

Research Data Distribution Center

LDS Home Health Claim Record

Data Dictionary

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

Variable Name

Label

CLM_TYPE

NCH Claim Type Code

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

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

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

DB2 ALIAS: NCH_CLM_TYPE_CD
SAS ALIAS: CLM_TYPE
STANDARD ALIAS: UTLHHAI_NCH_CLM_TYPE_CD
SYSTEM ALIAS: LTTYPER
TITLE ALIAS: CLAIM_TYPE

DERIVATION:

FFS CLAIM TYPE CODES DERIVED FROM:

NCH CLM_NEAR_LINE_RIC_CD
NCH PMT_EDIT_RIC_CD
NCH CLM_TRANS_CD
NCH PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(Pre-HDC processing -- AVAILABLE IN NCH) CLM_MCO_PD_SW
CLM_RLT_COND_CD
MCO_CNTRCT_NUM
MCO_OPTN_CD
MCO_PRD_EFCTV_DT
MCO_PRD_TRMNTN_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(HDC processing -- AVAILABLE IN NMUD)
FI_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED

FROM: (HDC processing -- AVAILABLE IN NMUD)

FI_NUM
CLM_FAC_TYPE_CD
CLM_SRVC_CLSFCTN_TYPE_CD
CLM_FREQ_CD

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

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE

DERIVED FROM:

(AVAILABLE IN NMUD)
CARR_NUM
CLM_DEMO_ID_NUM

OUTPATIENT 'FULL' ENCOUNTER TYPE CODE

DERIVED FROM:

(AVAILABLE IN NMUD)
FI_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE

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

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

STATE_CD

Beneficiary Residence SSA Standard State Code

The SSA standard state code of a beneficiary's residence.

DA3 ALIAS: SSA_STANDARD_STATE_CODE DB2

ALIAS: BENE_SSA_STATE_CD

SAS ALIAS: STATE_CD

STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD

TITLE ALIAS: BENE_STATE_CD

EDIT-RULES:

OPTIONAL: MAY BE BLANK

CODES:

REFER TO: GEO_SSA_STATE_TB

IN THE CODES APPENDIX

COMMENT:

1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement.
2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish.
3. Also used for special studies.

SOURCE:

SSA/EDB

THRU_DT

Claim Through Date

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

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

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

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_THRU_DT

SAS ALIAS: THRU_DT

STANDARD ALIAS: CLM_THRU_DT

TITLE ALIAS: THRU_DATE

EDIT-RULES FOR 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

SOURCE:

CWF

QUERY_CD

Claim Query Code

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

DB2 ALIAS: CLM_QUERY_CD

SAS ALIAS: QUERY_CD

STANDARD ALIAS: CLM_QUERY_CD

TITLE ALIAS: QUERY_CD

CODES:

0 = Credit adjustment

1 = Interim bill

2 = Home Health Agency (HHA) benefits exhausted (obsolete 7/98)

3 = Final bill

4 = Discharge notice (obsolete 7/98)

5 = Debit adjustment

SOURCE:

CWF

PROVIDER

Provider Number

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

DB2 ALIAS: PRVDR_NUM

SAS ALIAS: PROVIDER

STANDARD ALIAS: PRVDR_NUM

TITLE ALIAS: PROVIDER_NUMBER

CODES:

REFER TO: PRVDR_NUM_TB
IN THE CODES APPENDIX

SOURCE:

OSCAR

SGMT_CNT

Claim Total Segment Count

Effective with Version I, the count used to identify the total number of segments associated with a given claim. Each claim could have up to 10 segments.

2 DIGITS UNSIGNED

DB2 ALIAS: TOT_SGMT_CNT

SAS ALIAS: SGMT_CNT

STANDARD ALIAS:

CLM_TOT_SGMT_CNT TITLE ALIAS:

SEGMENT_COUNT SOURCE:

CWF

SGMT_NUM

Claim Segment Number

Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim.

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

For institutional claims prior to 7/00, this number will be either 1 or 2. For 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

PE_RIC

NCH Payment and Edit Record Identification Code

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

TRANS_CD

Claim Transaction Code

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

FAC_TYPE

Claim Facility Type Code

The first digit of the type of bill (TOB1) submitted on an institutional claim used to identify the type of facility that provided care to the beneficiary.

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

CODES:
REFER TO: CLM_FAC_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
CWF

TYPESRVC

Claim Service Classification Type Code

The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification 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:
BENE_RSDNC_SSA_S
TD_CNTY_CD
TITLE ALIAS: BENE_COUNTY_CD

EDIT-RULES:
OPTIONAL: MAY BE BLANK

SOURCE:
SSA/EDB

FI_NUM

FI Number

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

DB2 ALIAS: FI_NUM
SAS ALIAS: FI_NUM
STANDARD ALIAS: FI_NUM
SYSTEM ALIAS: LTFI
TITLE ALIAS: INTERMEDIARY

CODES:
REFER TO: FI_NUM_TB
IN THE CODES APPENDIX

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

SOURCE:
CWF

SEX

Beneficiary Sex Identification Code

The sex of a beneficiary.
COMMON ALIAS: SEX_CD
DA3 ALIAS: SEX_CODE
DB2 ALIAS: BENE_SEX_IDENT_CD
SAS ALIAS: SEX
STANDARD ALIAS:
BENE_SEX_IDENT_CD SYSTEM ALIAS:
LTSEX
TITLE ALIAS: SEX_CD

EDIT-RULES:
REQUIRED FIELD

CODES:
1 = Male
2 = Female
0 = Unknown

SOURCE:
SSA,RRB,EDB

RACE

Beneficiary Race Code

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

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

SOURCE:
SSA

BENE_DOB

Beneficiary Birth Date

The beneficiary's date of birth.
For the Limited Data Set Standard View
of the HHA files, the beneficiary's
date of birth (age) is coded as a range.

8 DIGITS UNSIGNED

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

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

MS_CD

CWF Beneficiary Medicare Status Code

The CWF-derived reason for a beneficiary's entitlement
to Medicare benefits, as of the reference date
(CLM_THRU_DT).

COBOL ALIAS: MSC
COMMON ALIAS: MSC
DB2 ALIAS: BENE_MDCR_STUS_CD
SAS ALIAS: MS_CD
STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD
SYSTEM ALIAS: LTMSC
TITLE ALIAS: MSC

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

DERIVATION:

CWF derives MSC from the following:

1. Date of Birth
2. Claim Through Date
3. Original/Current Reasons for entitlement
4. ESRD Indicator
5. Beneficiary Claim Number

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

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

CODES:

10 = Aged without ESRD

11 = Aged with ESRD

20 = Disabled without ESRD

21 = Disabled with ESRD

31 = ESRD only

COMMENT:

Prior to Version H this field was named:

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

SOURCE:

CWF

PDGNS_CD

Claim Principal Diagnosis Code

The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.

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

DB2 ALIAS: PRNCPAL_DGNS_CD

SAS ALIAS: PDGNS_CD

STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD

TITLE ALIAS: PRINCIPAL_DIAGNOSIS

EDIT-RULES:

ICD-9-CM

SOURCE:

CWF

NOPAY_CD

Claim Medicare Non Payment Reason Code

The reason that no Medicare payment is made for services on an institutional claim.

NOTE: Effective with Version I, this field was put on all institutional claim types.

Prior to Version I, this field was present only on inpatient/SNF claims.

DB2 ALIAS: MDCR_NPMT_RSN_CD

SAS ALIAS: NOPAY_CD

STANDARD ALIAS: CLM_MDCR_NPMT_RSN_CD

SYSTEM ALIAS: LTNPMT

TITLE ALIAS: NON_PAYMENT_REASON

EDIT-RULES:
OPTIONAL

CODES:
REFER TO: CLM_MDCR_NPMT_RSN_TB
IN THE CODES APPENDIX

SOURCE:
CWF

TRTMT_CD

Claim Excepted/Nonexcepted Medical Treatment Code

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

PMT_AMT

Claim Payment Amount

Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. **NOTE: In some situations, a negative claim payment amount may be sent; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid 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 reimbursement reported on the claims may be over or under the actual Medicare payment amount.

PRPAYAMT

NCH Primary Payer Claim Paid Amount

The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that 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

PRPAY_CD

NCH Primary Payer Code

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

DB2 ALIAS: NCH_PRMRY_PYR_CD

SAS ALIAS: PRPAY_CD

STANDARD ALIAS: NCH_PRMRY_PYR_CD

TITLE ALIAS: PRIMARY_PAYER_CD

DERIVATION:

DERIVED FROM:

CLM_VAL_CD

CLM_VAL_AMT

DERIVATION RULES

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

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

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

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

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

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

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

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

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

SET NCH_PRMRY_PYR_CD TO 'L' (or prior to 4/97

set code to 'J') WHERE THE CLM_VAL_CD = '47'

CODES:

REFER TO: BENE_PRMRY_PYR_TB
IN THE CODES APPENDIX

COMMENT:

Prior to Version H this field was named:
BENE_PRMRY_PYR_CD.

SOURCE:

NCH

CANCELCD

FI Requested Claim Cancel Reason Code

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

ACTIONCD

FI Claim Action Code

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

DB2 ALIAS: FI_CLM_ACTN_CD

SAS ALIAS: ACTIONCD

STANDARD ALIAS: FI_CLM_ACTN_CD

TITLE ALIAS: ACTION_CD

CODES:

REFER TO: FI_CLM_ACTN_TB
IN THE CODES APPENDIX

COMMENT:

Prior to Version H this field was named:
INTRMDRY_CLM_ACTN_CD.

SOURCE:

CWF

PRSTATE

NCH Provider State Code

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

NOTE: During the Version H conversion this field was populated with data throughout history (back to service 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 Limited Data Set Standard View of the HHA 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

OP_UPIN

Claim Operating Physician UPIN Number

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

OT_UPIN

Claim Other Physician UPIN Number

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

MCOPDSW

Claim MCO Paid Switch

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

STUS_CD

Patient Discharge Status Code

The code used to identify the status of the patient as of the CLM_THRU_DT.

COMMON ALIAS:

DISCHARGE_DESTINATION/PATIENT_STATUS

DB2 ALIAS: PTNT_DSCHRG_STUS

SAS ALIAS: STUS_CD

STANDARD ALIAS: PTNT_DSCHRG_STUS_CD

SYSTEM ALIAS: LTCLMST

TITLE ALIAS: PTNT_DSCHRG_STUS_CD

CODES:

REFER TO: PTNT_DSCHRG_STUS_TB
IN THE CODES APPENDIX

COMMENT:

Prior to Version H this field was
named: CLM_STUS_CD.

SOURCE:

CWF

DGNS_E

Claim Diagnosis E Code

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

PPS_IND

Claim PPS Indicator Code

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

NOTE: Beginning with NCH weekly process date 10/3/97 through 5/29/98, this field was 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

HHDGNCNT

HHA Claim Diagnosis Code Count

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

2 DIGITS UNSIGNED

DB2 ALIAS: HHA_DGNS_CD_CNT

SAS ALIAS: HHDGNCNT

STANDARD ALIAS: HHA_CLM_DGNS_CD_CNT

EDIT-RULES:

RANGE: 0 TO 10

COMMENT:

Prior to Version H this field was named:

CLM_OTHR_DGNS_CD_CNT and the principal was not included in the count.

SOURCE:

CWF

HHCONCNT

HHA Claim Related Condition Code Count

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

2 DIGITS UNSIGNED

DB2 ALIAS: HHA_COND_CD_CNT

SAS ALIAS: HHCONCNT

STANDARD ALIAS: HHA_CLM_RLT_COND_CD_CNT

EDIT-RULES:

RANGE: 0 TO 30

COMMENT:

Prior to Version H this field was named:

CLM_RLT_COND_CD_CNT.

SOURCE:

CWF

HHOCRCNT

HHA Claim Related Occurrence Code Count

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

2 DIGITS UNSIGNED

DB2 ALIAS: HHA_RLT_OCRNC_CNT

SAS ALIAS: HHOCRCNT

STANDARD ALIAS: HHA_CLM_RLT_OCRNC_CD_CNT

EDIT-RULES:

RANGE: 0 TO 30

COMMENT:

Prior to Version H this field was named:

CLM_RLT_OCRNC_CD_CNT.

SOURCE:

CWF

HHVALCNT

HHA Claim Value Code Count

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

2 DIGITS UNSIGNED

DB2 ALIAS: HHA_CLM_VAL_CD_CNT
SAS ALIAS: HHVALCNT
STANDARD ALIAS: HHA_CLM_VAL_CD_CNT

EDIT-RULES:
RANGE: 0 TO 36

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

SOURCE:
CWF

HHREVCNT

HHA Revenue Center Code Count

The count of the number of revenue codes reported on an HHA claim. The purpose of the count is to indicate revenue center trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: HHA_REV_CNTR_CD_CNT
SAS ALIAS: HHREVCNT
STANDARD ALIAS: HHA_REV_CNTR_CD_I_CNT

EDIT-RULES:
RANGE: 0 TO 45

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

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

SOURCE:
CWF

LUPAIND

Claim HHA Low Utilization Payment Adjustment (LUPA)

Effective with Version I, the code used to identify those Home Health PPS claims that have 4 visits or less in a 60-day episode. If an HHA provides 4 visits or less, they will be reimbursed based on a national standardized per visit rate instead of HHRGs.

NOTE: Beginning 10/1/00, this field will be populated with data. Claims processed prior to 10/1/00 will contain spaces.

DB2 ALIAS: HHA_LUPA_IND_CD
SAS ALIAS: LUPAIND
STANDARD ALIAS: CLM_HHA_LUPA_IND_CD
TITLE ALIAS: HHA_TOT_VISITS

CODES:
L = LUPA Claim
blank = Not a LUPA Claim

SOURCE:
CWF

HHA_RFRL

Claim HHA Referral Code

Effective with Version 'I', the codes used to identify the means by which the beneficiary was referred for Home Health Services.

NOTE: Beginning 10/1/00, this field will be populated with data. Claims processed prior to 10/1/00 will contain spaces in this field.

DB2 ALIAS: CLM_HHA_RFRL_CD
SAS ALIAS: HHA_RFRL
STANDARD ALIAS: CLM_HHA_RFRL_CD
SYSTEM ALIAS: LTHRFRL
TITLE ALIAS: HHA_REFERRAL_CODE

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

VISITCNT

Claim HHA Total Visit Count

Effective with Version H, the count of the number of HHA visits as derived by CWF.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991) using the CWF derivation rule (units associated with revenue center codes 042X, 043X, 044X, 055X, 056X, 057X, 058X, and 059X. Value '999' will be displayed if the sum of the revenue center unit count equals or exceeds '999'.

NOTE2: Effective 7/1/99, all HHA claims received with service from dates 7/1/99 and after will be processed as if the units field contains the 15 minute interval count; and each visit revenue code line item will be counted as ONE visit. This field is calculated correctly; but those users who derive the count themselves will have to revise their routine. NO LONGER IS THE COUNT DERIVED BY ADDING UP THE UNITS FIELDS ASSOCIATED WITH THE HHA VISIT REVENUE CODES.

3 DIGITS SIGNED

DB2 ALIAS: HHA_TOT_VISIT_CNT
SAS ALIAS: VISITCNT
STANDARD ALIAS: CLM_HHA_TOT_VISIT_CNT
TITLE ALIAS: HHA_TOT_VISITS

EDIT -
RULES +999

SOURCE:
CWF

QLFYTHRU

NCH Qualify Stay Through Date

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

DSCHRGDT

NCH Beneficiary Discharge Date

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

AT_NPI

Claim Attending Physician NPI Number

On an institutional claim, the national provider identifier (NPI) number assigned to uniquely identify the physician who has overall responsibility for the beneficiary's care and treatment.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, NPIs, OSCAR provider numbers, etc.) on the standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 – 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number.

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

SAS ALIAS: AT_NPI
STANDARD ALIAS: CLM_ATNDG_PHYSN_NPI_NUM

ORGNPINM

Organization NPI Number

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

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, NPIs, OSCAR provider numbers, etc.) on the standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 – 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number.

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

SAS ALIAS: ORGNPINM
STANDARD ALIAS: ORG_NPI_NUM

DGNSCD{x}

where { x } ranges from 1 to 10

Claim Diagnosis Code

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{x}
TITLE ALIAS: DIAGNOSIS

EDIT-RULES:
ICD-9-CM

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

RLTCND{x}

where { x } ranges from 1 to 30

Claim Related Condition Code

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{x}
SYSTEM ALIAS: LTCOND
TITLE ALIAS: RELATED_CONDITION_CD

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

CODES:
REFER TO: CLM_RLT_COND_TB
IN THE CODES APPENDIX

SOURCE:
CWF

OCRCCD{x}

where { x } ranges from 1 to 30

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{x}
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}

where { x } ranges from 1 to 30

Claim Related Occurrence Date

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

For the Limited Data Set Standard View of the HHA files, the claim related occurrence date is coded as the quarter of the calendar year when the related occurrence occurred.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_RLT_OCRNC_DT

SAS ALIAS: OCRCDT{x}

STANDARD ALIAS: CLM_RLT_OCRNC_DT{x}

TITLE ALIAS: RLT_OCRNC_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

SOURCE:

CWF

VAL_CD{x}

where { x } ranges from 1 to 36

Claim Value Code

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

DB2 ALIAS: CLM_VAL_CD

SAS ALIAS: VAL_CD

STANDARD ALIAS: CLM_VAL_CD

SYSTEM ALIAS: LTVALUE

TITLE ALIAS: VALUE_CD

CODES:

REFER TO: CLM_VAL_TB

IN THE CODES APPENDIX

SOURCE:

CWF

VALAMT{x}

where { x } ranges from 1 to 36

Claim Value Amount

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{x}

TITLE ALIAS: VALUE_AMOUNT

EDIT-RULES:

+9(9).99

SOURCE: CW

RVCNTR{x}

where { x } ranges from 1 to 45

Revenue Center Code

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{x}

SYSTEM ALIAS: LTRC

TITLE ALIAS: REVENUE_CENTER_CD

CODES:

REFER TO: REV_CNTR_TB
IN THE CODES APPENDIX

SOURCE:

CWF

REV_DT{x}

where { x } ranges from 1 to 45

Revenue Center Date

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 Limited Data Set Standard View of the HHA files, the date applicable to the service represented by the revenue center code is coded as the quarter of the calendar year when 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
STANDARD ALIAS: REV_CNTR_DT
TITLE ALIAS: REV_CNTR_DATE

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

SOURCE:
CWF

APCPPS{x}

Revenue Center APC/HIPPS Code

where { x } ranges from 1 to 45

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

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

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

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

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

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

CODES:
REFER TO: REV_CNTR_APC_TB
IN THE CODES APPENDIX

SOURCE:
CWF

HCPSCD{x}

where { x } ranges from 1 to 45

Revenue Center HCFA Common Procedure Coding

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

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

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

CODES:

REFER TO: CLM_HIPPS_TB
IN THE CODES APPENDIX

COMMENT:

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

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

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

Level I

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

MDCD1_{x}

where { x } ranges from 1 to 45

Revenue Center HCPCS Initial Modifier Code

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 first modifier to the procedure code to enable a more specific procedure identification for the claim.

DB2 ALIAS: REV_HCPCS_MDFR_CD

SAS ALIAS: MDCD1_{x}

STANDARD ALIAS: REV_CNTR_HCPCS_INITL_MDFR_CD

TITLE ALIAS: INITIAL_MODIFIER

EDIT-RULES:

Carrier Information File

COMMENT:

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

SOURCE: CWF

MDCD2_{x}

where { x } ranges from 1 to 45

Revenue Center HCPCS Second Modifier Code

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

DB2 ALIAS: REV_HCPCS_2ND_CD

SAS ALIAS: MDCD2_{x}

STANDARD ALIAS: REV_CNTR_HCPCS_2ND_MDFR_CD

TITLE ALIAS: SECOND_MODIFIER

EDIT-RULES:

CARRIER INFORMATION FILE

COMMENT:

Prior to Version H this field was named: HCPCS_2ND_MDFR_CD. With Version H, a prefix was added to denote the location of this field

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

SOURCE:
CWF

MDCD3_{x}

Revenue Center HCPCS Third Modifier Code

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

MDCD4_{x}

Revenue Center HCPCS Fourth Modifier Code

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

MDCD5_{x}

Revenue Center HCPCS Fifth Modifier Code

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

PMTTHD{x}

Revenue Center Payment Method Indicator Code

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

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

DB2 ALIAS: REV_PMT_MTHD_CD
SAS ALIAS: PMTTHD{x}
STANDARD ALIAS: REV_CNTR_PMT_MTHD_IND_CD
SYSTEM ALIAS: LTPMTHD
TITLE ALIAS: PMT_MTHD

CODES:
REFER TO: REV_CNTR_PMT_MTHD_IND_TB
IN THE CODES APPENDIX

SOURCE:
CWF

DSCTND{x}

Revenue Center Discount Indicator Code

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

PCKGND{x}

Revenue Center Packaging Indicator Code

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

PRICNG{x}

Revenue Center Pricing Indicator Code

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

OTAF1_{x}

Revenue Center Obligation to Accept As Full (OTAF)

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

IDENDC{x}

Revenue Center IDE, NDC, UPC Number

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

RVUNT{x}

Revenue Center Unit Count

where { x } ranges from 1 to 45

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

A quantitative measure (unit) of the number of times the service or procedure being reported was performed 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

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

EDIT-RULES:
+9(9).99

EFFECTIVE-DATE: 10/01/1993

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

SOURCE:
CWF

<i>RVBLD{x}</i>	<i>Revenue Center Blood Deductible Amount</i> <i>This field is no longer populated as it is unavailable from the data source.</i>
<i>RVDTBL{x}</i>	<i>Revenue Center Cash Deductible Amount</i> <i>This field is no longer populated as it is unavailable from the data source.</i>
<i>WGDJ{x}</i>	<i>Revenue Center Coinsurance/Wage Adjusted</i> <i>This field is no longer populated as it is unavailable from the data source.</i>
<i>RDCDCN{x}</i>	<i>Revenue Center Reduced Coinsurance Amount</i> <i>This field is no longer populated as it is unavailable from the data source.</i>
<i>RVMS1_{x}</i>	<i>Revenue Center 1st Medicare Secondary Payer Paid</i> <i>This field is no longer populated as it is unavailable from the data source.</i>
<i>RVMS2_{x}</i>	<i>Revenue Center 2nd Medicare Secondary Payer Paid</i> <i>This field is no longer populated as it is unavailable from the data source.</i>

RPRPMT{x}

Revenue Center Provider Payment Amount

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

RBNPMT{x}

Revenue Center Beneficiary Payment Amount

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

PTNRSP{x}

Revenue Center Patient Responsibility Payment Amount

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

REVPMT{x}

Revenue Center Payment Amount

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

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.

(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').

(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).

9.2 DIGITS SIGNED

DB2 ALIAS: REV_TOT_CHRG_AMT

SAS ALIAS: RVCHRG{x}

STANDARD ALIAS: REV_CNTR_TOT_CHRG_AMT

TITLE ALIAS: REVENUE_CENTER_CHARGES

EDIT-RULES:

+9(9).99

COMMENT:

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

SOURCE:

CWF

RVNCVR{x}

where { x } ranges from 1 to 45

Revenue Center Non-Covered Charge Amount

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}

where { x } ranges from 1 to 45

Revenue Center Deductible Coinsurance Code

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:

TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD

CODES:

REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB
IN THE CODES APPENDIX

SOURCE:

CWF