codes |